CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

NOVEMBER 1982 VOL. IX, NO. 3

PRESIDENT'S MESSAGE

Elsewhere in this issue of the newsletter an esteemed senior neurosurgeon, Dr. J. Garber Galbraith, presents a clear enunciation of the role of neurosurgeons in performing carotid endarterectomy. Position papers such as this are demanded by these times of increasing interdiscipline competition and "turf" infringement. Vascular surgeons have been particularly active in staking out territory previously assumed to belong, at least jointly, to neurosurgery. For example, recently one of our members who is qualified to perform carotid endarterectomy was denied privileges for the procedure until he satisfied somewhat unreasonable demands of the Hospital Board, dominated by the vascular surgery section. CANS is assisting in his rebuttal.

CANS certainly deplores any opinion which might begin to consider carotid endarterectomy, or indeed any neurovascular procedure as being outside the scope of neurological surgery. Surgical neurology has always been involved in aspects of the stroke syndrome, to include: the history, physical examination, angiography, aneurysm management, intracranial clot evacuation, carotid endarterectomy, A-V malformation and fistula management, surgical transposition of extracranial vessels, intracranial sepsis, and extracranial-intracranial arterial bypass.

The first internal carotid artery thrombectomy was indeed performed by a neurosurgeon, Dr. Kenneth Strully, and the account was published in the Journal of Neurosurgery in 1953. It should be noted that this was prior to Eastcott, Pickering, Rob and De Bakey's cases. Many of the larger series of carotid endarterectomy have been done at centers wherein the operation is performed exclusively by neurosurgeons.

Studies comparing the results of procedures done by neurosurgeons or vascular surgeons (not general surgeons) reveal no differences in morbidity or mortality. The technique itself is rather straight forward. The key to a low risk endarterectomy is proper selection of the candidate, proper timing of the operation, and meticulous attention to detail with gentle handling of the tissue. These latter requirements have always been the neurosurgeon's "stock-in-trade".

Vascular surgeons state that carotid endarterectomy is in their surgical repertoire since the carotid is a blood vessel. However, the organ which that blood vessel supplies, namely the brain, is complex; the suggestion that one needs special training to evaluate and treat dysfunction of that organ is doubtless, superfluous, in the concept of the vascular surgeon.

Now, with the advent of various cerebral bypass procedures, the stroke surgeon who is only able to perform carotid endarterectomy is much like someone rowing with only one oar. Perhaps it is not too early to ask: Why are the vascular surgeons performing carotid endarterectomy?

CANS has formed a new committee to help illuminate and intercede in those problem areas of practice encroachment and consumer unawareness. Termed the "Public Education Committee", its task will be to explain just what neurosurgery is to the public, other medical specialties, and even to our own neurosurgical colleagues. By developing position papers, guidance for dealing with the media on certain topics, public service announcements, and speakers bureaus, we hope to elevate our medical profile. Some of this endeavor will be accomplished by input to our national associations. However, to date these latter organizations have been less than successful. Much must be done on a local or state level. The upcoming negotiations mandated by AB 3480 are a good example of impetus for local action. These negotiations for fee structures can not be settled on a national scope. In the thicket of oncoming interdiscipline competition, perhaps the best "defense of the turf" will come from "the grass roots".

Douglas M. Enoch, M.D.
President

CANS 1983 ANNUAL SESSION PEBBLE BEACH LODGE

The next Annual Session of the California Association of Neurological Surgeons, Inc., will be held February 25-27, 1983, at The Lodge at Pebble Beach. The program is designed to inform CANS members on the forthcoming "Negotiation of Fees" by insurance carriers as provided by AB 3480 and AB 799. Key speakers will describe reasons for the legislation and experts will advise about coping with various problems. This session will be open to all members, applicants, non-member California neurosurgeons and guests. Information regarding the session will be provided on a continuing basis.

EDITORIAL — GOLDEN GOOSE OR ALBATROSS?

There is a new day dawning in the State of California relative to the reimbursement by third party insurance companies for medical and surgical care provided by hospitals and physicians. It is extremely interesting because before all of the proposed processes are finally delineated, there will be some revealing reactions from those who didn't really know what they were doing.

At present, we are seeing a new law, AB 3480, passed through the State Legislature in a hurried series of closed sessons and signed by the Governor before most hospitals or doctors knew what was happening. The new concept of "negotiated contract" for medical and surgical care is the most radical medical innovation ever enacted in the United States of America. It is justified by the reaction of State Legislators that <u>something must be done</u> to satisfy the pressures from government Medicare and Medi-Cal, insurance companies and labor for reducing medical costs. The general concept for action is that the medical world, hospitals and doctors, have created a golden goose that lays eggs only for them.

There is no recognition of the progressive escalation of medical costs that has developed through increased labor costs in hospitals and in doctors' offices, as well as the tremendous burden of malpractice insurance that has been generated by the legal profession that simultaneously dominates the State Legislature. There is no comprehension of the demand of the average patient for all of the complete diagnostic and therapeutic procedures that are, in themselves, extremely expensive but must be available, or the patient goes elsewhere.

One would normally assume that the average member of the California State Legislature, studying AB 3480, would want to have full ventilation of all of the problems of medical costs with appropriate groups, such as representatives of California hospitals and California physicians and surgeons. But nothing of this sort took place.

The State of California Legislature and the Governor have plotted a course that might be not greatly different from that of the Ancient Mariner who met his come-uppance with the albatross around his neck. Review of the epic by Samuel Coleridge might be helpful for the State legislators in evaluating what they have enacted, contrary to the best interests of their fellow citizens. One wonders if the retiring governor could care less. Basic truths and long-term concepts haven't changed very much since "The Rime of the Ancient Mariner" was published well over a hundred years ago.

Probably the reaction of so-called "labor" will be most important to watch. Labor unions have been fighting for a hundred years to resist "divide and conquer" techniques. If a large contractor were to enter a trade union hall and offer "negotiated" wages for a specific job, it would be no different from a medical insurance carrier contracting with a hospital or a doctor to provide care at the cheapest possible rate. It is inconceivable that labor unions really understand the basic issues involved. Possibly they should look at Warsaw and Gdansk, where all professional groups were neutralized before labor was finally suppressed.

it is true that there have been some abuses in charges for hospital care and for medical or surgical services. But this has not been the widespread status of a Golden Goose, such as many agitators try to advertise. Hospital books and financial accounting are wide open. Civilian hospitals are so much more efficient than government hospitals that the government will not allow any comparison, and will not even allow the Medicare or Medi-Cal restrictions to be applied to governmental hospitals. This should tell the Legislature something. Let us not be coy or uninformed. Good medical care is expensive. Negotiation should be in the direction of maintaining efficiency, rather than obtaining cheaper care without concern for standards. The law AB 3480 enacted in California is a new bird that will spread its wings in unpredictable experimental flight, but will probably return as an albatross for those who thought they were hatching an egg from their misconception of a medical Golden Goose.

Frank P. Smith, M.D.
Editor

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.

CMA VERSION OF AB 3480

The CMA version of AB 3480, which is now California State Law, authorizes contractual negotiation of insurance companies with hospitals and physician providers of medical and surgical care.

It is the legal counsel's opinion that the Legislature intended to allow commercial insurers and Blue Cross to do the following two things: (1) Negotiate "and enter into contracts for alternative rates of payment" and "offer the benefits of such alternative rates to insureds" who select contracting providers. CMA legal counsel believes that it is intended to mean "discounted rates" or preferred provider arrangements.

(2) The second provision added to the insurance code appears to go even further in allowing insurers to establish and control arrangements for the provision of care. The insurance industry's intent in seeking the second provision was to obtain authorization to pay only contracting providers (closed panels).

There have been two so-called "trailer bills" to obviate gross abuses, but to date, it is impossible to predict how any protection can be provided by so-called "trailer bills" in reference to the most dramatic change that has been provided by the State Legislature in reference to medical care provided by hospitals and professional care provided by physicians and surgeons since the very beginning of medical care.

WHO SHOULD DO CAROTID SURGERY?

Patients presenting with symptoms suggestive of cerebral vascular insufficiency require a neurologically oriented approach. The differential diagnostic possibilities in such cases are largely intracranial problems (tumor, hematoma, seizure disorder, etc.). The surgeon trained in general surgery is often poorly equipped to perform this evaluation. The indications for carotid surgery are primarily neurological. One does not operate simply because a vascular lesion is present.

Operations upon the carotid entail specific risks to the brain. A thorough knowledge and awareness of the pathophysiology of the cerebral circulation is essential if one is to properly safeguard brain function during such operations.

The potential complications of carotid surgery are mainly neurological. Skill in early recognition and proper management of such problems as cerebral embolism, edema or hemorrhage require specialized neurological and neurosurgical management.

It is readily recognized that the general vascular surgeon is admirably equipped to perform the technical procedure of carotid endarterectomy. However, for the reasons listed above, it is evident that the neurosurgeon is, by training, well prepared to manage this disorder in all of its aspects. The technical aspects of carotid reconstructive surgery can be performed equally well by either the vascular surgeon or by the neurosurgeon who trains in a program where this type of surgery is an integral part of the neurosurgical practice.

Recent years have seen a marked change in the field of carotid occlusive disease. The Joint Study Report of 1968 listed a series of 3,778 cases with symptoms of cerebrovascular insufficiency who underwent 4-vessel cerebral angiography. The distribution of carotid lesions was as follows:

Accessible lesion only	41%
Inaccessible lesion (distal carotid)	6%
Carotid occlusion	16%

Today cerebral revascularization surgery encompasses the management of all three categories of carotid lesions. They all present in similar fashion and depend on angiography for their separate delineation. The neurosurgeon who is trained to perform carotid reconstruction and extracranial-intracranial bypass surgery is best equipped to deal with carotid occlusive disease in all of its aspects.

Currently general surgeons doing carotid surgery in community hospitals in our area are endeavoring to make this procedure their exclusive domain. It is difficult or impossible for a well-trained neurosurgeon to obtain surgical privileges for carotid surgery. Unfortunately the term "vascular surgery" is all-encompassing and would tend to support this trend toward restriction of privileges to this group alone. Perhaps another term, such as special competence in "peripheral vascular surgery" or "general vascular surgery", would be more appropriate and less threatening to surgical specialists who do vascular surgery relating to the organ system with which they deal.

J. Garber Galbraith, M.D.

EXCHANGE OF CORRESPONDENCE

Correspondence with Senator John Garamendi, Majority Leader of the California State Senate, Regarding AB 3480.

At the request of your CANS President, Douglas M. Enoch, M.D., your Secretary wrote to various key members of the California Legislature concerning AB 3480 and the urgency for passage of the so-called trailer bill SB 2012. Copy of the correspondence is printed for your information, particularly in reference to the comments by Senator Garamendi in the latter part of his letter. Hopefully, we will "not have the situation that gets out of hand."

To The Legislative Conference Committee of the State of California, regarding AB 3480 — A Negative Reaction.

August 23, 1982

The passage of AB 3480 through the California Legislature is possibly understandable as a means of providing lower cost for health care through negotiation of payment for services rendered to insured members of various health coverage units. However, from a practical standpoint, this involves the possibility of practices which would be repugnant to both the physician providing the care, and to the patient receiving the care.

There is no substitute for good medical care. It has become somewhat expensive because of the increased labor costs associated with hospital care. In past years, nurses and other dedicated workers have actually been subsidizing medical care through their very low wages. Now that nurses, nurses aides and various hospital attendants have been brought into a more realistic wage scale, the cost of hospital care has risen to a relatively high level. Fees charged by physicians and surgeons have increased to a certain extent, but have not kept pace with the income developed by tradesmen such as plumbers, electricians and carpenters.

Now, apparently the hastily passed AB 3480 would offer the opportunity to insurance companies for negotiating cut-rate services with those who might be willing to provide what would have to be a type of inferior care. This type of invasion of services would never be allowed by the unions that govern the wage level of union workers. This law, AB 3480, would be not much different from a law which could allow contractors to hire various union workers of the trades to come in and work for wages that they might offer. Such a law invading the trade unions would send every plumber, carpenter and electrician out on strike in about twenty minutes.

It should be kept in mind that the cost of medical care has been accelerated by factors beyond the control of those who provide the medical care. The average hospital finds that the major part of its annual budget is allocated for paying wages to the nurses, ward secretaries, nurses aides, and the various people who keep the hospital going. The various protective expenses that have been necessary have greatly inflated the cost of medical care because of the lawsuits that have been directed by attorneys against hospitals. The threat of a major lawsuit is a very expensive issue for the average hospital.

The physician practicing in California must guard himself with excessive malpractice insurance. This is an extremely expensive issue for surgeons, and particularly in certain specialties. It seems quite unlikely that an ethical specialty surgeon could lower his current rates to provide a "negotiated contract" with an insurance carrier, because a well qualified surgeon, under the proper circumstances, is actually following a program of decreased net income. Most surgical specialties are having a problem with excessive manpower, so that the average specialist is now having a problem balancing his budget. Possibly it is on this basis that the law AB 3480 was designed to provide a "hunting" type of arrangement, whereby the insurance carriers would be able to seek out those specialists who are willing to provide services at any rate. This is a very bad solution to a problem which is already reaching an element of settlement. Surgical fees are levelling off at an appropriate level, and will undoubtedly be adjusted to a realistic level as time goes on. There is no opportunity for insurance carriers to think that they can get highly skilled medical services at cut rate levels, any more than they could succeed in getting the plumbers, carpenters and electricians to go back to payment of five to eight dollars per hour. It just wouldn't work.

There is always a compromise to a problematic situation. It would be appropriate for insurance carriers to look for a proper fee schedule, such as has been designed by the Blue Shield insurance program. There is no great mystery or difficult accomplishment in reference to providing an adequate fee schedule for services rendered. By the same token, it is highly inappropriate for insurance carriers, through their great lobby interests, to push through the bill AB 3480, since the fulfillment of this would only serve to ruin the type of medical care and services that the insurance carriers should theoretically be interested in providing. In summary, the members of the California State Legislature should make every effort to either repeal AB 3480, or support SB 2012, which is designed to "clean up" the various problems created by AB 3480. It is not acceptable that the legislature of our State could enact a law which would seriously deteriorate the care of patients suffering from medical problems through techniques that could be used by various insurance carriers which would be entirely unacceptable in areas of service provided by such specialized groups as carpenters, electricians, masons and plumbers. If the same principles as provided by AB 3480 were applied to all types of trades and professional groups in the State of California, there would be a complete loss of life as we know it now, in reference to our social and economic well being. The warning may sound incredible, but by the same token, all great societies or cultures that finally disappeared, failed to heed the warning signs. The units remaining strong have been alert to problems that lead to deterioration.

Frank P. Smith, M.D.

To Frank P. Smith, M.D., from Senator John Garamendi, California State Senate.

October 1, 1982

Frank P. Smith, M.D.
880 Cass Street, #101
Monterey, CA 93940

Dear Dr. Smith:

I appreciate hearing from you concerning the closed-panel option for health care insurance plans which was embodied in Assembly Bill 3480.

By now, you are probably aware that on August 31, the Legislature passed a trailer bill to AB 3480. The trailer bill was Senate Bill 2012.

SB 2012 amends the Insurance Code to guarantee patient access to medical care, and provides for third-party peer review. SB 2012 also enacts other protections designed to insure that closed-panel health insurance contracts are implemented in a safe and prudent manner.

These amendments were proposed by the California Medical Association and the United Foundation for Medical Care.

Additional amendments were proposed by CMA and UFMC but were not adopted because they would have severely curtailed the closed panel option which was authorized by AB 3480.

As you undoubtedly know, there has been considerable speculation surrounding the real-world implications of AB 3480. On the one hand, some physicians argue that it may be the beginning of the end for fee-for-service medicine and patient freedom of choice. On the other hand, some insurance companies argue that the importance of AB 3480 has been grossly overexaggerated and changes will be slow, if not imperceptible.

The reaction from the medical community has been mixed. A number of physicians welcome AB 3480 as an opportunity to compete in the market place on the basis of price and quality. Other physicians are concerned that the principle of freedom of choice is threatened by AB 3480 and that patients will seek care on the basis of cost—not adequate health care.

Of course, the results are not known and will not be for some time. If any lesson has been learned, it seems to be that medicine, as well as all other services, must be responsive to economic pressures. AB 3480 was not conceived from thin air. The ever rising health care costs created economic pressures which activated influential groups of business, labor, senior citizens, and taxpayers who, in concert demanded that some new approach to control medical costs be inacted. Hence, AB 3480 was conceived and became law.

It may very well be that AB 3480 will, in time, moderate the increasing cost of medicine by fostering increased competition. It is conceivable, however, that the impact of AB 3480 has been overstated. Some believe that the principle of freedom of choice is so strongly held that large numbers of consumers will be willing to pay the higher premium for this form of insurance.

I don't know the answer. But I do know that the Legislature intends to monitor the situation to make sure that we do not have a situation that gets out of hand.

Thank you for your correspondence. It is important that your opinion be expressed.

Sincerely,

John Garamendi

California Association of Neurological Surgeons, Inc.

P.O. Box 41761, Sacramento, CA 95841
(916) 966-9760

November 22, 1982

Dear Colleague:

Recently enacted "contracting" legislation (AB799, AB3480, SB2012) provides for negotiated contracts between physicians and third party payers beginning July 1, 1983. The far-reaching ramifications of this are explained in detail in the recently mailed special issue of CMA News. Current information can be obtained by calling a 24-hour toll free "hotline" 800-242-2020.

The impact of these laws will have far greater effect on the private practice of medicine than any other recent development. Physicians will be coalesced into groups providing stratified "efficient" care to private and non-private patients alike, at "preferred" rates.

Understandably, physicians have reacted to this perceived threat to quality of care through economic exploitation with feelings of confusion, fear, anger and frustration. Our advice for the moment is do not panic. There is little to be gained and much to be lost by the premature precipitous and injudicious execution of negotiated contracts with insurance companies, hospitals and other health care organizations.

The leadership of the California Association of Neurological Surgeons has dedicated its resources to this problem. A special task force is being formed to review the various options, which will be available to neurosurgeons in order to protect the integrity of their clinical practice. It is hoped that a definitive stratagem will have been developed in time for presentation at our Annual Meeting in February 1983. In the meantime, we will keep you apprised of new developments.

CANS
Task Force on Negotiations

REPORT ON CSNS AND JSEC MEETINGS IN TORONTO, CANADA, PRIOR TO ANNUAL MEETING OF THE CONGRESS OF NEUROLOGICAL SURGEONS

It was extremely interesting that as the quadrant sections of the Council of State Neurosurgical Societies met in caucus on the evening of Friday, October 1, 1982, the primary subject of interest in the session of the Southwest quadrant, which includes California, was that of the possible "burned out syndrome" in reference to all of us coming twice a year to these sessions and talking about the same issues without having any specific solution. There were enough elements of encouragement to indicate that we should continue, and the final conclusion was that if the basic problems of practicing neurosurgeons around the country do not get more consideration and some evidence of action in the two major societies, namely the AANS and the CNS, that the Council of State Neurosurgical Societies may rise into a more prominent and powerful status. There were some sobering remarks from those who indicated that many of the State societies have lost interest, and possibly would not be active in this type of organization. There were also comments that the forthcoming issues of socio-economic nature may serve to activate the various states that have not been participating in the program to this time.

The meetings on Saturday morning, October 2, 1982, were highlighted by the report from our California delegation as given by Dr. Doug Enoch. He described the impending crisis relative to the new legislation in the State of California authorizing insurance carriers to conduct contractural negotiations with hospitals and doctors relative to providing medical care. This report provided an element of surprise to most of those attending the meeting, and there was considerable concern about possible ramifications.

In the afternoon of the same day, a report on neurosurgical manpower was given by Dr. Frank P. Smith, Chairman of the Subcommittee on Manpower. This report involved the recommendation for a resolution to the main body of JSEC that a resolution be passed to ask the Board of Directors of AANS to establish a liaison committee between neurological surgery, orthopedic surgery and neurology, to study the possibilities of limiting the training of residents in all three areas. After much discussion, a resolution was finally made, seconded and passed along these lines. The general intent of this proposed motion was that a broad level of consideration be given to the current programming of residents being trained in various surgical and neurological specialties, so that we would not be promoting a reduction in neurosurgical residents alone.

As a secondary part of the report of the Subcommittee on Manpower, a recommendation was made for extending a questionnaire to members of the AANS and CNS as to their opinion relative to two matters, namely whether or not neurosurgeons were performing fewer major neurosurgical procedures, and whether or not it was felt that there should be some reduction in the numbers of neurosurgical residents being trained. After much discussion, this type of questionnaire was approved, with the addition that there should be some designation as to the home state of the person answering the questionnaire. It should be noted that the person answering the questionnaire was also asked to identify whether or not he was practicing at an academic level, in community practice, or in a mixed type of arrangement. The general concept of the Subcommittee on Medical Manpower was that this type of questionnaire might possibly provide us with some so-called "hard data" as to the feeling of neurosurgeons in reference to whether or not their surgical practice is diminishing, and whether or not they feel this is related to the numbers of neurosurgeons being released each year from training programs.

The program presented on Sunday, October 3, 1982, extended from 7:30 a.m. to 5:00 p.m. and involved various subcommittee reports as well as a very important "negotiations seminar" which provided much background information and proved to be quite timely in reference to the potential crisis that may be developing in the State of California in reference to the relatively new legislation involved with AB 3480. At the conclusion of the sessions, it was fully agreed by all that we are still faced with the same problems that have been discussed in the past ten years or more, and that the solutions are going to become more and more difficult as we are faced with the tremendous pressures from various agencies to decrease the cost for medical care.

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.

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 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.

PROPOSED CHANGES OF CANS BY-LAWS

(As approved by the Board of Directors and to be presented for vote at the Annual Meeting, February 25 - 27, 1983

ABSTRACT: The proposed changes provide:

1. A new category of Inactive Membership
2. Expediency in securing delegates to JSEC meetings whenever elected delegates are unable to attend.

Revision of Section 3.02, to be listed as follows:

THE CATEGORIES OF MEMBERSHIP OF THE ASSOCIATION ARE AS FOLLOWS: HONORARY, ACTIVE, ASSOCIATE, INACTIVE, SENIOR AND JUNIOR

Insertion of new — Section 3.03-3

INACTIVE: AN ACTIVE MEMBER OF THE ASSOCIATION MAY APPLY TO THE BOARD OF DIRECTORS FOR A PERIOD OF INACTIVE MEMBERSHIP, SUCH AS: FOR PLANNED MILITARY SERVICE FOR A SPECIFIC PERIOD, OR WITHDRAWAL FROM NEUROSURGICAL PRACTICE FOR A GIVEN INTERVAL, NOT TO EXCEED ONE YEAR, SUBJECT TO REQUEST FOR RENEWAL. DUES SHALL BE RESCINDED DURING INACTIVE MEMBERSHIP.

Revision of Section 8.08 — Joint Socio-Economic Committee

Deletion of last sentence paragraph 2 and replace with:

THE DELEGATION SHALL ANNUALLY ELECT A CHAIRMAN FROM ITS MEMBERSHIP. THE PRESIDENT IS EMPOWERED TO APPOINT SUBSTITUTE DELEGATES, PRO TEM, TO REPLACE ELECTED DELEGATES WHO FIND IT IMPOSSIBLE TO ATTEND CERTAIN JSEC MEETINGS.

Frank P. Smith, M.D.
Secretary

CMA MEDICAL EXECUTIVES MEMO NO. 911

Many California Physicians have been appointed to AMA's panel that answers medical-practice questions. The new Diagnostic and Therapeutic Technology Assessment (DATTA) project evaluates the safety and effectiveness of a given procedure or therapy in light of the current state of knowledge. The following members of CANS have been selected to serve on this important project: Drs. James B Golden, Philipp M. Lippe and Byron C. Pevehouse.

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