CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

OCTOBER 1988 VOL. XV, No. 3

PRESIDENT'S MESSAGE

"RECERTIFICATION"

by DeWitt B. Gifford, M.D.

Why would anyone title a message with a word that is anathema to 98% of his readers? Recertification is an idea that has been voted down again and again at every level, both in our own state and nationally, but like the cat with nine lives, it just won't seem to go away. The American Board of Neurosurgery is again discussing its proposals for recertification, and our own Representative, Fortney Stark, has introduced legislation in Congress which would require this for all physicians, at least every seven years. No matter how much we downplay this, lay people continue to believe that recertification is an effective and reasonable method for assuring the competence of their specialist physicians.

What has been found wrong with this idea in the past? The most obvious defect is that we have never achieved a satisfactory definition of what primary certification stands for. After nearly fifty years, our Board Certification still carries little or no clout in terms of credentialing,staff privileges, or reimbursement. If we move to recertify, we must also deal immediately with the problem of the 350 to 400 neurosurgeons who are more than five years out of their residency and have never passed the Board exam. Any recertification program will severely tax the capacities of the American Board of Neurological Surgery, which has a hard time recruiting the manpower and the time to conduct its present operations. Finally, and most seriously, we conduct our primary certification programs as if every neurosurgeon should know every aspect of neurosurgery. It is clear, however, that after time has elapsed, many neurosurgeons no longer include in their practice pediatric, or cerebrovascular, or trauma, or aneurysm surgery, etc. How can we expect them to maintain competence in those areas and be prepared for an examination in them?

It is clear to most neurosurgeons who have thoughtfully examined the problem that a multiple-guess examination is no real measure of competence in a field as complex as neurosurgery. What we, along with the rest of medicine are moving towards, is a genuine analysis of outcomes and of process which will eventually enable every neurosurgeon to be judged by what he does and how it works out for his patients, rather than what he knows, or has memorized long enough to pass a test. It is this kind of evaluation that will enable us to conduct honest peer review and meaningful recertification, if and when it ever comes. What we seek now is ideas from all of our members as to how such an ongoing and intensive evaluation could be implemented, given reasonable constraints of manpower, time and money. If we are to have examinations of our competence, let us strive together to make them meaningful ones, to enhance our professional abilities and to to make more rewarding our own and our patients' lives.

HIGHLIGHTS OF JCSNS SESSIONS — SEATTLE, WASHINGTON

DeWitt B. Gifford, M.D.

The JCSNS meeting in Seattle proved to be the shortest and best organized on record, and for once the committee finished all its work in less than the allotted time. Few new issues were introduced at this session, and indeed the major issue that the session had been planned around, the report of the resource-based Relative Value Scale, was delayed in its publication past the time of the meeting. The session was brightened on Saturday by excellent luncheon discussions, particularly the announcement of an outstanding new publications program by Dr. Tindall for the AANS, and a stirring presentation by our Past CANS President, Dr. Melvin Cheatham, of his work as a medical missionary in Africa.

The previous plan to sponsor an investigation of the Hsiao Report was tabled at this time and there has been no development to date of the Trauma Committee. There has been continuing improvement in the management and availability of medical/legal testimony through the AANS file, and members are again encouraged to make use of this where appropriate. The most exciting development of the meeting was a strong vote to develop a national program for the provision of neurosurgical care to the indigent. If this is approved by the Boards, as we are certain it will be, this will be a major step forward for American neurosurgery, and your Association will be moving forward to implement this program in California. The JCSNS continues to receive strong support from both of its parent organizations, and is moving in the development of a long-range plan and ongoing programs, rather than being only a continuing wailing wall.

We look forward to the next meeting in April.

Dr. DeWitt Gifford
President

WHO ARE THE "KAPOS" OF THE TRIAL LAWYERS?

By Peter Dyck, M.D.

Heinrich Himmler's endeavor to fulfill Hitler's genocidal madness would have been even more difficult were it not for the "kapo." Every concentration camp had a prisoner in each barrack who sold his soul for small favors in food rations, greater liberty and even sexual favors. In return, he functioned as an informant to the prison guards and did much of the "dirty" work for them. He suggested prisoners for various projects, including their destruction. He was known as the "kapo," but unknown to his fellow prisoners.

I would like to suggest that we have some individuals in our professional ranks who play a similar role for trial lawyers. These individuals form an alliance with trial lawyers and are financially gratified by entrapping innocent neurosurgeons. I will concede that there is some medical malpractice in a true professional sense, but I suspect that at least 75% of so-called "malpractice" is based on devious and nefarious grounds.

As an illustration, a patient with a serious head injury, respirator-dependent and on Dopamine was found to have perenchymal hematoma. When a well-known state authority on trauma was asked whether the patient's clot should be evacuated, his answer was an unreserved "yes," explaining that otherwise he would be medically negligent. This patient was operated on and died only hours postoperatively. In spite of the surgeon's precautionary measures, a lawyer claimed negligence based on the contention that the surgery should have been done an hour earlier, not at 12:30 a.m.

An example of more specific malice was found while reviewing a deposition. In this case a delayed onset of postoperative facial weakness was glibly explained as, "Your surgeon must have cut the facial nerve." This particular plaintiff's expert is on the faculty of one of our medical schools.

In a statement by the chairman of a neurosurgery department, allegations about another neurosurgeon were made as follows: "He plowed around in the brain. He was lost. He cut cranial nerves." This department chairman also testified that a craniectomy for microvascular decompression of the trigeminal nerve should not exceed 1.5 centimeters and that one should never see other cranial nerves when decompressing CN-V for trigeminal neuralgia. This malicious testimony was disproven at the time of trail, and the verdict was unanimous for the defense.

In another legal action, a "kapo" proposed that if the hypokalemia in a patient with traumatic quadraplegia had been corrected, the patient might have been left with very little neurological defect.

I would like to emphasize that when we rely solely on legal documents and trial testimony, we are viewing only the tip of the iceberg. Much malice and harm is created outside a court setting. About 85% of malpractice cases are settled out of court for an endless array of technical and devious reasons which fall in the category of "nuisance value."

The Canadian Neurosurgical Association has recently included in its by-laws a clause that allows expulsion of a member from the society for medico-legal malfeasance. The AANS has also established a registry by which medico-legal testimony of "kapos" can be logged, but it offers no disciplinary action.

I believe that all suspect testimony should be reviewed by a committee of AANS, and if it is found to breach common wisdom, the guilty party should be expelled from that national society. This will make him an instant persona non grata in the trial lawyers' arena because the dishonesty will have been exposed. By this mechanism alone, we as physicians can dramatically reduce the number of fabricated malpractice suits. In this organized manner, we should be able to identify and rid ourselves of these "kapos" who work at night and, tragically, often in the shade of the groves of academia.■

The California Medical Association's 1989 Annual Session and Western Scientific Assembly Neurosurgery Section — March 4, 1989

Anaheim, California

SUBJECT: Lumbago 1989 — An Ancient Curse with Modern Cures

Moderators: **Martin H. Weiss**, M.D., Los Angeles, Chairman, Dept. of Neurosurgery, USC
Donald J. Prolo, M.D., San Jose, Clinical Associate Professor of Surgery/Neurosurg., Stanford.

8:00 a.m. SOCIO-ECONOMIC PERSPECTIVES IN LOW BACK PAIN
Renee Steele-Rosomoff, BSN, MBA, Adjunct Assistant Professor of Neurological Surgery, Univ. of Miami, Florida

8:25 a.m. CHIEF COMPLAINT: "Doctor, Fix My Aching Back"
Peter Dyck, M.D., Los Angeles, Clinical Professor of Neurosurgery, USC

8:50 a.m. MEDICAL INTERLOPERS: The Arthritides
Rodney Blueston, M.D., Los Angeles, Clinical Professor of Medicine, UCLA

9:15 a.m. CONSERVATIVE TREATMENT: Objectives, choices, results.
Scott Haldeman, M.D., Ph.D., D.C., Neurologist, Santa Ana, Assistant Clinical Professor, Department of Neurology, UCI

9:55 a.m. MYOFASCIAL TRIGGERS OF SCIATICA AND THEIR ARREST
Hubert L. Rosomoff, M.D., Chairman, Dept. of Neurological Surgery, Univ. of Miami, Florida

10:25 a.m. SURGICAL INTERVENTIONS FROM PAPAYA TO FUSIONS
Ulrich Batzdorf, M.D., Los Angeles, Professor, Dept. of Surgery/Neurosurgery, UCLA

11:00 a.m. AN ULTIMATE RECOVERY: The Professional Athlete.
Lindsy McLean, P.T., A.T.C., **Jerry Attaway**, M.S., **Joe Montana**, San Francisco Forty-Niners

12:00 noon ADJOURNMENT

★★★★★★★★★★★★★★★★★★★★★★★★

ANNUAL SESSIONS - CANS
The Lodge at Pebble Beach
January 13-15, 1989

Program begins with the Welcoming Cocktail Party at 6:00 p.m. Friday, January 13, 1989. The sessions on important socio-economic matters will be Saturday and Sunday mornings. A super dinner is arranged for Saturday evenings, preceded by an Open Bar Cocktail party. Don't miss this important time for us neurosurgeons to get together!!

★★★★★★★★★★★★★★★★★★★★★★★★

M.R.I. REPORT: "BULGING DISC"

Frank P. Smith, M.D.

In the late 1970's, we weathered the storm of CT spine scans showing disc problems that did not check out at the time of spinal surgery. Now, the "new kid on the block," MRI, has become a support for various claims for disability above and beyond the call of duty.

Who would ever have supposed that the technological achievement of Magnetic Resonance Imaging would prove to be an "Open Sesame" for those who would wish to make the most of any possible spinal trauma? But, let us look at the current development of claims arising from an interpretation by a radiologist, indicating that the MRI shows some degree of bulging of one or more intervertebral discs. All of this is rendered to the patient and his attorney with the rather reserved disclaimer that there really is no actual rupture of disc. By that time, the patient is already convinced that he has "bulging" pathology, and his attorney equates the problem in direct proportion to his inspiration for his own "bulging" pocketbook.

There has developed a surge for chiropractors to gain access to the MRI. They have learned that in the present milieu of radiological interpretations, there will be description of some degree of "bulging of the annulus" or similar terminology. This, of course, will justify another course of chiropractic treatment, often extending for more than a year. Unfortunately, neither the radiologist nor the chiropractor has the expertise to know whether or not the minimal findings on the MRI have any clinical significance. The patient's attorney is no referee, and can only "go for the gold."

We cannot lay all of this on the doorstep of chiropractors. It is the responsibility of the physicians, namely neurosurgeons and orthopedists, to step in and say to radiologists, "You are building up a hotbed of activity with your innocent interpretations. You know that all working men of 55-60 years of age have various structural changes in the spine, not necessarily related to trauma. You know, or should know, that intervertebral discs can show some indentation of cerebrospinal fluid in the T2 image, without relating to a recent auto accident or WCAB episode."

It does seem essential to quote an example of the problem that has come across my desk recently. This is in reference to a lumbar MRI of a patient whom I have examined and found to be completely free of any neurosurgical problem. After various comment in the body of the MRI report, the radiologist states in his Impression:

" 1. Moderate bulging of the L4-5 disc. "
" 2. Mild bulging of the L5-S1 disc. "
" 3. Mild spinal stenosis of the L4-5 level. "
" 4. Slight loss of height and moderate desiccation of the L4-5 disc. "
" 5. No evidence of herniated nuculus pulposus on this study is identified. "

The tacked-on disclaimer is interesting, but ineffective. The report, as I have quoted, was enough to convince the patient that he has a serious disc problem.

He has assured me that he feels that his working days are finished. Anyone can estimate how his attorney feels impelled to pursue all possible recovery, at a considerable cost to the system.

This clinical "connection" has developed innocently, but must come under circumspect analysis and control. We must develop clarity in writing MRI reports that will indicate whether or not the findings are within the range of normal for the age of the person having the study. We cannot condone terminology that encourages a very expensive study on all those reporting trauma, where the findings, though miniscule, serve to escalate the cost of medical care. Of course, this invites more and more MRI studies. Possibly the State Society of Radiology would be willing to look into the matter for developing realism in terminology.

It is with deep sorrow we inform our members of the death of Dr. Edwin Barkley Boldrey in San Francisco on June 6, 1988, six weeks before his 82nd birthday. A memorial service was held at the University of California Medical Center, San Francisco on June 23, 1988. Dr. Boldrey will be greatly missed. The Annual Session in Carmel in January 1989 will be dedicated to the memory of this founding member.

NEW PEDIATRIC NEUROSURGICAL ASSOCIATION

Announcement has been received by **CANS** relative to the organization of the California Neurosurgical Association for Pediatrics. Current issues of pediatric neurosurgical importance are being addressed by the Association which is composed of neurosurgeons dedicated exclusively to the practice of pediatric neurosurgery in California.

Hector E. James, M.D.
CANAP Secretary
7930 Frost Street
San Diego, CA 92123

LETTERS TO THE EDITOR

Members are invited to participate in the newsletter. Letters will not necessarily represent the opinions of the editorial staff of CANS Board, but will reflect opinions of the membership on pertinent issues. Send your comments to:

Frank P. Smith, M.D., Editor
2740 Fulton Avenue, Suite 208A
Sacramento, CA 95821

California Association of
Neurological Surgeons, Inc.
2740 FULTON AVENUE, SUITE 208A
SACRAMENTO, CA 95821

ADDRESS CORRECTION REQUESTED.