CALIFORNIA ASSOCIATION OF NEUROLOGICAL SURGEONS, INC. NEWSLETTER

SEPTEMBER, 1984 **VOL. X, NO. 5**

PRESIDENT'S MESSAGE

David G. Scheetz, M.D.

In a time of crisis, unity prevails. The team effort needed to combat the medical socio-economic problems is lost when there is no dynamic charge. With the status quo it is "business as usual". One asks, "Why belong to a collection of colleagues, associates and friends?", or, "What's in it for me?" As entrepreneurs of medicine, it may be the selfishness of our economic state that causes us to ask, "Why should I join the California Association of Neurological Surgeons, Inc.?"

The established trust of one dispensing an expensive service or merchandise for a signature, a piece of plastic demands a mutual trust of both parties in completing the transaction. A unit of friends and colleagues can provide protection in the risk-filled environment.

Again, what do we gain from **CANS?** - the common meeting ground of academic and private practice in the nonscientific fight against THEM. Who are THEM? The ever-present third party carriers, our BOSSES, the ones who sign our paychecks. THEM includes hospital administrators and the staff of non-neurosurgically oriented physicians in our communities, with whom there are increasing areas of concern to maintain the right to practice as we were trained. The constant battle for turf-control by the ever-impinging surgical specialties invades the neurosurgical sphere of practice. Once we have defined these areas of concern, the possibility of formulating a plan to engage and develop our position can be accomplished. This is not a bloody war but a day-to-day effort to survive in an ever-changing world of medical practice.

WE ARE NOT ALONE. We try hard to reach the goal of survival in this increasingly competitive field, as do our colleagues in their respective surgical and medical spheres.

WHAT IS A NEUROSURGEON? — WHAT DOES HE DO? How many times have you been approached by a referring physician with a comment, "I didn't know you did that." *That*, being your ability to perform a carotid endarterectomy or a carpal tunnel decompression. Is it time to advertise our expertise on our outgoing letterhead as has been suggested or to list our good and bad results on the Operating Room doors?

CANS can help solve this problem; not *for* you, but *with* you. We ask you to serve yourself through a unit of colleagues and friends who share similar experiences. Offer not only your support, but your ideas and suggestions to make California a better place for the practice of neurosurgery. As the times change, so must we. Whether we practice alone or as a group, an effort must be made to move both with and against the external forces.

CANS can offer evaluation and, if necessary, appropriate support for individual positions in this ever-changing market place. For over ten years the Board of Directors and Executive Committee have acted as the moving force for the practice of neurosurgery in this state. Now, this movement needs involvement of *all* neurosurgeons in California to make this an effective and democratic activity.

CANS is blessed with the best of minds and expertise. We should maximize these resources. All may participate as they wish, and the culmination of this input will be for the best neurosurgical climate possible for all.

In conclusion, what can the California Association of Neurological Surgeons, Inc. do for you? We have the capability to offer review of your area of concern whether it is a colleague involved in a peer issue; a malpractice action or whether it involves a place to practice. The Executive Office of **CANS** in the Sacramento area (Roseville) is staffed and ready to offer prompt response to your inquiries regarding professional problems. We have help available through a network of respected colleagues. Life should have a positive reaction to negative issues, and we offer this to you, through **CANS**. We are planning ongoing courses of continuing medical education at a non-profit cost, as well as holding retreats for mutual reflections to improve our organization, our practices and ourselves. **CANS** will offer informational literature explaining the field of neurosurgery for those who wish to further educate patients and referring physicians.

All of this demands an investment, both in time and in money, but it will be worth it! We will prevail by starting with *ourselves*. □

EDITORIAL
MEDICARE MEDICAL FEE FREEZE
A Punitive Approach

Frank P. Smith, M.D.

The United States Congress has passed, and the President has signed, a massive budget-deficit-reduction bill that includes legislation for a fifteen-month freeze on the customary and prevailing physicians' fees allowed by Medicare. The general concept is not all that surprising, since physicians themselves, through the American Medical Association have already volunteered, some months ago, to hold fees at current levels for at least a year. This legal budgetary omnibus clearly demonstrates what the heavy hand of politicians can do to unsuspecting do-gooders moving down the primrose path. It isn't so much the "freeze" that hurts, but the techniques established to reduce budgetary expenses raise the question regarding the fairness to all concerned.

The new law, retroactive to July 1, 1984, doesn't just fix fees at current levels, but it also orders a classification of physicians as to whether or not they accept "assignment" and then the law provides subsequent penalties for those not accepting "assignment." The "participating physicians" would enter into a one-year agreement to accept the frozen Medicare fees, and thereby qualify for increases in customary fees for future screen updates, as of October 1 of each year. Other incentives would be offered to those complying physicians. However, non-participating physicians could continue to accept "assignment" on a case-by-case basis, but "would be subject to civil fines of up to $2,000 and possible suspension from Medicare for up to five years if they increase their fees during the freeze." (Ref. CME Memo No. 992, July 6, 1984.)

All of the above categorization of physicians into the "bad guys" and the "good guys" by virtue of fee structure runs countercurrent to the ordinary professional practice, whether it is in medicine, law, architecture, or other professions. Certainly a physician should have the free choice of accepting an assigned fee in some cases, and yet render his customary and prevailing fee where justifiable by the patient's economic status, in other cases.

The conditions of the law at present actually enforce a very low standard of payment for medical care provided to the ever-increasing number of senior citizens. The AMA has been described as being disappointed that the law attempts "to coerce physicians into accepting assignment." AMA Executive Vice-President, James H. Sammons, has pointed out that the provisions reward participating physicians, but that "Doctors who choose not to participate 100% of the time, but believe they should make a decision, case-by-case, would thereby be punished by the government." All of this does not sound so great as the recently televised comments of Senator Robert Dole who benevolently commented that the Medicare program should not bother doctors, since there is no enforcement that they must treat Medicare patients. Certainly Senator Dole must realize that physicians do not like to abandon their patients who mature into Medicare status, nor do physicians like to refuse patients relative to a lower fee structure. Senator Dole's comments have a familiar ring to the "Let them eat cake" reaction of the very poorly informed Marie Antoinette.

One should keep in mind that the Medicare program gained adoption because physicians endorsed it. Before Medicare, physicians took care of senior individuals at a lower rate, or for free, whenever economic conditions warranted. In the early years, the Medicare program functioned adequately. Doctors were satisfied to treat senior citizens, and became accustomed to having all services subsidized, balancing their books accordingly. In recent years, two complications have developed: one, the number of senior citizens being treated has greatly increased, and second, the costs of medical care, with new technology and greatly increased hospital costs due to labor requirements. Thus, governmental agencies, Federal, state and county, have all felt the pinch and the need to reduce their budgets for medical care. The obvious target has been medical fees, with budgeteers reducing these to an unrealistic level. This comes at a time when doctors' expenses have risen enormously in terms of office rent, staff salaries, medical malpractice expense and various factors related to continued medical education.

Reduction of governmental payment for medical care to a substandard level does not have approval from senior citizens. Those unable to pay any premium are obviously at the mercy of welfare agencies. Those able to pay the basic premium are concerned that they will have substandard care. The relatively affluent, who are fully able to support their own insurance program above and beyond Medicare are confused as to whether or not they would be able to continue under the care of their own physician in terms of whether or not he might be a participating or non-participating physician. They obviously are interested and concerned about what has happened in Great Britain and other socialized countries.

Mr. Peter F. Drucker, Clarke Professor of Social Sciences at the Claremont Graduate School (CGS) has described how the triage system of the National Health Service of Great Britain has really provided restriction of care to those indigent for whom the plan was originally devised. The process is so slow, particularly for elective operations, that only the wealthy, apart from the system, are able to manoeuvre themselves into the proper care status. Mr. Drucker has stated that the British triage system "brazenly favors the wealthy and penalizes the poor." He adds, "Those who can afford private health insurance do not have to wait, but go immediately to the head of the

queue when it comes to being seen by a specialist or having elective surgery." They have their own ability to pay. There has been a move in Canada to prevent the physician from accepting a fee above the socialized schedule rate. The new regulation for our Medicare seem to be headed in that direction, ultimately.

New laws are always expensive, not only in regard to administration of the new program, but especially in enforcement with regard to any infractions. Just think of the bureaucratic machinery that would be necessary to check on all doctors who did or did not accept assignment for Medicare patients. The punitive axe on some doctors would be filled with errors. This would be accompanied by a punitive effect on patients. One could easily visualize a punitive effect on the Medicare system itself, where unscrupulous "providers" would merely increase the number of services to provide the eventual "take." Abuses of this type have been documented in the low fee system of Medicaid-Medi-Cal.

Politicians want to glorify their benevolence, but sooner or later they must recognize that there is no "free lunch" in medical care of proper standard. Good medical care is an expense item, no different from good food, good housing, or good government. The decision to selectively freeze payments for Medicare, within a bureaucratic framework, is nothing more than an irresponsible and punitive approach, affecting patients, doctors, and those who eventually pay for all governmental programs. □

FORMAT AND SITE SELECTIONS OF ANNUAL SESSIONS OF CANS

Frank P. Smith, M.D.

Born in the heated crisis of medical malpractice issues, in 1973, the format for annual meetings of the California Association of Neurological Surgeons in early years consisted of "fly-in sessions" for a full day at an airport hotel, either in San Francisco or Los Angeles. The first "weekend meeting" was at the Biltmore Hotel in Los Angeles in 1979, followed by an annual meeting in Monterey, then Palm Springs, next Coronado, followed by Pebble Beach, and most recently Newport Beach. The Board of Directors has selected the Silverado Country Club in Napa, California for the 1985 meeting, in the format of people arriving on Friday afternoon with a welcoming cocktail party that evening, and then the organized sessions Saturday and Sunday mornings. Saturday afternoon is free for local adventures, and then all get together Saturday evening for cocktails and dinner. The Sunday sessions end at noon. There is frequent jitney service from the San Francisco Airport or rental cars are available, allowing opportunity to tour the scenic Napa Valley, offering winery hospitality.

The Board of Directors is interested to hear from all members of CANS as to whether or not they approve of this general format, or if they would prefer a single day weekend meeting at an airport hotel in coming years. It would be appreciated if all those interested would send their comments to our central office, P.O. Box 1395, Roseville, California, 95661. We are hoping to have a record setting attendance at Silverado, in the Napa Valley, where members and their wives will become better acquainted with one another, and share enthusiasm for meeting the ever-mounting problems in our specialty of neurological surgery. □

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.

LETTERS TO THE EDITOR

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

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1984 CLINICAL CONGRESS, AMERICAN COLLEGE OF SURGEONS

San Francisco, California

NEUROSURGICAL SESSIONS

Continental Parlor 7-8-9 — Hilton Hotel

MONDAY, OCTOBER 22, 1984:

9:00 a.m. - 12:00 noon	Myelodysplasia
1:30 p.m - 5:00 p.m.	Imaging of Lumbar Spine

TUESDAY, OCTOBER 23, 1984:

8:30 a.m. - 12:00 noon	Lumbar Spine Surgery, including Fusion
1:30 p.m. - 5:00 p.m.	a. Cranio-Cerebral Lesions b. Transthoracic Spinal Surgery

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