



# CANS

# NEWSLETTER

California Association of Neurological Surgeons

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## President's Message

*Moustapha Abou-Samra, M.D., F.I.C.S., F.A.C.S.*

The first Surgical Advocacy Conference was held in Washington, DC, March 9-11, 2008. Neurosurgery was well represented. Several PAC, CNS and AANS members were in attendance. Eddie Zusman and I were the California representatives. The American College of Surgeons, the American Academy of Otolaryngology, the American Academy of Facial Plastic and Reconstructive Surgery, the American College of Osteopathic Surgeons, the American Society of Cataracts and Refractive Surgery, the American Society of Plastic Surgeons and the Society of American Gastrointestinal and Endoscopic Surgeons participated. I was pleased to see so many young faces.

The attendance was strong and the interest of the surgeons was clear. The organizers, including our Washington bureau staff did an excellent job preparing us and generally making our lives easy; the conference was very informative. Surgeons in attendance, a dedicated, serious and somewhat nerdy group, seemed to give their undivided attention to the topics at hand.

There was a minor distraction, however.

The conference was held at the Mayflower Hotel, where an infamous encounter between "Client 9" and "Kristen" took place in room 871 ... The news about Spitzer and his improbable dalliances broke mid afternoon on Monday and all of a sudden, reporters, photographers and security personnel were everywhere. Luckily, the media was more impressed with the presence of the funeral directors, who were attending a bigger and fancier conference in the same hotel, than it was with our group. So, there were several references to them in the Press, but we escaped the notoriety.

In general it was an effective advocacy conference, whose major objective was to lobby Congress to reverse the planned 10.6% physicians' fees cut scheduled to take effect July 1, 2008, and to permanently solve this issue by budgeting appropriately for physicians and surgeons' fees.

At the conclusion, I felt good about making the effort and about the things I learned, but was not entirely convinced that our presence on the Hill made a bit of difference; we were competing for the attention of our Senators and Congress people, with many groups including the Dental Students Association of America who were better looking and, oddly, had perfect smiles!

The fact that in politics you don't have "permanent friends or eternal enemies" was reinforced!

The Honorable Thomas E. Price, M.D., the Congressman from Georgia who is also an orthopedic surgeon, gave us a passionate talk about physicians, our importance to Society and the need to stick together and to support him, because he is very much opposed to the 10.6% cut. He left out the fact that he was prepared to accept a much bigger cut in three years. Being a conservative, it is more important to him to balance the budget than anything else, I guess. Our PAC has been supporting him financially!

The Honorable Fortney "Pete" Stark, from San Francisco, one of the most liberal members of Congress and who is the most powerful when it comes to influencing the purse that controls medical spending, shocked me! He was friendly and sympathetic to physicians. He said that he does not believe the Country is ready for a single payer system and that he firmly believes in the right of physicians to collectively bargain! Where was I when his change of heart happened? Our PAC should support him.

Oh, and Washington DC was beautiful: we enjoyed two early spring days!



January 17-18, 2009  
Quail Lodge Resort, Carmel, CA  
CANS ANNUAL MEETING

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## When a Chat can be a Cause for Action Against You

*Randall W. Smith, M.D., Editor*

CAP/MPT, the professional liability carrier endorsed by CANS, has a nice area on their Web site called Risk E-Notes which every two weeks briefly addresses an issue that could expose the doc to risk. Their March 21 item, not yet posted, discusses the legal pitfalls of disclosing a patient's medical information to family members. According to CAP/MPT, because of both California State Law & the Federal Health Insurance Portability and Accountability Act (HIPAA), a doc may not discuss a patient's diagnosis or treatment with any family member including a spouse without the patient's permission. If a spouse or other relative accompanies the patient to the exam room and is present during your discussion with the patient, consent to discuss information may be implied. However, it is still wise to ask for permission and to document the patient's consent in the medical record. It would seem wise to add a section to the office document you have the patient fill out and sign that, in addition to the common authorization for treatment, asks them to list with whom you can discuss their case and the relationship of those listed to the patient. It was not rare in my practice to not meet a patient's spouse before surgery and then to track down the spouse in the surgical waiting room immediately post-op, introduce myself then and pour out the surgical story at that time. In

35 years of practice, I ever so rarely had this raised as a confidentiality issue. However, in the present malpractice environment, if one has a poor result or other problems with a case, why give the patient's attorney yet another bullet? CAP/MPT covers any damages that might accrue to the patient should you disclose without permission but who needs another "cause for action"? ❖

## More News from the Editor

**AMA House of Delegates** Don Prolo reports that 550 AMA Delegates and an equal number of Alternate Delegates assembled November 10-13, 2007, in Honolulu. A major focus was to seek legislation enabling physicians (a) to bargain collectively, (b) to restore lost rights to contract privately, (c) to balance bill patients covered by all commercial and governmental insurers. Resolutions that were adopted and will result in actual AMA activity were:

**RESOLVED**, That our AMA redouble its efforts to make physician antitrust relief a top legislative priority, providing the necessary foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision making to patients and physicians. (Directive to Take Action)

**RESOLVED**, That our AMA affirm its commitment to undertake all appropriate efforts to seek legislative and regulatory reform of state and federal law, including federal antitrust law, to enable physicians to negotiate effectively with health insurers. (Directive to Take Action)

**RESOLVED**, That our AMA devote the necessary political and financial resources to introduce immediately national legislation to bring about implementation of Medicare balance billing and to introduce immediately legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interfere with patient access to care. (Directive to Take Action)

**RESOLVED**, That our Board of Trustees report back to our AMA House of Delegates electronically by March 15, 2008, and at other times as appropriate and every House of Delegates meeting on its progress toward the completion of all of these goals. (Directive to Take Action)

**RESOLVED**, That our AMA ask the appropriate state and federal agencies to investigate ventures between retail clinics and pharmacy chains with an emphasis on the inherent conflicts of interest in such relationships, patients' welfare and risk, and professional liability concerns (Directive to Take Action)

**RESOLVED**, That our AMA continue to work with interested state and specialty societies in developing guidelines for model legislation that regulates the operation of store-based health clinics. (Directive to Take Action)

**RESOLVED**, That our AMA oppose waiving any state and/or federal regulations for store-based health clinics that do not comply with existing standards of medical practice facilities. (Directive to Take Action) ❖

### **Getting Old is Dangerous**

Richard Fantus reports in the March 2008 issue of the Bulletin of the American College of Surgeons that falls account for almost 50% of the 102K hospital trauma admissions in the national Trauma Data Bank in the 60-69 year old age group with 39% due to MVAs. Since almost 6% of these old codgers die while near 11% end up in a nursing home, the trauma experience in sexagenarians isn't to be taken lightly. It would appear that discretion suggests the 60+ year-old should stay home and stay seated. In further consideration of the recommendation for physical and mental exercise to ward off heart attack and Alzheimer's, prudence would encourage using a semi-reclining stationary bicycle at home while doing the NY Times crossword puzzle. This is why we old folks worked so hard? I choose to take up sky diving which sure tends to focus the mind and body--as well as helping to thin the herd. ❖

### **Is Better the Enemy of the Good?**

Millennium Research Group (MRG), a proprietary company that provides strategic advice to the healthcare sector, has just issued a new market research report for the spinal non-fusion market. In the report, Millennium's analysts have concluded that the global cervical artificial disc market will grow from a value of just under \$60 million in 2007 to approximately \$1 billion in 2012—a 65% average annual rate of revenue growth. The key drivers for this market, according to Millennium, include increased adoption of Synthes Spine's and Medtronic Spinal and Biologics' cervical artificial discs in the U.S. plus others in the pipeline, a familiar surgical approach to that of anterior cervical fusion as well as an increased (off label) use of multiple discs in a single procedure.

The manager of MRG's Orthopedics division feels that patients and surgeons are “excited” about the artificial discs because of motion preservation, shorter recovery times and minimization of adjacent level disease. One could have a debate about shorter recovery times and minimization of adjacent level disease hasn't been conclusively proven over prolonged follow-up. Motion preservation is attractive potential attribute though just how much pain residual spondylosis and facet arthrosis will cause over time at the still moving spondylitic operative level remains to be seen. Still and all, one must admit there is some real potential for the artificial cervical disc to be useful to the neurosurgical and orthopedic spinal army out there and helpful to their patients. The more immediate decision one might reach is whether or not to invest in these medical device companies. ❖

## **Executive Office Report**

*Janine Tash*

### **Member Input**

The Board of Directors will meet in Oakland on Saturday, April 19, 2008. If you have any items for discussion, please send them to me ([janinetash@sbcglobal.net](mailto:janinetash@sbcglobal.net)) by April 16 and the Board will be happy to review them and provide feedback.

### **Membership Dues**

Second notices for 2008 membership dues will be mailed out in April... please pay promptly to continue your membership and your access to our monthly newsletter.

### **Welcome New Members**

Membership applications were approved for Drs. Farbod Asgarzadie (Loma Linda), Robert Dodd (Stanford), Sherwin Hua (Valencia), Mark Liker (Valencia) and Jongsoo Park (Stanford).

## Letter to the Editor: Myths about the Healthcare Crisis in the U.S.

*James I. Ausman, MD, PhD, Professor, Neurosurgery, UCLA Medical Center  
President, Future Healthcare Strategies; Editor, SURGICAL NEUROLOGY*

I read the "President's Message: Health Care Reform" by our CANS President Moustapha Abou-Samra in the February issue of the CANS Newsletter. After talking with physicians in California and around the country, I felt compelled to write the following editorial to correct some of the misconceptions physicians have about the facts related to healthcare problems in the United States.

We are in the midst of a presidential campaign and there is an intense focus on healthcare. The decisions that are made will be crucial to the future of medicine, your practice and your patients.

Let's get some fundamental facts correct first:

1) This is the story behind the claim that 47 million people in the U.S. do not have health insurance. This statistic, often quoted by politicians and medical publications (including the lay press), is inaccurate. The figure is determined by one question asked by the Census Bureau during a census to anyone in the home who will answer: "Do you have healthcare coverage now?" The answer is "Yes" or "No". In actual fact, in a more detailed study by the Census Bureau, about two-thirds of the uninsured are in and out of work for a year, and 45 percent of those people lack healthcare coverage for four months or less. Twelve million people do not want insurance even if they are eligible. One-half of uninsured adults are under the age of 35. Many young people do not choose to have healthcare insurance and are not covered. Many of the uninsured earn more than \$50,000. Immigrants represent 86 percent of the growth in the uninsured. Only 10 million people (3 percent) do not have coverage for one year.

2) The high infant mortality statistics in the U.S. compared to other countries are based on comparing our statistics with those of others. In most countries, newborn deaths are declared as stillborn. Japan records infant deaths as stillbirths. In Switzerland, infants must be 12 inches long at birth to be declared "live". In Canada and Australia, one-third of the deaths are reported to occur in the first day while in France and Hong Kong, 16 percent and 4 percent of deaths, respectively, reportedly occur within the first day. Why is there a difference? In the U.S. everything is done to save a newborns. This is a tribute to a healthcare system and should not be a criticism. Let's compare what other countries do with premature births and low birth-weight infants with the same statistical measures we use in the U.S. Similar data errors occur comparing life expectancies. There are also many variables in these statistics. What would you think if a neurosurgeon competitor said he/she had no complications in spine surgery? Would you believe it? You would want to look at their statistics and make sure that they were reporting the same things that you are. Why do we accept these statistics about healthcare without questioning the data?

3) The claim that the \$1,500 cost per automobile for each worker's healthcare reduces the competitiveness of U.S. manufacturers is not correct either. During the years when SUVs were hot sellers, the healthcare costs were the same, and there was little complaint about these costs from the auto companies while they made 4- to 5-percent profits. With dealer incentives the prices of American cars are lower than those of foreign-made cars, and still the public will pay more for the foreign automobiles. The real problem is that the public is buying more foreign-made automobiles because the foreign autos are more appealing and economical, even though the cost of foreign cars is higher. So, let us not blame the healthcare system for the failures of business strategy and execution.

4) The 98,000 deaths attributed to medical errors in our hospitals each year is also incorrect. The figures are extrapolated from a very small study that was not even intended to ask the question about medical errors, and the figure may be grossly overestimated. Let's do a real study that is designed to answer that question.

5) There is no socialized medical system in the world that is working. There are waiting lines for care, and deaths occur while waiting for this care. There are limitations on the choice of drugs and devices for patients and runaway costs in socialized systems. Patients who can afford to leave these countries get care elsewhere. The government has become the doctor in these socialized countries, and like any bureaucracy, is doing badly managing the system. Our V.A. hospitals are an example of government care. What about the recent complaints concerning Walter Reed Hospital and the care for Iraq veterans? The problems are the same in any socialized system. Our government has not resolved the energy crisis after 30 years, and its inaction has resulted in high-energy costs and our dependency on foreign powers. Our elected politicians have not solved the immigration issue. Medicare and Social Security are headed for bankruptcy, but the politicians fail to act. How can the government be expected to deal with the healthcare problems? Is this what your patients want?

6) Fifty percent of all deaths each year, in this country, are related to auto accidents, drug abuse, guns, sexually transmitted diseases and alcoholism. These are social problems, yet the healthcare system is held responsible for the

outcomes of such unresolved social problems. The illnesses that these problems create place economic stress on the healthcare system and the doctors and nurses who care for these patients.

7) The rising costs of healthcare can be attributed to everyone trying to game the system to make money. Insurance companies, hospitals and healthcare businesses are major accomplices. With them are the politicians, who have passed legislation restricting the freedom of patients and doctors, while every other person in the country has the freedom to engage in personal business transactions without excessive regulation. What is broken is the record of government regulations that have created a system that does not work. Look at the restrictions that prevent doctors from developing specialty hospitals and other business ventures. Look at the immense paper work doctors are required to do to practice in the system, amounting to wasted time that could be spent on patients. There are estimates that 25 percent or more of the healthcare budget for Medicare is spent on administrative costs. What about costs every doctor has assumed in adding staff to deal with payments from insurance companies when bills should be paid immediately? What business allows customers to delay payments for months without penalties? Let the free market decide the outcome of healthcare. Regulation has led to increased costs and less care as is seen in socialized medicine systems around the world. Is this what everyone wants? We need a system with open competition that allows creativity among physicians and other healthcare providers to reduce costs. The market place works if we let it. Socialism and governmental controls do not.

8) Unfortunately, doctors have been made the scapegoat for many social and political problems, and they have not responded appropriately. Their silence is viewed as acquiescence. A good part of the problems in medicine is the fault of doctors who do not stand up to defend themselves and medicine. Everyone knows the doctor will take whatever he/she is told and not object. What would you do if you were on the other side? If they can get away with treating doctors to their disadvantage, they will do more of the same. That is what we have all seen for years. The capitulation seen by doctors around the country to the disinformation on healthcare is wrong.

9) If healthcare costs are to be controlled, let's apply the formula across the board. Healthcare businesses, pharmaceutical companies and instrument makers should have defined limits on the profits they make and limits on the money paid to their executives. Hospitals should also have limitations on salaries for administrators and on hospital profits. Legislators should receive the same cuts in their incomes that doctors do. Doctors' incomes have actually declined in the past 10 years, while others have risen. (By the way, the Democrat party is not far from proposing some of the socialized recommendations stated here, and you know such socialistic changes will not be enacted against businesses.)

10) Two-thirds of the country's population is overweight. Is that the fault of doctors? No. It is a symptom of a society that will deny itself nothing. Obesity also extends to the poor. What does this mean?

11) Healthcare is not a *right*; it is a *choice* that people have the freedom to make for themselves. If people believe that they have a right to your knowledge, you have a right to refuse. No profession is regulated as much as medicine. No wonder the quality of applicants going into medicine has declined over the years—it is not as attractive a profession as it once was.

12) What needs to be done? A.) Health insurance should be owned by the citizen. If a company wants to provide the benefit to choose that insurance then the employee can decide what plan they want for themselves, but will own the insurance. Health insurance should be portable. For those who cannot afford insurance, they should be given vouchers or credits by the government to buy that insurance. The free market should be preserved. The healthcare contract should be between the patient and the doctor not a disinterested third party and the doctor. We have credit card medicine with runaway costs. Would you expect anything different in a credit card system where someone else is paying the bill? B.) Medicare should be for those who cannot afford health insurance. It makes no sense to have the poor pay for the healthcare of the rich. There should be a means test for Medicare. C.) There should be a scaled premium for health behavior as in auto insurance. Meeting good health standards should be rewarded with lower premiums. The change will incentivize healthy behavior. Patients who are overweight, have uncontrolled hypertension, diabetes, and smoke should have higher premiums. Make the public responsible for its health. Nearly 100 percent of the population has TVs and VCRs. Where are the priorities? D.) Health savings accounts are working. Make them more available. E.) Close the borders to immigrants. Would you allow anyone to come into your home and settle there? After closing the borders we have to deal with those who are here illegally—which affects healthcare costs for all of us. F.) For those who are self employed, let them have the same tax credit for health insurance that large companies enjoy for their workers. Let's make the playing field fair and equal. G.) Nationally, solve the malpractice crisis as in California. Illinois lost one-third of its neurosurgeons because of \$300,000 worth of yearly premiums. H.) Reduce the paper work and bureaucracy. Increase the payments to doctors and more people will be attracted to medicine as a profession. I.) Fine insurance companies for payments to physicians beyond 30 days, or require a deposit by the insurer before the service is rendered. Why should physicians wait to be paid when executives and legislators receive their pay regularly?

13) The Governor of California's health plan failed because the state was already \$14 billion dollars in debt. The Massachusetts plan is now in debt. With the coming shortage of doctors and nurses, the shortage of hospital beds, and the rising demands for healthcare of the aging population in the country, how can one expect a universal system to work? There is a shortage of neurosurgeons around the country. We cannot staff all the emergency rooms that want our services now. Why did that occur and how do you solve that problem? The state of California just reduced the MediCal payments to doctors. Why would doctors want to care for this population while losing money doing it? Are physicians being singled out to solve the state's budget deficit because the lawmakers showed no fiscal responsibility?

14) The American healthcare system is the best in the world. Even with the flawed figures of 47 million uninsured, the system covers 85 percent of the population and the percentage climbs to more than 95 percent with the correct figures. So, why the rush to throw out a successful system for a certain failure? Is that what the public wants? Let's improve the parts that do not work. The rush to universal healthcare is a liberal agenda to establish Socialism based on the belief that the individual is not competent to make the right choice. I sure don't trust a politician to make my life choices. Do you? This is what's happening in the countries of Europe with socialized medicine. In England the government found that too many caesarian sections and epidurals were being done. So, the government said that women should deliver their children at home without epidurals but with midwives—this is 1900s medicine. Neither the doctor nor the patient are involved in the choice. The government is the doctor. Is that what your patients want? It will certainly happen here with universal healthcare or whatever it is called. Let each person decide what he or she wants to do with their life and their children's lives, not some bureaucrat or politician.

15) Physicians have the most powerful lobby in the country, in their offices, every day: the patient. Take a minute during each visit and explain one of the points above to the patient. Let them know that you receive 20 cents on the dollar from Medicare and not much more from the rest. MediCal payments may not even come, although the government promises to pay the bill, so, you may receive nothing for caring for the indigent. Treat businesses the same as doctors and see how far you get. "We can't make any money that way," they will say. So, why is it wrong for a doctor to say the same thing? Ask your patients if they want the politicians to make their healthcare decisions or do they want to decide what to do for themselves?

16) What CANS and physicians need to do is to get the facts straight and to offer sound proposals to solve the problem. We are highly educated scientists. Why do we blindly accept information that is untrue? Who is standing up for medicine? Physicians are the only ones who have the patient's concerns as a priority—the rest are interested in profits, not in the patient.

17) Yes, we can help the state with its problems, but let's get the facts straight first.

I would be happy to come and address your hospital's medical staff on these issues. We need to get the message out. Call me, and I will be there.

You may get references for the points made in this editorial on request from [jamesausman@mac.com](mailto:jamesausman@mac.com). ❖

## NEUROSURGEON WANTED in NORTHERN CAL

Board Certified/Eligible Neurosurgeon needed to join busy private neurosurgical Practice and trauma center in Northern California. FT or PT position will be considered for qualified individual. Competitive salary, bonus and benefits. Please fax or email resume to: 916/773-8702 or [laura@snamg.com](mailto:laura@snamg.com).

### Neurosurgical Position

*Any CANS member who is looking for a new associate/partner/PA/NP or who is looking for a position (all California neurosurgery residents are CANS members and get this newsletter) is free to submit a 150 word summary of a position available or of one's qualifications for a one time posting in this newsletter. Submit your text to me by E-mail ([rws-avopro@sbcglobal.net](mailto:rws-avopro@sbcglobal.net)) or fax(858 683-2022).*

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Please contact the executive office for complete price list and details

Questions or comments can be sent to the editor, Randall W. Smith, M.D., at [rws-avopro@sbcglobal.net](mailto:rws-avopro@sbcglobal.net) or to the CANS office at [janinetash@sbcglobal.net](mailto:janinetash@sbcglobal.net). Past issues of the monthly newsletter are available on the CANS website at [www.cans1.org](http://www.cans1.org). *The newsletter is a mix of fact, rumor and opinion. The facts are hopefully clearly stated. The rest is open to interpretation. The opinion is mine. R.S. The assistance of Janine Tash and Moustapha Abou-Samra, M.D. in the preparation of this newsletter is acknowledged and appreciated. If you do not wish to receive this newsletter in the future, please E-mail or fax Janine Tash [janinetash@sbcglobal.net](mailto:janinetash@sbcglobal.net), (916-457-8202) with the word "unsubscribe" in the subject line.*

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