CANS NEWSLETTER

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President' Message: Health Care Reform

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Is it over? Health care reform in California is now officially dead!

The recent Senate hearings, chaired by Senator Sheila Kuehl, resulted in a relatively strong sentiment (7-1 with 3 abstentions) against the compromise Assembly Bill that was crafted by Governor Arnold Schwarzenegger and Assembly Speaker Fabian Nunez. Several of the usual culprits united to defeat ABX1 1.

In a guest editorial I wrote in these pages, exactly one year ago, I voiced my support for the Governor's plan. This was even before the very unpopular idea of the 2% tax on doctors was dropped. My thinking, then, was that universal access to care in California was an absolute necessity, and that in order to make it work, everyone must sacrifice.

My opinion has not really changed. In fact, I am more convinced than ever that we need not only universal access to health care, but a radical make-over of the present system: it is hopelessly broken!

In order to pass meaningful healthcare reform legislation, we must all be serious about it. Each and every citizen must be involved, must act responsibly and must sacrifice for the public good. Somehow I can't see an effective and successful health care reform without the Federal Government being involved and committed as well.

Without commitment from each of us, any plan, no matter how reasonable, is dead on arrival. We must be thinking of our children and what is best for them. Nor does it hurt to think of our senior years; soon we will be the major users and possibly victims of our health care system.

In addition to personal commitment, the following ingredients will be necessary:

- Patients should be expected to take an active role in their own care.
  - They should have some financial responsibility: making it more likely that they would participate in cost cutting if such cutting does not interfere with care. It is not too much to ask patients to pay modest premiums much like they do for car insurance, etc; paying to stay healthy should be as important if not more than paying for vacations, entertainment and sport events.
  - They must be better educated about their options.
  - They must be free to choose their physician.
- Preventative care should be made available to everyone; this will prove to be cost effective in the long run.
- Catastrophic care should be made available to everyone: no individual can afford it!
- End of life issues must be addressed and dealt with openly: this will reduce a tremendous amount of wasted resources, presently spent on futile care. And, in all likelihood, will free up enough resources to cover preventative care and then some.
- The system should not be driven by employers and industry, though some employers may choose to contribute as a benefit for their employees.
- Financial gain must be eliminated from the entire system:
  - Insurance reform
    - It must be affordable
    - It must be portable
    - No one may be excluded
    - It must consider that the relationship between the patient and his physician is sacred: insurance companies are here to help pay the bills, not tell doctors what can or cannot be done.

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- Pharmaceutical and device companies must be better regulated and the Federal Government should be allowed to negotiate better rates with them. The cost of drugs is so expensive and it is not in keeping with what we see in other industrialized nations.
- Payment formulas that apply to doctors, hospitals, skilled nursing facilities, outpatient facilities and ancillary services must be overhauled and simplified. Doing more should not necessarily translate into getting paid more.
- We must be clear on the fact that Pay for Performance (P4P) schemes are nothing more that methods to cut cost and restrict access to care.
- Tort reform; the California model is a good one and can be followed nationally.

- Doctors should be allowed to bargain collectively so that they are not relegated to slavery status; they should have the same rights as everyone else in America. And let us not forget that Doctors are professionals and not mere providers!

Leadership and Vision in Washington will also be required. Let us hope that the best person for the job of president wins!

I will remind you that the next U.S. president will be inaugurated on January 20, 2009, a short 48 hours after the completion of our next annual meeting in Carmel, at the Quail Lodge, January 16-18, 2009. Please plan to attend; we may have some answers for you! ❖

News from the Editor

Randall W. Smith, M.D.

Little Interest in ED Stipend Data

It is noteworthy that fewer than 20 CANS members have requested the ED stipend data offered to all CANS members in last month's newsletter. The Board of Directors had labored under the impression that this kind of information, available nowhere else, would be eagerly accessed by CANS members to enhance their negotiating position with hospitals for ED coverage stipends. Although the data is not meant for unrestricted distribution or publication, it can be shown to hospital representatives as part of the negotiating process. Apparently the huge majority of CANS members are happy with their individual arrangements and don't feel this data is useful to them or the limited data requests reflect only those who are presently in negotiations. Either way, CANS owes major thanks to Bill Caton for over a year of his time and trouble gathering this information. ❖

California Ranks Low on Medicare Expenditures

The Feds have released the 2005 data on Medicare expenditures per person by states. One might have expected California to lead the cost per beneficiary pack but that honor goes to Massachusetts closely followed by Maine, New York and Alaska. Alaska one can understand but the bay state is a bit surprising with its $6700 per person expenditure. Except for the Los Angeles basin whose beneficiaries consumed over 10K per body, California as a whole ranked 8th cheapest at $4750. Maybe our seniors who live away from LA are a healthy, hearty lot. Or they can't find a doc who accepts the crummy Medicare rates so they tough it out. One wonders what the Medicare population death rate is in California as compared to Massachusetts. Less may be more. ❖

Get Sick in Florida or Pennsylvania

HealthGrades, a health care ratings company has released its second annual America's 50 Best Hospitals report. The hospitals on the list "have demonstrated superior clinical quality for the most consecutive years" from 2003 to 2008, states the report. The list is based on Medicare data on mortality, in-hospital complications, and HealthGrades' Distinguished Hospital Award in clinical excellence. And the data specifically focus on 27 procedures and diagnoses, including heart attack, hip fracture, pneumonia, and stroke, but not cancer. California, which as I recall has about 10% of the nation's hospitals, comprised 8% of the fab 50 which seems about right. Of some interest is that the four California hospitals that made the list are all in the LA area (Cedars-Sinai, Glendale Memorial, Good Samaritan and St. John's). Further, Florida got 9 hospitals on the list and Pennsylvania scored 7. Maybe we need to rethink the location for our retirement. ❖

The Washington Committee—Looking Out for the Docs

Randall W. Smith, M.D., Editor

Most neurosurgeons in active practice are just too busy to do the socioeconomic scene surveillance necessary to keep current on who is trying to do what to our relatively small neurosurgical flock. For this watchfulness, we need assuredly astute guard dogs to keep potential predators (Feds, State, County, plaintiff's bar, other specialties) at bay as well as search about for a bigger or better pasture for ourselves and others we value (patients). So who is looking after Neurosurgery's collective behind?

Well, at the national level it certainly in part is the AMA who is regarded at Medicine's spokesperson by Congress and governmental agencies and who commits enormous sums to defend and promote the practice of medicine. AMA's advocacy is by the nature of its membership makeup somewhat general, not pro-surgeon, and they have to watch all the range and can't be expected to constantly circle the neurosurgical flock. I think they are pretty good at what they do but what they do (or don't) doesn't always lead us to water.

The American College of Surgeons is a smaller, more focused breed whose long suit is how we should behave and best care for our patients and whose surgical advocacy role has been more muted to the point that neurosurgery has some trouble hearing them. Again, they are pretty good at what they do but our more diminutive flock is just a small part of their general herding concerns.

Thus we should expect our two large national societies to police the national neurosurgical arena—and they do. Beginning in 1976, the AANS and CNS have funded a joint politico-socio-economic endeavor in the capitol called the Washington Committee. Although a true committee of 6 neurosurgeons—3 appointed by the AANS and 3 by the CNS—this committee also includes the president and president-elect of the AANS and CNS and virtually every section and other important neurosurgical organization has a liaison to the Washington Committee. To help guide its efforts, the Washington Committee also has a physical DC office staffed with 5 full time employees who act as watchdogs and lobbyists only and solely for neurosurgeons. The Director of this office, Katie Orrico, J.D., has spent years successfully monitoring the legislative scene and cultivating contacts so nearly every legislator's staff or governmental department knows where to go to get some brain surgery input. Conversely, Ms. Orrico knows where to apply the pressure when neurosurgery has an issue with her access to legislators enhanced by your NeurosurgeryPAC political contributions.

Within the Washington Committee are focus groups that either populate other organizations' official activities (such as the neurosurgery members of the RUC which decides on CPT codes and reimbursement) or monitor particular activities of other organizations, governmental or otherwise, to keep our oar in their waters. The latter include Drugs and Devices (so our input into what we use is heard), Quality Improvement (analyzing what is going on with "quality" initiatives) and Guidelines (seeing what the "how we should do it" crowd is up to and making sure we draw up the neurosurgery stuff). The Committee also underwrites our 6 delegates and alternate delegates to the AMA as well as paying for Neurosurgery's membership in the Alliance of Specialty Medicine, Doctors for Medical Liability Reform, Health Coalition on Liability and Access and the Coalition for the Advancement of Medical Research.

The Committee members and DC staff know full well we can't wag the medical dog or even the surgical dog but are fully committed to being enough of the tail so that any wagging that goes on will require some neurosurgical fur.

So what do we pay for all this? The current Washington Committee budget is $1.1 million borne equally by the AANS and CNS with the AANS underwriting the 60K it takes to run the Political Action Committee so that 100% of your contributions are used for lobbying. Is that enough? Too much? Answers to those questions will be intensely personal. I just know that the existence of the Washington Committee makes writing that AANS and/or CNS dues check easier. ❖

Loma Linda University Neurosurgery Training Program

(Each month we plan to feature one of the California Neurosurgery residency programs. It is hoped these program highlights will acquaint our readers with our colleagues, how they are running their programs, their interests and some of their clinical research projects to which you might want to refer a patient. The programs will be presented in an order totally at the whim of the editor. This month: Loma Linda. –Ed.)

Loma Linda University's training program is under the aegis of the Department of Neurosurgery chaired by Austin Colohan who has been at the helm since 1999. They alternate one with two residents a year and will apply to go to two residents every year in 2009 since they have the faculty and material to justify the increase. The annual second resident will help coverage issues created by the mandated 80 hour work week which like in all other programs strains coverage and adequate training exposure. Four Nurse Practitioners and one Physician's Assistant are used to maintain adequate care levels. The training program runs 6 years including internship with 2 years set aside for electives and research. They estimate that about half of their graduates leave California and of the half who stays, a majority goes into academic practice.

The Department hasn't much trouble with EMTALA issues and the Loma Linda University Hospital, an 800 bed Level I trauma center, generally absorbs transfers without much problem. A children's hospital is on campus as well as an East Campus Medical Center where all spine operations are performed.

The University, founded in 1905, has 4,000 students on this medical only campus located in Riverside which along with San Bernardino, form the nidus of the Inland Empire, a sprawling two county area of 4 million residents sandwiched between the Los Angeles basin and the high desert to the East. Dr. Colohan estimates the area could use about 12 more neurosurgeons now with additional bodies needed in the future for the anticipated 1.5 million additional residents expected by 2020. The department runs neurosurgical clinics in Apple Valley, Lancaster, Palm Springs, Corona and Temecula.

Clinical capabilities of the Department and faculty are extensive and cover the usual gamut of cranial and spine work with the Pediatric Service and its 344 operative case load a particular success for the community and for resident training.

Although their clinical interests are varied and well supported, Proton beam treatment for base of skull tumors, such as chordoma, is a particular unique offering and their series comprises the largest group of chordomas and chondrosarcomas treated by radiosurgery. Deep brain stimulation for movement disorders and minimally invasive arthrodesis are other strong clinical programs. A particularly robust basic research program is under the direction of John H. Zhang, MD, PhD.

In the near future, the on-campus VA hospital will be included in the training rotation further increasing exposure to clinical material in a somewhat more autonomous setting for the residents.

Three clinical research protocols (with contact persons) that are accepting patients are:

1. Deep brain stimulation for the control of essential tremor. Contact Annette Brock, 909 558-4952.

2. Vagal nerve stimulation for control of depression. Contact Rosa Villalon 877 558-0800.

3. Artificial discs in the treatment of cervical disease. Contact Annette Brock 909 558-4952.

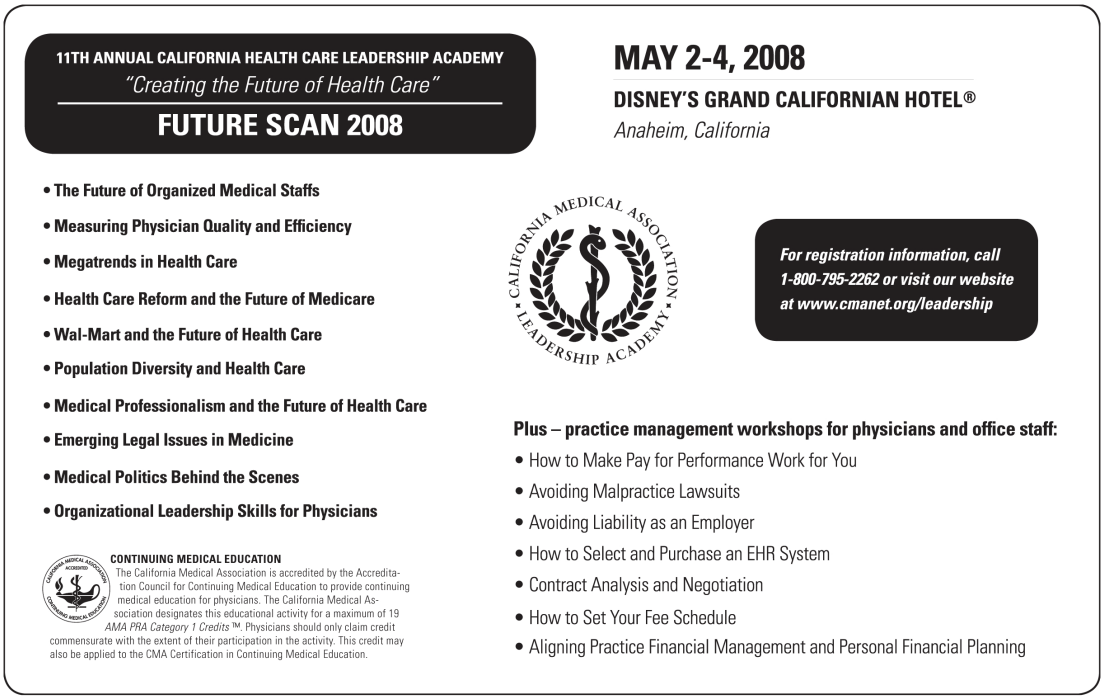
Loma Linda's neurosurgical faculty is listed below. Their Web site at http://lomalindahealth.org/health-care/services/neurosurgery/ can be perused to obtain faculty addresses and phone numbers should you wish to contact them. The toll-free number is **877 558-0800.**

Austin R. T. Colohan, MD
Walter D. Johnson, MD
John H. Zhang, MD, PhD
Frank P. K. Hsu, MD, PhD
Farbod Asgarzadie, MD
Alexander Zouros, MD
Simon Salerno, MD

Plan now to attend the CANS Annual Meeting the weekend of January 16-18, 2009 in Carmel Valley.

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) or fax (858 683-2022).



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Questions or comments can be sent to the editor, Randall W. Smith, M.D., at rws-avopro@sbcglobal.net or to the CANS office at janinetash@sbcglobal.net. Past issues of the monthly newsletter are available on the CANS website at 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, (916-457-8202) *with the word "unsubscribe" in the subject line.*

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