The American Association of Neurological Surgeons and the era of issues

The 1973 AANS presidential address

WILLIAM F. MEACHAM, M.D.
Vanderbilt University Hospital, Nashville, Tennessee

As I reflect on the success of this meeting and others preceding it, I cannot stifle a feeling of gratitude for those stalwart, individualistic persons who generated the groundwork and planning that produced a society of this caliber. Without giving over to a sentimental nostalgia, we must keep in mind the debt we owe to our founders and others who have kept alive the spirit and motivation that has produced this conclave—truly, the "Voice of American Neurosurgery," providing a forum for all certified neurological surgeons as well as for our confreres in other neuroscience disciplines.

This liberality toward membership was not always in effect. A brief glimpse into the past will reveal that the birth of the Cushing Society was stimulated by the exclusiveness of the only existing organization of neurosurgeons, the Society of Neurological Surgeons, whose ranks were closed, for the most part, to the second generation. Thus it was that in 1931, Spurling, Fay, Van Wagenen, and Semmes met to organize a second society and named it after their idol, Harvey Cushing. A Founders Group of 30 was selected and the first meeting held at the Brigham Hospital in May, 1932. Like its predecessor, the Cushing Society soon generated its own brand of exclusiveness which ultimately provided the impetus for the founding of another, and another, and yet another organization to keep pace with the growing neurosurgical population. When, by great good fortune, I was elected to membership in 1948 (can it really be a quarter of a century ago?), it was still a rather private organization composed of members who were all friends, who enjoyed...
the intimacy of each other’s company, and who, nevertheless, felt that this society should continue gradually to enlarge its roster so as to embrace all certified neurosurgeons.

There is little doubt that an early motivation on the part of certain members of the society has been to project the Cushing Society into a role of national leadership in neurosurgery. This sentiment first surfaced in 1948-1949, when committees from the Cushing Society and the Society of Neurological Surgeons earnestly attempted an amalgamation of the two groups so as to obviate any possibilities of competitive rivalry and to prevent the continued fragmentation of organized neurosurgery by the formation of additional societies. In reviewing this somewhat ancient correspondence, it is surprising how heated were the arguments for and against the proposed amalgamation. For one reason or another, probably due to the personalities involved, the incorporation movement became bogged down, and was abandoned but not forgotten. As one member caustically put it: “Each society was left to go to hell in its own way.”

By this time, the American Academy of Neurological Surgery was well on its way, followed by the Neurological Society of America, the Congress of Neurological Surgeons, and the Canadian Neurosurgical Society—the four additional groups that now comprise the governing mechanism of the AANS.

For 25 years, therefore, neurosurgery was abundantly represented by organizations of national scope as far as title and roster were concerned, yet the discipline of neurosurgery had no official voice or representative society. The Cushing Society owned and published the *Journal of Neurosurgery*, the “Senior” Society affiliated its interests with neurosurgical training, the Congress with the younger neurosurgeon, and so on, but governmental agencies, the AMA, the College of Surgeons, and others could find no official spokesman for our specialty. This fact was soon perceived as a distinct handicap. Already, by the early 1960’s, orthopedics, ophthalmology, general surgery, urology and others had appointed a spokesman designate for their own specialty, and it became a necessity that neurosurgery do so as well.

As the principal theme of his presidential address in 1965, Mayfield pointed out clearly the need for unification in organized neurosurgery and was bold enough to issue a proclamation challenging all neurosurgical societies to cooperate in formulating an official group, the Harvey Cushing Society, to “represent” our specialty. The fact that this was acceded to and accomplished smoothly without jealous bickering and interminable arguments within a year is laudatory, especially when one is a daily witness to the eternal debates and long months of infighting that currently consume the time and effort of some of our national medical organizations in trying to settle contemporary problems.

Thus ended the period of our society that can be called “The Formative Years.” From 1965 until the present, we have been engaged in a second phase, “The Reorganization Years.” At first glance, it would seem wasteful to have allocated so much time (8 years) to the restructuring of the foundations and machinery of this organization, but five other societies had to nominate their representatives to this Board and to its committees. The constitution and bylaws had to be rewritten, and the articles of incorporation changed repeatedly as the official name was changed by stages to its present title. Furthermore, committee appointments and assignments required time and effort, and much committee and executive labor was required to secure the appropriate balance of responsibility among the constituent organizations. During this difficult period, it has been impractical to involve a sizable proportion of the membership in organizational work because of the loss of momentum that inevitably occurs when a new team takes over an assignment.

Through the efforts of the Coordinating Committee, a roster of all members who wish to engage in organizational work has been made and their special fields of interest noted. This list will be drawn upon for committee assignments in the future. The Planning-Liaison Committee has helped in formulating the basic directions the society should maintain in its attempt to weld into one structure the sometimes disparate opin-

William F. Meacham
The AANS and the era of issues

ions of its component groups. The Bylaws Committee, in its wisdom, has provided us with a document that is democratic, fair, workable, and easily altered as the necessity arises. The system of graduating committee members from neophyte to committee chairman in limited 3-year terms is now in effect and will avoid the “clean sweep” system of annual appointments; it will also increase the involvement and training of new personnel for committee work each year. The growth of the society during this period has made it essential to abandon the old system of having a part-time convention manager and to use a year-round executive secretary to relieve the burdensome routines of the secretary’s and treasurer’s offices. This major transition has been accomplished with amazingly few mishaps.

Throughout this entire transition phase, it has been possible to produce each year an outstanding scientific and social program with record attendances, increasing scientific and commercial exhibits, innovative programs, and educational devices; to institute the “Cushing Oration,” to expedite the Van Wagenen Award system, and to begin the simultaneous scientific sessions, the system of breakfast seminars, and the morning cinema sessions. The appointed officials who manage the production and editorial affairs of our Journal have succeeded in producing the world’s finest and most respected neurosurgical publication, and to top it all, we have also managed through all these problem-filled years to lend a helping hand to launch the American Association of Neurosurgical Nurses and its journal. And, believe it or not, we have remained financially solvent in spite of an extremely modest dues schedule.

Now comes the host of problems that must be coped with currently and in the immediate future, most of which are created by the revolutionary trends already under way in the conduct of medical affairs, only a few of which can be laid at our own doorstep. Perhaps it is unfortunate that our time and energies must be diverted away from research, teaching, and patient care to wrestle with administrative, economic, and legislative problems, but this has become a contemporary way of life and there is little hope of avoiding it.

Your executives and Board of Directors are acutely aware of the fact that we must encourage more and more of the general membership to become involved in the organizational and committee work of this association. We are a “grass roots” society, and the “grass roots” neurosurgeon must be involved. A careful look at the committee roster will indicate the trend in this direction. You can rest assured that your directors are making every possible attempt to appoint the most knowledgeable and highly motivated persons to each assignment. Internal problems that relate to us as members of this association can easily be solved if we maintain mutual confidence and respect and eschew the dangers of provincial bickering. In 1908, in an address entitled “The Educational Value of the Medical Society,” Dr. William Osler cited the most important functions of the medical society:

“to lay a foundation for that unity and friendship which is essential to the dignity and usefulness of the profession; to enable the individual to refurbish his mental shop with the latest wares; and to stimulate the mind, preventing that tendency to premature senility which overtakes those who live in a routine.”

Let us now give some consideration to the problems of national scope that might affect us individually or collectively. We are all aware of the trend for government to influence, and conceivably to control, the conduct of medical practice. If this becomes a fact and we find ourselves operating under legislative statutes, we will be licensed and relicensed at the whim of every state or federal bureaucratic policy. Already, the labyrinth of bureaucracy has proven too unwieldy for efficient management, and a radical restructuring is in the offing. How will it be if such controls embrace the activities of physicians at all levels? The only permissible prediction would seem to be that of chaos. We must have the courage and the facts to disprove such allegations as the charge that 15,000 doctors in the United States are licensed but unfit to practice. However, if this is true, then it is our duty to rectify the situation. Such statements along with accusations of unnecessary surgery, excessive charges, and general incompetence have done much to tarnish the image of
medicine generally, even though the average person still regards his own doctor with respect and confidence.

A glance at the scientific program at this meeting should convince the most skeptical that we are striving to expose neurosurgeons to innovative and original ideas in patient care and to avoid at all costs the mediocrity that follows the use of accepted routines of obsolete and archaic methods of clinical conduct. There is no doubt that we must escape from the growing tendency for all things to be regimented and compressed into a uniform mold, thus stifling original thinking and independent action. Harry Schwartz, eminent student of our health system and a program participant at this meeting, stated it well: "In an area of increasing and justified disenchantment with the government, it is astonishing that so many well-meaning and intelligent reformists essentially want to nationalize American medicine. One would have thought that the postal and public school systems would have taught them long ago that nationalization does not mean efficiency. Based on the record of the past, we have every reason to suspect that if the revolutionary proposals for transforming American medicine are adopted and implemented, medical care in this country will cost more while providing less satisfaction treatment for millions."

There can be no doubt that we have shouldered an extra burden of responsibility which now is superimposed on our clinical, research and teaching duties. We are caught up in the "era of issues," which requires us to devote our energies to the complexities of social, economic, and political problems. To this end, we must, in our small way, fight against the "doctrine of inevitability of gradualness," that is to say, we have added to our statutes a few more socialistic laws from time to time until we have found ourselves in a frightful mess without really knowing how we got there. This is what some have called the real Communist conspiracy, namely, social changes that occur so slowly that there is little momentum for significant opposition to develop (the process of gradualism). Are we to let come true the predictions of a British professor 200 years ago who indicated that: "A Democracy cannot exist as a permanent form of government. It can exist only until the voters discover that they can vote themselves largess out of the public treasury. From that moment on, the majority always votes for the candidate promising the most benefits from the public treasury with the result that Democracy always collapses over a loose fiscal policy, always to be followed by Dictatorship." Are we close to this? It behooves us to follow the counsel of Thomas Paine who advised that "those who expect to reap the blessings of freedom must, like men, undergo the fatigue of supporting it."

How do these political and social philosophies concern us as neurosurgeons? Just what are the issues that may prevail and influence our professional activities? While I do not pretend to pose as a political or socioeconomic pundit, I do know something about neurosurgeons. I know that they are usually individualistic, that they cherish freedom of action, and, for the most part, avoid the mechanistic concept and resist regimentation.

But, we are now involved in a new ball game and it appears that the days are gone when we each enjoyed our own privileged and unchallenged position. We are gradually being forced to march to the drumbeat of somebody else's tune. Take, for instance, the recent curtailment of federal funds for training grants. The bureaucratic system that dangled these funds as an enticement for scientific training now states that such training should be equated with future income potential and that trainees should assume the financial responsibility for their own specialized education as an investment in their own futures. Many of us might agree with this concept, but the problem of sudden financial withdrawal may exert a crippling effect on some programs whose training structure was primarily based on federal grant support. Will this withdrawal of funds act as a deterrent to potential trainees, or will it create a moratorium on the establishment of new training programs in neurosurgery?

Some contend that already there are too many neurosurgeons, that the distribution is all wrong, and that some accountability should be assumed by us relating to supply
The AANS and the era of issues

and demand. Such a study is currently under way by our Neurosurgical Manpower Committee whose report and recommendations will soon be forthcoming.

The issues associated with professional liability now assume proportions greater than anyone would have imagined 20 years ago. Once, the lawsuit against a physician for presumed malpractice was a rare and curious thing, but now the opposite is true. Rare is the individual now who has not experienced the anxieties and the time-consuming battle of defending his actions against the punitive assault, and often upon the merest pretense of wrongdoing, or alleged negligence. Why is this? I know of no other profession that is so vulnerable to this sort of action, a tendency now so rife that liability insurance is fantastically expensive and to some, virtually prohibitive. Your Committee on Professional Liability is studying this problem and has met with representatives from the Trial Lawyers Association for discussions. We are trying to define our role in this problem area. Should we attempt to be an arbitration resource, available to all who ask for expert and unbiased advice when under the cloud of a civil suit? This we have done in a small way, but should this service be expanded and its availability broadcast? If, indeed, we are the voice of neurosurgery, perhaps we should devote more time and effort to aid in the application of justice to both the plaintiff and the defendant when requested.

The Commission on Medical Malpractice appointed by HEW Secretary Richardson in 1971 has reported that the main cause of the increased number of lawsuits is injury to patients and not, as some contend, fee seeking lawyers. Yet, another member of that same commission (a physician) has indicated as his personal view, the zealous performance of lawyers as the major reason. Now, as a major by-product of the official report of the commission, it is now recommended that all physicians be subject to periodic relicensure based on continuing education, periodic reexaminations for specialists such as ourselves and stronger procedures for disciplining incompetent doctors. If physicians are to be relicensed and recertified, why should this concept not apply also to lawyers and other professionals?

Fortuitously, we are not behind the times. A recently appointed Socioeconomic Committee of this association and the Congress of Neurological Surgeons is actively engaged in the study of these problems along with the posture we should assume in the HMO and PSRO concepts. The latter is now a fait accompli, with our alternative of choices reduced to a basic one; either we participate and give our assistance to the review process by 1975 or it will be done for us by other groups appointed by the Secretary for that purpose.

At issue also is the problem of peer review as it relates to neurosurgeons and how it should be managed. The only peers we have are ourselves and it appears that some mechanism for national guidelines that relate solely to our discipline must be generated. As a corollary, it is almost a certainty that we shall be painted into an economic corner unless we can establish some acceptable device that will cover a fee for service schedule such as a relative value scale for neurosurgeons that will be acceptable to all. It is currently very difficult to answer our critics who want to know why a lumbar disc operation in one area costs $350 and in another $750. The demands of government, the public, and fiscal agents make it mandatory that we have intelligent and cogent answers to these problems. These are included in the charge to our appropriate committees.

Our Committee on Education has spent the last two years working diligently on the problems associated with neurosurgical manpower, the number of training centers needed, and the problem of continuing education. Recognizing that "medical education" now refers to that which is embraced by the medical school curriculum, and that "graduate medical education" refers to the training period, and "continuing education" refers to all past the training period, we see a somewhat arbitrary polarization of the sectors described. A liaison committee will formulate the guidelines for the conduct of each sector and an overall coordinating committee for medical education will oversee the entire educational structure. We need to be involved in each, but in particular in the latter two, and specifically in the last. Consideration is to be given to the merits
associated with documentation of continuing education for our members. While it may be repugnant to some to accept a system of “Brownie Points,” perhaps this may be advisable and meritorious. We need to remember that the broad objectives of medical education must be adhered to, namely, 1) integrity, 2) intellectual ability, 3) capacity for work, 4) common sense and judgment, 5) a faculty for ascertaining the truth, and 6) the acquisition of knowledge. Only the last one may require periodic documentation.

The need for continuing education has long been accepted, and, you will note, is written into our own constitution. This has been a traditional concept of medical practice and was included in the Parliamentary Act of 1511, presented to Henry VIII and stated, in part, “the science and cunning of Physick and Surgery is daily within this realm exercised by a great multitude of ignorant persons to the high displeasure of God, great infamy to the Faculty, and the grievous hurt, damage, and destruction of many of the King’s people especially of them that cannot discern the cunning from the uncunning.”

The thorny problem of recertification and relicensure will be coped with in some fashion not yet clear, although active and periodic participation in scientific programs, postgraduate courses, and self-assessment examinations may act as shields against statutory requirements being established universally.

Just recently, the American Board of Medical Specialties has agreed that recertification of all specialists by their respective boards should be carried out periodically, and this should go into effect within the near future. How many of us heaved the long sigh when we finished our Boards and said, “Never again”? Now, it appears we are to do it over and over again, presumably in the hope of documenting competence, a feature still not achieved by any certifying examination yet devised. By inference, however, it has been assumed that certification could be equated with competence, although we all know that it can be assessed only by performance.

In a “Proposal for a National Academy of Continuing Medical Education,” Ward Darley in 1961 stated that: “Unless the total profession shows more active concern for its self-renewal, the question of relicensure and recertification will change from handwriting on the wall to reality much sooner than most of us think.” It would appear that that time is close at hand, particularly when the National Advisory Committee on Health Manpower recommended that “professional societies and state governments should explore the possibility of periodic relicensing of physicians and other health professionals. Relicensure should be granted either upon certification of acceptable performance in continuing education programs or upon the basis of challenge examinations in the practitioner’s specialty.” Is it not paradoxical that the largest group of professionals in this country (300,000 physicians) cannot be trusted to supervise their own self-assessment when we are daily entrusted with the health care of the nation? It would seem unfair that the medical profession is to be singled out for possible statutory enactments to “insure” competence when no other profession is required to do so. I have not heard that judges, lawyers, clergymen, teachers, and engineers are to be recertified or relicensed from time to time. And, who will certify the nonspecialist, and how? And what of the hundreds of conscientious physicians who represent the sole health provider in a community; will they be disfranchised or defrocked?

Without meaning to be too critical, I seriously submit that only our own profession can effect the continuing educational responsibilities that we admit are necessary for the public welfare and, as neurosurgeons, only we should be responsible for our own educational discipline.

Now, to turn for a moment to the problem of public and governmental criticism of medicine, it would appear that it is the surgeons who receive a major share of blame for several presumed reasons: unnecessary surgery, excessive fees, professional incompetence, lack of informed consent, conspiratorial actions, and the like. As neurosurgeons, we live in the surgical milieu and must accept our share of any blame for misconduct, but we must refute unjust accusations with equal vigor.
The AANS and the era of issues

In a pamphlet entitled "A Shopper's Guide to Surgery," it was pointed out that one surgeon could easily be a rascal, guilty of performing "remunerectomies" or he could be a modern genius. Advice was given concerning the best method of choosing a surgeon and closely follows the definition of a "surgical specialist" recently approved by the Board of Regents of the American College of Surgeons. Government has asked for such a definition for its own purposes and we should be familiar with its wording since it defines each of us:

A "surgical specialist" is a physician:

a) who is certified by an American Surgical Specialty Board approved by the American Board of Medical Specialties, or who, by reason of his education, training and experience is judged eligible by such a Board for its examination, or
b) who is a Fellow of the American College of Surgeons, or
c) who has obtained, in a country outside of the U. S., graduate surgical education which satisfies the training requirements for Fellowship in the American College of Surgeons.

It is recognized that surgery may be performed by others in categories that would preclude their classification as "surgical specialists."

If, as it seems, we are now "defined," we must as Francis Moore has suggested: 1) validate the credentials of hospital surgical staff appointments, 2) control the flow of residency training, and 3) the placement of surgical specialists. It should be obvious that if we can accomplish these things, we will have solved, in large measure, the issue of voluntary regulation versus government control.

Two recent issues that your Board is addressing concern the militant attack of some members of a sister discipline upon neurosurgeons who conduct operations categorized as "psychosurgery." The unprecedented nature of the virulence of this assault using aggressive and disruptive techniques as well as the introduction of proposed statutory limitations upon this aspect of our specialty is regrettable. It is hoped that effective reconciliation of these differences can evolve through intelligent dialogue and objective study rather than by coercive methods.

Second, the sporadic charges made by certain third party fiscal agents regarding accusations of "overcharging" on the part of certain individuals have reached proportions amounting to harassment. Where such charges and accusations prove groundless after review, it behooves us to present a dignified and united countercharge to this scurrilous affront. To be cavalier about it is to invite further and more emboldened inroads upon us. Yet, we must expect that physician income, while related to productivity, will be subjected in the near future to further regulation by national health insurance and other devices.

Inevitably, the recounting of troublesome issues takes on the cloak of pessimism and an aura of impending doom. I have not meant this to be an address designed to send everyone to the closest bar for relief from reality. In the words of John Day; "Can we make it to the year 2000? Will it be a 'Brave New World' or will it be a never-ending series of clashes between the haves and the have-nots on an increasingly crowded globe?" The answer is one of optimism. The human species is ingenious and has survived many terrible and more important crises in the past, and we still enjoy many of the privileges of self-determination. As DuVal has pointed out, we still are privileged to select our students, design their curricula, and oversee their certification and licensure. Our graduates are free to determine where they will live, whom they will serve, with whom they will associate, what institutions they will join, and how they will limit their practice. This still adds up to a lot of freedom and self-determination.

Year after year, I have watched new generations of neurosurgeons come into this society, fresh new faces, keen young minds tackling the mysteries of our profession, eager for participation in the mainstream of their chosen discipline, and above all, performing in an exemplary manner. This is where the action is, and I am confident that these generations of neurosurgeons will continue to add luster to our specialty.

I am not certain about the fate of old neurosurgeons. Certainly, they do not "fade away" like General McArthur's old soldiers.
It seems to me they remain active for a very long time. This is providential because they possess the experience and wisdom accumulated from years of success and failure. From them, I have learned much that is beyond the traditional concepts of learning. In them I have witnessed the subtle and desirable trait of being wise while maintaining humility. For the encouragement, counsel, and motivation that our senior neurosurgeons have contributed, I express our sincere gratitude.

To the younger members and neophytes I express admiration for your energies and enthusiasm, and thankfulness for the stimulation you have provided in our own careers. The future of our specialty seems secure in your hands, a testimonial to your dedication and to the efforts of those who contributed to your training.

Finally, this era of issues will pass and ultimately be consigned a passing note in the history of our specialty. There will then be new and more perplexing problems to reconcile, new issues, new committees, more work, more involvement. I salute all of you who will inherit these future responsibilities, have carried them in the past, or are struggling with them now. You have rendered sacrificial service to our specialty, and that's what it's really all about!

Address reprint requests to: William F. Meacham, M.D., Vanderbilt University Hospital, Nashville, Tennessee 37232.