Neurosurgery 1977: problems and attainments

The 1977 AANS presidential address

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The President of the American Association of Neurological Surgeons (AANS) discusses the many elements that appear to restrict the professional activities of neurosurgeons and other physicians. He stresses the importance of the active role required of the AANS, the American Medical Association, and the American College of Surgeons in finding solutions to problems related to neurosurgery.

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Neurosurgeons and other specialists, as well as primary care physicians, are finding their professional activities more and more restricted by third parties. Local, state, and federal governments are the chief offenders, but insurance companies, lawyers, and the public, including our own patients, are also involved. Furthermore, the press rarely misses an opportunity to take a jab at the medical profession, thereby tending to undermine public confidence in the profession. In spite of this, a Gallup poll rated physicians at the top of 11 occupational groups in honesty, ethical standards, and credibility.

Utilization Review Committees decide whether our patients will be admitted, when their surgery will be done, and how long they will be hospitalized. Professional Service Review Organizations (PSRO’s) tell us whether we are performing properly. The Health Services Agency can rule whether we can obtain a major piece of equipment, or can continue to have neurosurgical or other services in a hospital. This agency can even decide that an entire hospital is unnecessary. Medicaid and Medicare are regulating our fees; insurance companies, including Blue Cross and Blue Shield, are attempting to do the same. No other profession has been subjected to such harassment.

Patient expectations are at an all-time high in terms of both services and results. Further, if we do not make them well we may be sued. Additional services and prolonged hospitalization are often demanded by patients when payment comes from third parties. This places the physician in the undesirable role of policeman. Utilization control should be as much a responsibility of the patient as it is of the physician, but patients are not adequately informed of the limitations of their health insurance coverage by the third party payers, who emphasize complete coverage when they sell their policies, just as trade unions emphasize complete coverage to their
members. The fact that 92% of the population of the United States is now covered by private or government insurance and only 8% are not covered emphasizes the magnitude of the problem.

Paying for Medical Care

The total bill for medical care has escalated from $42 billion to almost $140 billion, more than the military budget, in just 10 years. This is due to such factors as inflation, unionization of medical care personnel, professional insurance premiums, increased professional fees, defensive medicine, expensive equipment for tests, overuse of the system and many other factors. A great deal of the waste of medical care could be avoided if patients paid for routine care and initial hospital costs out of their pockets. Because of the rising costs of medical care, more of the public is asking the government to pay the bills. Former Secretary of the Army, Robert F. Froehlke, now President of the Health Insurance Association of America, called on the health industry to control the inflationary spiral of the cost of health care or face nationalized health insurance. Nationalization of health insurance would lead to nationalization of auto, life, and workman's compensation insurance at a cost of $80 billion in additional taxes. As we all know, federal health care could be much more expensive, since virtually everything the government does costs three to seven times more than in private industry.

President Carter, in his pre-election campaign, committed his administration to national health insurance, and also to a balanced budget by 1980, an election year. It is obviously impossible to do both; however, in a recent speech to Health, Education and Welfare (HEW) employees, he said that his administration will seek to implement the proposal in phases in "a year by year progression toward a national health insurance system." He has asked for the establishment of a health care financing administration to administer Medicare and Medicaid, and to create an intergovernmental task force to design a national health insurance plan. Secretary of HEW Joseph Califano said that there will be no national health insurance bill this year from the administration, but he hopes to have Congress pass such a bill during President Carter's first term. He added that outside groups will be asked to participate in a special task force to help HEW develop a national health insurance program. Two bills may be enacted this year: one deals with catastrophic health insurance, and the other, national insurance for mothers and children. Senator Jacob Javits of New York has introduced the latter and there is broad bipartisan support for the Long-Ribicoff-Talmadge bill for catastrophic health insurance. In January at the Fifth Medical Leadership Conference, sponsored by the American Medical Association (AMA), Senator Talmadge said he was opposed to federalization that would turn this country into another Great Britain.

"If the time comes that Congress seriously addresses national health insurance as distinguished from a national health service then we are going to push hard for our own bill," said James H. Sammons, Executive Vice-President of the AMA. The Comprehensive Health Care Insurance Act of 1977 (HR 1818 and S 218), the AMA bill, provides comprehensive coverage for the entire population. There would be varied sources of funding, both private and public, with premium subsidies and cost sharing. Federal funding would be limited to assisting the poor, and those with a low income in paying health insurance premiums. The program would be administered primarily by the private sector with a minimum of federal involvement.

Over 1500 neurosurgeons are already members of the AMA, which has an enrollment of over 170,000. At this point I should like to urge each of you who does not belong to support the AMA by becoming a member. What has the AMA done for you lately? The AMA has a large staff, including one in Washington, which is working effectively in our behalf, and in cooperation with county, state, and specialty societies has been able to alter or influence legislation. It has joined North Carolina in contesting the constitutionality of the National Health Planning and Resources Development Act of 1974, which allowed amateurs to regulate health services. It provided leadership to get the Keogh Plan increased to allow annual contributions to retirement of 15% of earned income or $7,500, whichever was less. It has extensively sponsored or supported legislation to improve health care. It has worked in behalf of
the profession to assure quality education and care. It provides benefits and services such as insurance plans, a retirement fund, scientific publications, and many others. The AMA is a very democratic organization. If you do not approve of any of its activities, it is possible for you to become active in the Association and to participate in the formation of policy.

It is also important to belong to the American College of Surgeons (ACS), whose many programs you already know. There are 1367 neurosurgeons who presently belong to the ACS. Because we represent only 1% of all MD’s, we have limited political impact; hence, we must work closely with the ACS and the AMA. However, our impact is much greater than our size.

Federal Involvement in Medical Training

When the government is supplying the funds, it would be irresponsible if it did not have a strong voice in how the money is used. This was predicted by this Association in the early 1960’s, and for many years neurosurgeons did not accept government money for their training and fellowship programs. Our medical schools have been progressively more regulated by our government. At present the government tells the medical schools that they must accept a given percentage of minority applicants and women, that they should admit more medical students, and that 50% of the students must go into primary care. The results are illustrated by the following: in 1975-1976, of the total enrollment of 56,244, 20.5% were women, representing an increase of 1700 over the previous year, and the minority students increased to 8.5%. From 1965 to 1976, the size of entering classes almost doubled; this year 60% of all the students in the matching program chose primary care specialties, and only 16% chose surgery or surgical specialties. He who pays the fiddler calls the tune.

There are only four medical schools that are saying “Thanks, but no thanks,” to our government. These are Yale, the University of Indiana, Wright State of Ohio, and Stanford. This may be only a threat. The confrontation occurred when the latest manpower law decreed that the medical schools must accept in their junior year foreign medical students who are United States residents. Most of these students have previously been refused admission to United States medical schools. This really means that the government is acting as the admission committee in selecting the students. If these four medical schools carry out their threat they will lose their capitation of $1,270 per student. If, instead of capitation, loans by the federal government were made to students to pay tuition, the medical schools could be freed from some of their servitude to the government. The fund could be a rotating one. Repayment of the loans would provide money for further loans, and the cost to the taxpayers would ultimately be much less. There could also be a provision that bankruptcy could not be used to avoid repayment of the loan.

Malpractice Suits

Allegations of malpractice continue to haunt the neurosurgical community. Professional insurance premiums continue to increase 10% to 20% per year. In 1975, $7 billion were paid in premiums amounting to 6% of the total health care expenditures and another $7 billion in defensive medicine, a total of 12% of health care costs. However, none of our political leaders mentions this as one of the causes of the rising health care costs, nor is it suggested in our newspapers. How litigious the public has become is illustrated by the fact that lawyers reject 88% of possible suits, according to the American Bar Association. There does not appear to be an end in sight. How long can we continue to practice under these circumstances? In the words of our Professional Liability Committee, “Patients who have suffered adverse consequences as a result of an illness and medical treatment, whether or not this is caused by negligence, fall back on the tort law-liability insurance system to make up their economic losses.” The courts have tended to subvert the “fault issue” to “who can best bear the loss.” The attorneys for both the plaintiff and the defense continue to get the lion’s share, more than 50%, of the professional insurance premium. The insurance companies receive the next greatest amount, and the plaintiff is awarded only up to 19%. However, the neurosurgeon defendant has won 90% of the cases that have gone to trial. The national average of suits per neurosurgeon is 0.93, but in the more densely populated areas of New York and California it is 1.4. This is reflected in
more costly insurance premiums in the higher populated areas. Of all neurosurgeons in the United States 7% are going bare and in California approximately one-quarter of all neurosurgeons have no professional insurance.

In Great Britain and Canada there are very few malpractice suits. The reason for this is a significant difference in the laws, namely, if a plaintiff does not win his suit, he must pay the court expenses and those of the defendant. The chances of getting such a law passed in the United States are not good at present since so many of our legislators are attorneys. Governor Carey of New York appointed the McGill Commission to study the malpractice problems and to make recommendations for reforms. Very few of the reforms have been enacted into law because of the effective lobbying of the trial lawyers. Furthermore, in the past few months in New York, legislation was proposed that arbitration laws do not apply to malpractice cases. It is encouraging that of the 65 legislators who were elected in 1974 and 1976, only 20% are lawyers. The situation may be changing.

Only 5% of malpractice cases go to court; 10% are dropped, and 85% are settled out of court. This means in 85% of the cases that the defendant was either guilty, or that he was talked into settling since it would cost more to take the case to court even if he did win, or that he did not wish to take the time to defend the case in court. We should defend every case in court if it is meritorious, and if it is a frivolous suit a countersuit should be undertaken. There have now been three successful countersuits, not enough to establish any statistical significance, but in Illinois the number of cases filed decreased substantially after a countersuit was won. The jury verdict award in the Reno case was $85,000, of which $35,000 was for compensatory damage and $50,000 for punitive damage. We must fight all the way if we expect to overcome this expensive and serious blot on our profession.

Activities of the AANS

Education

What is the AANS doing for you? The answer is many, many things. The Education Committee has been changed in structure and function to a Joint Committee on Education of the AANS and the Congress of Neurological Surgeons (CNS). The Chairman and Associate Chairman of the Joint Committee are appointed alternately by the AANS and the CNS, and are each responsible to the Board of Directors and Executive Committees of the two societies. The Subcommittee Chairmen are selected by the Chairman and Associate Chairman with the approval of the Presidents of the two societies. All of the committee members are selected because of their qualifications and not because of their society identification. Significant items to be presented to outside organizations are cleared with the Presidents of the AANS and the CNS.

In regard to undergraduate education, the reduction in the teaching of clinical neurosciences as a prerequisite component of the curriculum is alarming. Primary physicians are being produced with very little training in disorders of the nervous system. How will they be able to identify, manage, and refer neurosurgical patients before irreparable damage has been done? How will talented medical students be attracted to neurosurgery if they have little or no exposure to it? It is necessary for the neurosurgical community to do everything possible to upgrade the undergraduate medical curriculum in clinical neurosciences, to participate in administrative roles in medical schools as well as in various medical groups locally, regionally, and nationally, especially the Health Services Agency, PSRO's, and utilization review.

The Physicians Merit Award in neurological surgery is now a prerequisite for active membership in our association. The accreditation will be by one of our five continuing education committees. The development of a working syllabus for the merit award is underway. The Self-Assessment Examination is being refined and upgraded to improve its educational and learning potential. Our regional workshops are rapidly expanding in terms of numbers of workshops, subjects presented, and geographical distribution. Our annual meetings also reflect the breadth and depth of our educational aims.

Joint Socio-Economics Committee

The Joint Socio-Economics Committee (JSEC) was founded in 1973. This is a large committee with many subcommittees, excellent leadership, and much industry. Some of us thought that the members of the commit-
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tee were trying to establish a separate socio-
economic society when really they were only
concerned about our welfare now and the
future of neurosurgery. Observations and
recommendations of this Committee are for-
warded for action to the Board of Directors of
the AANS and the Executive Committee of
the CNS. It was through the efforts of the
JSEC that procedural terminology and guide-
lines for PSRO's were formulated. The JSEC
urged the opening of a Washington office to
give neurosurgeons an impact on health care
delivery system out of proportion to our
numbers. The Joint Committee has also
urged the formation of state neurosurgical
societies. It is by way of the state societies
that the AANS has easy communication with
neurosurgeons in all states. Through the
AANS representatives from the four re-
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The Washington Committee

The Washington committee has been very
active in gathering and disseminating infor-
mation regarding the activities of our federal
government relating to health. Plans have
been made to send this information in detail
to the executive bodies of the AANS and the
CNS and in summary form to our members
by way of a Washington report in the news-
letters of our two organizations which are
sent to all neurosurgeons at two-monthly in-
tervals. By way of our Washington repre-
sentative we are able to provide input into the
formation of various bills. It is much easier to
change the wording of bills before they are
recorded in black and white. In addition to
this, the Washington committee has given
testimony on psychosurgery, the National
Institutes of Health (NIH) budget, Medi-
care-Medicaid reimbursement in teaching
hospitals, Medicaid fraud and abuse, the
Health Planning Resources Act, utilization
review, national health insurance, salary of
NIH directors, and privacy and computers.
The inclusion of a factor for professional in-
surance premiums in the computation of
reimbursable charges by the Bureau of
Health Insurance is attributable to actions of
the Washington committee.

The Washington committee is trying to an-
ticipate activities of both the Administration
and Congress in order to inform the neuro-
surgical leadership so that action can be taken
to influence legislation that affects our
specialty. It is our hope that governmental
agencies will recognize our representative,
Mr. Plante, as a source of knowledge and in-
formation to help them solve problems
regarding the delivery of health care. At the
same time he will be able to protect our
interests.

Manpower Monitoring Committee

The Manpower Monitoring Committee
plans the compilation of additional infor-
mation pertaining to neurosurgical man-
power and workloads. The major thrust of the
Committee's work at this time is collabora-
tion with the medical activities and man-
power projects of the Division of Research
and Medical Education of the University of
Southern California under the direction of
John S. Lloyd, Ph.D. The funding is by the
Federal Manpower Commission and the
Johnson Foundation. The purpose is to con-
duct diary log-keeping studies of all the medi-
specialties. A number of these studies
have already been completed, but the results
are not yet out of the computer. Logs will be
sent to neurosurgeons picked randomly
throughout the country. The representative
group will be a larger segment of the neuro-
surgical population than that of any other
specialty; hence, we shall be in an excellent
position to respond to manpower needs. This
study has also been endorsed by the Con-
gress of Neurosurgeons. I urge all of you who
will receive these logs to cooperate in the
study. All the members of the Manpower
Monitoring Committee have already com-
pleted the diary log study. It was a fortuitous
circumstance that we learned of Dr. Lloyd's
project. The Manpower Monitoring Com-
mittee had been planning such a study, and
our participation in the study with Dr. Lloyd
will help to insure its accuracy and will save
the association $20,000.

Joint Materials and Devices Committee

The Joint Materials and Devices Commit-
tee has expanded into 20 subcommittees that
are able to give expert commentary in their
respective areas. The government agencies in-
volved have been notified of our capabilities.
Their knowledge of the capabilities of our committees has resulted in our participation in the preparation of the Medical Devices Amendments Act. Due to the vigilance of this committee, ill-advised but proposed regulations which appeared in the Federal Register have been revised by the Food and Drug Administration (FDA). Another example of the Committee's activities is a 2-day scientific symposium set up as a workshop of the AANS and CNS with the financial sponsorship of the FDA. The subject was "Safety in clinical efficacy of implanted neuroaugmentative devices." The subcommittees are continuing their efforts to establish standards for the benefit of improving neurological instrumentation. Just think how handicapped we would be if the FDA ruled, as it almost did, that we could no longer use aneurysm clips. How fortunate we are to have such a committee of devoted neurosurgeons.

Other Activities of the AANS

Our Annual Meeting Committee has presented us with excellent and well arranged scientific and social programs. Only 24% of the papers submitted could be accepted. All the members have worked hard and deserve our appreciation and gratitude.

Your Board of Directors has been very dedicated and diligent, and in the past year several innovations have been made. Extensive changes in our by-laws have been proposed. These changes reflect present or anticipated future practices. Two new membership categories will be introduced for your consideration: one is candidate membership, in order to bring young neurosurgeons into the mainstream at the earliest possible time; the second, which will follow next year, is lifetime membership, which will help to keep senior neurosurgeons as active members until they retire, after which time they would become lifetime members. Senior membership would be phased out. The proposed increase in our "membership at large" representing each of the four regional districts will give representation on the Board to all neurosurgeons, even those who are not certified. Hence, the Association can truly speak for all of the neurosurgical community.

The Board decided that the Association should honor one of our members each year for outstanding service to neurosurgery and to the Association. This award will be called the Harvey Cushing Medal and will be presented to the recipient at the annual banquet. Advisory nominations will be made by the Committee on Awards, which is also a new committee, and the Board will select the winner.

Close personal contact and working arrangements have been established with the American College of Surgeons and the AMA so that mutual activities can be easily coordinated. It has been determined that the Association now requires a National Office located in Chicago close to the ACS and the AMA. Subject to the policies, direction, and authorization of the Officers and the Board of Directors, the Executive Director will maintain the office and employ secretarial and other help commensurate with the needs of the Association. The proximity to the ACS and the AMA will allow coordination of policies, professional advice, and use of some of the facilities of the ACS. The plans are to start small and expand slowly in a carefully considered manner according to developing requirements. The Congress of Neurosurgery and the American Association of Neurosurgical Nurses will share some of the facilities of the National Office.

The needs, the wants, the aspirations, and the ideals of the neurosurgical community demand the cooperation and continued dedication of all of us. In that spirit at some time in the future an amalgamation of the AANS and the Congress may be considered desirable.

In closing I wish to express my appreciation to the membership of the AANS for the privilege and honor of serving as your President.

This address was given at the Annual Meeting of the American Association of Neurological Surgeons at Toronto, Canada, on April 25, 1977. Address reprint requests to: Lester A. Mount, M.D., Neurological Institute, 710 West 168th Street, New York, New York 10032.