November 2006

PNS NEWS

Pennsylvania Neurosurgical Society in Association with Mid-Atlantic Neurosurgical Society

President's Report

Raymond C. Truex, Jr., MD, FACS, President

As your president, I recently attended two Pennsylvania Medical Society events, which included the Specialty Leadership Cabinet meeting on September 5 and the House of Delegates convention on October 20-21. Through these activities, I became aware of several important issues that all Pennsylvania neurosurgeons should be familiar with.

First, let me direct you to the Pennsylvania Medical Society website, www.pamedsoc.org. This website contains a report entitled "The State of Medicine in Pennsylvania 2005," which provides an astounding amount of graphically presented information pertaining to the malpractice and reimbursement problems facing all Pennsylvania neurosurgeons. The net result of these two issues is that more and more neurosurgeons are forced to find fiscal security by becoming hospital employees. The private practice of neurosurgery is soon to become a thing of the past. One of the tasks I intend to complete this year is a survey of our membership to determine how pervasive this trend has become. This website is a font of information which can be very useful to the neurosurgeon who wishes to speak to a patient or media representative about the problems we are facing, the net result of which will be a serious lack of access to neurosurgical care in the next decade.

As all of us know, we practice a "high risk" specialty, and thus qualify for a 100 percent abatement from the Mcare Fund surcharge each year. This abatement will probably remain intact through 2007 and 2008, but obtaining the abatement is somewhat of a political football each year, and by no means a certainty. In 2009, however, the State will probably commence discontinuation of the Mcare Fund, transitioning responsibility for obtaining private malpractice insurance entirely to the practicing neurosurgeon. After 2009, no new malpractice suits will be assigned to the Mcare Fund, and the $2.3 billion unfunded liability currently borne by the Mcare Fund will be retired by cigarette tax and auto CAT fund monies. Each physician must carry $1 million of malpractice insurance as of January 1, 2009. This obligation is, of course, an improvement over the Mcare Fund, but it will pose a significant financial burden on each neurosurgeon, especially those still remaining in private practice. How is this transition to be handled?

There exists a consortium to address the transition. Participants in the consortium include the Pennsylvania Medical Society, the Pennsylvania Orthopedic Society, the Hospital Association of Pennsylvania, the American College of Nurse Midwives, and the Pennsylvania Podiatric Association. The state legislative commission to review the Mcare Fund must report to Governor Rendell by November 15, 2006, and the above groups represent health care providers to this commission.

What is being recommended to the commission by this consortium is that a new fund be established to help physicians bear the fiscal stress of increased malpractice premiums after 2009. They have proposed the formation of a *Health Care Provider Rate Stabilization Fund* to help offset the additional premium costs to physicians caused by the transition. The stabilization fund will be supported by cigarette tax revenues and auto CAT fund revenues, and will provide a progressively declining level of support over the next five years, from 2009-2014. This program will be supervised by the State Insurance Commissioner.

The difference to neurosurgeons is this. Under the current arrangement, neurosurgeons, as "high risk" specialists, receive a 100 percent abatement in their Mcare surcharges, whereas "low risk" physicians receive a 50 percent reduction in their Mcare Fund surcharge. This is fair because our malpractice premiums are much higher. However, as things now stand, that differential will not be recognized by the *Health Care Provider Rate Stabilization Fund*, which will support all physicians equally during the post-2009 transition. Although our malpractice premiums may be higher, our reimbursement from the State fund may not consider that extra expense. I will be talking to Scot Chadwick, Director of Governmental Affairs, and Larry Light, Vice President of Legislative & Political Affairs at the

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Opinions expressed in this newsletter do not necessarily reflect the Society's point of view.

Editorial

The Best Medical Care in the World: A Modern American Dilemma

Bruce L. Wilder, MD, MPH, JD, Editor

It is fair to say that we in the United States have the best medical care in the world, if "we" happen to be both privileged to be able to pay for it (or have it paid for), and are lucky enough to receive it in a relatively prompt, safe and efficient manner.

The statistics vary, and one can debate the actual numbers, but all seem to follow a common theme: over forty million Americans without health insurance. The average cost of health care per person in the United States is three times that of other developed countries, without a demonstrated corresponding better level of health; a third to a fourth of all personal bankruptcies due to medical expenses. The cost of health insurance for a family up to one fourth of the bread-winner's salary; the crushing burden on employers, of employee health insurance; the inability of persons with chronic illness to obtain health insurance. While the new Medicare Part D has helped patients to a degree, it appears that most of the government financial outlay will go to the pharmaceutical industry.

We have developed an incredibly sophisticated armamentarium of medical and surgical therapies for just about any symptom, illness or injury. While many of such treatment modalities can confer a benefit—sometimes dramatic, occasionally miraculous—on the patient, too often they do not, and in either case, the cost is too often beyond the means of the individual.

The inaccessibility of timely, efficient health care because of economic reasons is adversely affecting more and more Americans. The reasons for this phenomenon, which some people are already calling a "broken" health care system, are many. The Clinton health plan, the aspirations of which created expectations among people that, at least arguably, decided the 1992 Presidential election, failed for many reasons. In my view, there were several major flaws. One was the assumption that health insurance should be employer-based. Another was that compensable injuries should not be covered by primary health insurance, i.e., the patient must look to a separate legal claim for health care coverage. A third was its inability to free itself of the reimbursement-based model of private insurance, and let the primary health insurer seek reimbursement from the liable party. Perhaps the most fundamental, and least discussed, was that it avoided the opportunity to decide, and neglected the necessity of deciding, how limited economic resources should be acquired and allocated so as to provide everyone with a basic level of health care (including integration with public health measures), and an equitable system of support for more expensive forms of treatment, and perhaps a different category of highly sophisticated, costly, and innovative and/or not clearly efficacious forms of treatment. In other words, we needed then, and more so now, to recognize and deal with the fact that our egalitarian notions of health care are incompatible with the costs of the level of medical science and technology which we have brought to our health care system.

American intellectual property law has fueled astonishing advances in medical technology, a phenomenon that has prolonged and improved the quality of life for a relatively small

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Pennsylvania Trauma Systems Foundation Update

Jack Wilberger, MD, Neurosurgical Representative to the PTSF

This year, the Pennsylvania Trauma Systems Foundation (PTSF) celebrated its 20th anniversary of its establishment by the state legislature to advance the care of injured patients in the state through accreditation of Level I/II and now III trauma centers.

The Board of Directors meets quarterly with its primary objective to ensure the public that a trauma center meets the rigorous criteria necessary to provide quality care for the most seriously injured patients.

A number of neurosurgical issues are currently being studied and addressed by the PTSF. A recent survey of neurosurgical manpower and the utilization of physician extenders in the state's 26 trauma centers further corroborated the significant decline in neurosurgical availability and the aging of the neurosurgical workforce. This information will be used to explore innovative back-up coverage systems to ensure timeliness of neurosurgical care while reducing the burden on current manpower.

In response to the same issue, an alternate pathway to the board certification requirement for neurosurgical participation in the trauma call panel has been endorsed and, indeed, already implemented in several trauma centers.

The requirement for 16 hours of yearly trauma-related CME for every neurosurgeon taking trauma call is also being revisited. It is highly likely that by the end of 2006 this requirement will be eliminated and only the designated neurosurgical liaison to the trauma program will be required to maintain such CME activity.

The Board of Directors continually revisits the accreditation standards to ensure that they are responsive to the changing needs and resources of patients and trauma centers.

Another significant function of the PTSF is to maintain the statewide trauma registry, which currently has extensive information on over 500,000 trauma patients treated in the state's trauma centers. This provides an invaluable resource for research in trauma and is available to anyone with a legitimate research proposal.

The PNS Returns to Chocolate Town: Annual Scientific Meeting News

Kevin M. Cockroft, MD, MSc, Program Chair

While many of you are busy with holiday shopping, the members of the Pennsylvania Neurosurgical Society's Program Committee have already been working diligently to prepare for the 2007 Annual Scientific Meeting, scheduled for **Friday and Saturday, July 27 and 28 at The Hotel Hershey**. This will be the fourth year since the PNS moved to a single annual meeting and this year's meeting will follow a similar format to last year's one and one-half day event.

Last year's meeting, also at The Hotel Hershey, was an unqualified success. Dr. Paul Nelson, Betsy Barton Professor and Chairman of Neurological Surgery at Indiana University, was our honored guest and keynote speaker. In his keynote address, Dr. Nelson, a former long-time resident of Pennsylvania, drew on his experiences with organized neurosurgery's national efforts for medical liability reform to provide an insightful look at the future of professional liability, including the potential impact of upcoming patient safety and quality of care initiatives. In addition to a strong showing of practicing neurosurgeons and neurosurgery residents from across the state, the meeting showcased over 20 different exhibitors of various neurosurgical products and services. Special thanks are due in particular to Boston Scientific Corporation, Integra Life Sciences Corporation and Penn State Milton S. Hershey Medical Center for their generous educational grants.

The meeting's Friday afternoon symposium, new in 2006, was extremely popular and the presentations on the latest techniques in posterior lumbar motion preservation surgery, moderated by Dr. William Welch, generated considerable discussion. The Saturday morning abstract session included 27 oral and poster presentations. As previously, the President's Award was given to the most outstanding oral and poster presentations. Scientific quality was especially good this year, making the judging exceedingly difficult. In the end, the Best Oral Presentation Award was won by Dr. John Birknes of Thomas Jefferson University for a presentation entitled *"Decreased Cholinergic Neurons in Rat Basal*

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Legislative Report

Bruce L. Wilder, MD, MPH, JD, Legislative Chair

The following will update legislative activity of interest to Pennsylvania neurosurgeons. Members who become aware of other such legislation that has been introduced, or that is contemplated to be introduced, are invited to submit that information so that it can be included in subsequent columns in the *PNS Newsletter*.

Medical Professional Liability

HB 132 (Payne (R) Calls for a constitutional amendment that would permit the General Assembly to "cap" non-economic damages in medical professional liability cases. Joint Resolution, referred to Committee on State Government, January 31, 2005.

HB 138 (Turzai (R) Amends the Judicial Code rules on comparative negligence. This bill remains on the House calendar on third consideration.

HB 166 (Godshall (R) Amends the MCARE Act to place a $250,000 "cap" on non-economic damages. Referred to Committee on Judiciary, February 1, 2005.

HB 167 (Godshall (R) A Joint Resolution to permit the General Assembly to enact a limit on the amount of non-economic and punitive damages. Referred to Committee on State Government on February 1, 2005.

HB 210 (Godshall (R) Amends the MCARE Act to restrict the amount of contingency fees for attorneys in medical professional liability actions. Referred to Committee on the Judiciary, February 2, 2005.

HB 212 (Godshall (R) Provides immunity for hospitals from non-economic and punitive damages in traumatic injury treated in a Level I or II Trauma Center. Referred to Committee on Health and Human Services, February 2, 2005.

HB 502 (Gannon (R) The Fair Reimbursement for High Risk Specialists and Trauma Act requires "fair medical bill payments" to health care providers in one of the four specialties in the highest category of professional liability insurance premiums. Referred to Committee on Insurance, February 14, 2005.

HB 503 (Gannon (R) requires managed care plans to enter into "equitable and reasonable" contracts with health care providers. Referred to Committee on Insurance, February 14, 2005.

HB 536 (Readshaw (D) Prohibits discrimination in health insurance coverage on the basis of genetic information. Referred to Committee on Insurance, February 15, 2005.

HB 743 (Mundy (D) Amends the MCARE Act to provides A 20 percent discount on medical professional liability premiums to physicians and health care facilities that implement a total quality management system specifically designed to reduce medical errors. Referred to Committee on Insurance, March 1, 2005.

HB 1346 (Harper (R) Amends the Judicial Code rules on comparative negligence, and abolishes joint and several liability. This was re-reported from the House Rules Committee and placed on the House tabled calendar on September 26, 2005. It is expected that the House (and the Senate) will revisit this issue sometime after they return to session. Laid on the table, November 17, 2005. This bill remains on the House calendar for third consideration.

HB 1752 (Quigley (R) Amends the MCARE Act of 2002 by providing for collateral sources. Referred to the Committee Health and Human Services, June 15, 2005. Reported with request to re-refer to Judiciary Committee on Feb. 7, 2006.

HB 1221 provides for establishment of the appellate division of Medical Professional Liability Court. This bill was referred to Judiciary on November 14, 2005.

SB 435 was passed by the Senate on December 6, 2005, places limitations on joint and several liability in medical malpractice cases. Any defendant who is less than 60% liable for an injury may only be held financially responsible in proportion to her percentage of liability, and not potentially for 100% of the judgment. This bill was passed by the Senate and the House on March 15, 2006, but vetoed by the Governor on March 24, 2006. It was laid on the table March 27, 2006.

SB 585 is similar to HB 2221, above. It was referred to Judiciary on April 1, 2005.

SB 628 provides for healthcare powers of attorney, (PN 1943) Sponsor: Greenleaf

Amends Titles 18 (Crimes and Offenses) and 20 (Decedents, Estates and Fiduciaries) providing for offenses of neglect of care-dependent person & for implementation of out-of-hospital nonresuscitation; making amendments & repeals. was amended on third consideration by the Senate on October 3, and passed by the Senate on October 16, 2006. It was laid on the table on October 23, 2006 by the House.

SB 972 extends the Mcare abatement through 2007. This was passed by the Senate on October 18, and by the House and presented to the Governor on October 23, 2006. It is expected to be signed into law.

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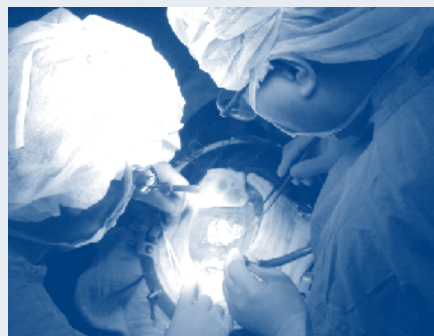
Chinese Penn State Neurosurgery Collaboration

Robert E. Harbaugh, MD, Council Member At Large

In January 2005, a delegation from the Bureau of Public Health of Tianjin, China visited a number of hospitals in the United States looking to establish partnerships for clinical care, clinical research and basic science research in various disciplines. Following this visit, we received correspondence that the Bureau would like to establish a formal relationship with Penn State as its Neurosurgery partner. In October 2005 a delegation, including James Connor, PhD, Vice-Chair for Research of the Penn State Department of Neurosurgery and I visited Tianjin to sign a formal collaboration agreement for clinical care, clinical and basic science research between Penn State and the Tianjin Bureau of Public Health.

These signs in the Tianjin Eye Hospital, as in all modern hospitals we visited, are written in Chinese and English

The hospital facilities we visited were modern, well-equipped and had excess capacity.



Craniotomy for resection of a parasagittal meningioma in Tianjin.

Tianjin is the third largest city in China with a population of about 10 million people. The city is investing heavily in its medical infrastructure. As one example, we saw a new hospital under construction. This will be a 1000-bed hospital devoted entirely to neurological and neurosurgical patients. Of note, all of these new facilities have signs written in Chinese and English. It is very clear that they hope to be a medical referral center for the world.

During our trip we visited many of the medical facilities of Tianjin. These facilities spanned the spectrum of care from traditional Chinese medicine to the most advanced Western medical and surgical treatments. The health care system is much different from what I had anticipated. As China remains a Communist country I expected a socialized medical system. This is not the case. Government workers have government-sponsored health insurance but non-government workers must either purchase private insurance or self pay. There is also a dramatic difference in the type and quality of health care available to city dwellers and rural Chinese citizens. Chinese who live in the major cities have access to Western medicine plus traditional Chinese medicine of excellent quality. Rural Chinese citizens have access to traditional Chinese medicine only with very questionable quality of care. This dichotomy of medical care is considered a growing problem for Chinese society.

The next step of our developing relationship with Tianjin involves three Chinese neurosurgery fellows who will be working in the Penn State Department of Neurosurgery for six months starting in November 2006. All will observe clinical cases in neuroendovascular, radiosurgical and functional neurosurgery. They will also work in the Neurosurgery basic science and clinical research laboratories. Upon their return to Tianjin, they will serve as the nucleus of clinician scientist who will work with Penn State Neurosurgery faculty to develop joint clinical, basic science and clinical science research endeavors. We anticipate a further exchange of fellows and faculty as this relationship develops.

Our travel to Tianjin was supported by grants from Synthes and Medtronic. The fellowship exchange program is being supported by a generous grant from Integra. Our thanks to these corporate partners for making this endeavor possible.

(Dr. Harbaugh is Professor and Chairman of the Department of Neurosurgery and Professor of the Department of Engineering Science and Mechanics at the Penn State University - Milton S. Hershey Medical Center.)

Legislative Report

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SR 160 is a Concurrent Resolution directing the Joint State Government Commission to establish a task force for a review of current status of alternative dispute resolution services, to identify best practices, and to educate PA citizens on conflict resolution was adopted on February 7, 2006, and was the subject of an organizational meeting held by the Joint State Government Commission on October 17.

Patient Safety

HB 1614 (Manderino) provides that expressions of apology or admissions of fault in the course of discussions with a patient or patient's family following an adverse health care outcome are not admissible as evidence against a health care provider. This protection would not apply after suit has been filed. The purpose of such a rule is to encourage open and frank discussion between a health care provider and a patient or patient's family when an adverse event occurs, the theory being that such open and frank discussion is a necessary first step in analyzing the root causes of medical errors so that future errors may be prevented. This has been referred to the Judiciary Committee of the House on June 3, 2005. The PMS House of Delegates passed a resolution on October 15, 2005, that would support this proposed legislation.

Electronic Health Records (EHR)

SB 934 (Corman (R) Establishes a Medical Safety Automation Fund (M-SAF) to provide matching grants of up to $1,000 to health care providers to implement a medical safety information system for patient electronic health records. This bill was amended on September 25, 2006, and passed by the Senate on October 16, 2006. In the House, it has been referred to Health and Human Services as of October 18, 2006.

Federal

SB 1262 (Frist (R) The Health Technology to Enhance Quality Act of 2005 (Health-TEQ) is intended to facilitate the implementation of EHR, including standards of interoperability. Referred to Committee on Health, Education, Labor, and Pensions on June 16, 2005.

H.R. 2234 (Murphy (R), Kennedy (D) The 21st Century Health Information Act of 2005 would, among other things, authorize HHS to make health information technology grants. Referred to House Ways and Means, Subcommittee on Health, May 26, 2005.

Other

HB 134 (Fleagle (R) Allows the Department of Health to create and maintain a Health Care Advance Directive Registry. This bill was re-referred to Appropriations and re-reported on October 23, 2006.

Current versions of bills and bill history in Pennsylvania can be found at www.legis.state.pa.us, http://www.legis.state.pa.us/cfdocs/legis/home/session.cfm, or http://capwiz.com/pamedsoc/state/main/

Status of Federal legislation can be found by bill number or key word search, at www.govtrack.us or at http://thomas.loc.gov/home/bills_res.html

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President's Report

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Pennsylvania Medical Society, to investigate this issue in more detail.

Finally, all neurosurgeons should be aware of the potentially injurious Senate Bill 1293, introduced by State Senators Vance, Browne, Fontana, Rhoads and White. This bill is essentially a punitive Stark Law on anabolic steroids, intending to eliminate all forms of currently acceptable self-referral. For example, under this law, if you are a neurosurgeon and your brother is a practicing urologist, you would not be permitted to refer a patient with a neurogenic bladder to your brother, even if he is in an entirely different practice group, simply because he is related to you. You would not be allowed to take an x-ray in your own office, or send a patient to an MRI unit or surgicenter in which you have a financial interest. This is an onerous bill that we should oppose.

More detailed documentation of these issues is available through our Executive Director, Michele Gaiski, at the Pennsylvania Neurosurgical Society office, located at the Pennsylvania Medical Society headquarters.

Finally, I want to thank Kevin Cockroft for organizing an outstanding Pennsylvania Neurosurgical Society meeting this last July at The Hershey Hotel, and Michele Gaiski and Jessica Judy for implementing the many details that contributed to the success of the meeting. Please note that next year's meeting will also be held at The Hershey Hotel from July 27-28, 2007, and we urge all Pennsylvania neurosurgeons to attend.

Editorial

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number of people. While many would attribute the myriad advances in medicine that occur in American hospitals, laboratories, and other venues of research and development, to "American ingenuity," it is perhaps more accurate to state that our "ingenuity," rather than being the result of some unique, innately American quality, exists because there are huge profits to be made from innovation in this country, as compared with most other places in the world, due, in large part, to our system of intellectual property law. In essence, the success of our innovation has created more medical technology than we can afford, and more than we want to pay for, yet none of which would one forego if one's life were at stake.

I recently heard a speaker comment that, if the present growth of health care expenditures as a percentage of gross national product were to continue, in another fifty years or so we would be doing nothing but operating on each other. It is a modern Pandora's jar: But instead of the escape of all manner of evils, we are overseeing the development of an astonishing level of technology to extend the quality and duration of life, but which only a few of us can actually have. Given limited resources, our concentration on, and commitment to, a highly advanced level of medical technology is arguably sapping resources that could go toward making basic healthcare and public health measures available to tens of millions in our own country and hundreds of millions of people world-wide. Given our inability and/or unwillingness to simply forego such technology if it exists, we have to ask if indeed, would we not, all of us, be better off as a society if it were simply not there because we had committed our resources and efforts to more basic needs of vastly larger numbers of people?

In searching for possible solutions to this dilemma, we should, among other things:

> Consider other paradigms of intellectual property. I have previously written about open source licensing in health information technology (HIT), which, by the way, is the latest example of how a badly needed technology that is sure to improve the delivery of health care, may wind up costing more than we can afford, and require providers to cede a major chunk of control over how health care is delivered, if left to the traditional copyright protections available to proprietary software vendors.
>
> Be cognizant of the notion that physicians—like most people, to varying degrees, depending on their own concept of law, ethics, and morality—make decisions based in part on the anticipated economic consequences for themselves. If we can do a better job of structuring systems so that the consequences of medical treatment decisions are economically neutral with respect to the decision-maker, and, in cases where such a strategy is not possible, develop better ways for physicians to learn the consequences of their decisions (in my view, an aspect of our medical care system that needs much more attention), all but the most craven will tend to modify their behavior in a way that will favor good medical care over economic gain. For instance, we may be well aware of the consequences of a decision to operate on a patient with lumbar spine disease, but usually never hear anything more about the patient whom we saw in the office and advised that surgery would not help.
>
> Move away from the reimbursement-based method of paying for services. Whether that necessitates a single-payer system is not clear. The fact remains that our present reimbursement-based system of compensation to both individual and institutional providers is riddled with incentives for fraud and unnecessary or questionably indicated treatment, and those phenomena, in turn, have spawned huge civilian bureaucracies that have an immense interest in preserving their sinecures—another severe drain on the dollars we put aside for health care. I should add here, that by use of the phrase "unnecessary or questionably indicated treatment," I do not mean to imply that all such treatment is the result of behavior of bad or dishonest people—I believe that much of it, perhaps the majority, is due to lack of adequate information on the part of key decision-makers, who, in the last analysis, want to do what is best for their patients. For example, better interaction between providers and patients or their families, geared toward providing a realistic set of expectations with a proposed treatment, would do much toward supplying critical information to both provider and patient.

To summarize, there is a widening gap between the sophistication and the technological possibilities of health care services, and the availability and affordability of those services to our citizenry, and this gap will continue to expand unless fundamental changes are made in the way we allocate resources available to us. Few, if any, contenders for public office, including incumbents, have the courage and leadership skills to rip the heads of government and the electorate out of the sand and address this dilemma, until the crisis is so out of hand that it will take years and years, and additional billions of dollars, to resolve.

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Annual Scientific Meeting News

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Forebrain Following Iatrogenic Ventral Pallidum Intracerebral Hemorrhage." Second and third place awards, respectively, were won by Dr. (fill in) of the (fill in) for a presentation entitled *"Oral Presentation Title"* and Dr. (fill in) from (fill in) for an abstract titled *"Oral Presentation Title."* Dr. Jack Klem, also from Thomas Jefferson University took home the Best Poster Award for a presentation entitled *"Histopathological Analysis of Neointimal Formation Following Endovascular Occlusion of Aneurysms Using a Novel Canine Model."* Winners received cash prizes totaling $750 donated by past presidents of the PNS.

The format for the upcoming 2007 meeting will be very similar. A full-day program is again planned for Friday. Next year's theme will be **"Advances in the Treatment of Neurosurgical Emergencies and Trauma."** This year's keynote speaker will be (fill in). Again, lunch will be provided on Friday, prior to a special afternoon session focusing on the management of spinal emergencies and trauma. A cocktail reception will follow in the evening. As usual, Saturday's session will include oral and poster presentations of current neurosurgical topics. Monetary prizes will be awarded for the best clinical and the best basic science presentations.

Overall, we look forward to another thought provoking and educational meeting. We hope you will join us for some fellowship, food and fun…not to mention a few CME credits, and even some trauma CME credits. A call for abstracts will go out in January and registration materials will be mailed in early April. **On-line registration** will be available again this year, along with traditional paper materials.