January 2006

PNS NEWS

Pennsylvania Neurosurgical Society in Association with Mid-Atlantic Neurosurgical Society

President's Closing Message

Daniel M. Bursick, MD, Immediate Past President

By the time you receive this newsletter, I will have completed my term as President of the Pennsylvania Neurosurgical Society. As I neared the end of my presidency, I reflected on what I learned and the insights I have gained during the last two years. Doctors Raymond Truex and Loren Amacher have opened my eyes to a new world of organized medicine and Harrisburg legislative struggling that I never knew existed. Below are just a few of my notes from newfound knowledge.

1. Not all Republicans are our friends and not all Democrats are our enemies.
2. You really do not want to see either sausage or legislation being made.
3. Every political action has an opposite and sometimes surprisingly unexpected reaction.
4. Our Harrisburg people work very hard and exceptionally diligently for us. Roger Mecum, Pennsylvania Medical Society's Executive Vice President, sorts through reams of data, tons of legislative bills, and meets with everyone from the Governor to the small automobile association dealers to help not only organized neurosurgery but all physicians in this state. Larry Light, Vice President, Legislative and Political Affairs at the Medical Society, and his staff run from aisle to aisle in Harrisburg lobbying for bills and carrying our legislative agenda up the Harrisburg hill. Michele Gaiski, our Executive Director, and Jessica Judy, our Meeting manager, continue to make sure the Pennsylvania Neurosurgical Society runs on time, pays the bills and keeps the President's head above water.

Again, I am very impressed with the amount of work being done on our behalf by these people, many of whom work behind the scenes and seem to get little credit from a number of physicians in the state.

Just recently, I have come to realize that a small group can indeed make a difference. I am referring to the summer legislative secret pay raise and its

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Think Summer: PNS 2006 Annual Scientific Meeting

Kevin M. Cockroft, MD, MSc, Program Chair

There may be snow on the ground and the temperature may be hovering below freezing, but summer will be here in a few short months. So plan ahead and mark your calendars for the Pennsylvania Neurosurgical Society's 2006 Annual Scientific Meeting, scheduled for **Friday and Saturday, July 14th and 15th at The Hotel Hershey**. This will be the third year since the PNS moved to a single annual meeting format and with about six months to go, the meeting program is already shaping up to be as informative and engaging as ever.

Last year's meeting, also at the Hotel Hershey, was a resounding success, with increased attendance, more abstract presentations and lively discussion around the topic of "Controversies in Neurosurgery." Dr. Edward R. Laws, president of the American College of Surgeons and World Federation of Neurological Societies, was our honored guest and keynote speaker. In addition to giving a stimulating address and being an active participant in subsequent discussions, Dr. Laws also assisted in the judging of Saturday's abstract presentations. In the end, the Best Oral Presentation Award was won by Dr. Nodar Surguladze of the Penn State College of Medicine for a presentation entitled "*A Role for Nuclear Ferritin in Tumorigenesis*." Dr. Anand V. Germanwala of the University of Pittsburgh Medical Center, took home the Best Poster Award for a presentation entitled "*The Use of Gamma Knife Radiosurgery in the Multi-Modality Treatment of Medulloblastoma in Adults: A Long-term Follow-up*." Winners received a cash prize, while runners up in each

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

Legislative Report

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

Medical Professional Liability

H.B. 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.

H.B. 138 (Turzai (R)) Amends the Judicial Code rules on comparative negligence. This, and H.B. 1346, below, were re-reported as committed from the House Appropriations Committee on December 6, 2005. It is expected that the House (and the Senate) will revisit this issue sometime after they return to session on December 12, 2005.

H.B. 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.

H.B. 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.

H.B. 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.

H.B. 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.

H.B. 501 (Gannon (R)) Provides that health care providers other than hospitals need not maintain medical professional liability insurance, but in order to practice without such insurance, they must notify the licensure board. Neither a hospital or a health insurance plan may require a physician to maintain professional liability insurance, nor may a health insurance plan require an enrollee to use a health care provider who maintains professional liability insurance as a condition of coverage. This has been referred to the Committee on Insurance, February 14, 2005, and hearings have been held.

H.B. 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.

H.B. 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.

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

H.B. 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.

H.B. 1346 (Harper (R)) Amends the Judicial Code rules on comparative negligence. 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.

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Negative Forces Hurting Pennsylvania's Medical Practice Climate

Roger F. Mecum, Executive Vice President, Pennsylvania Medical Society

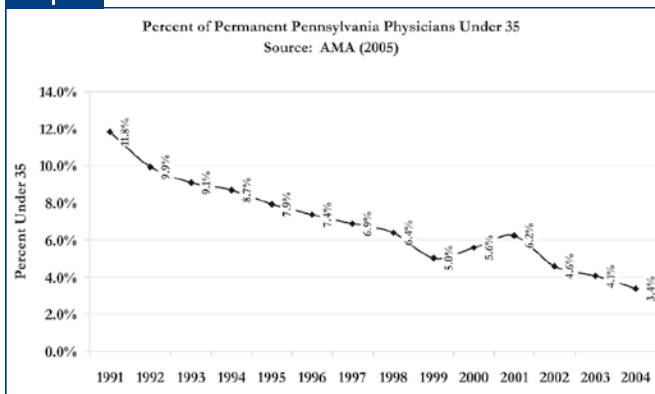
In February 2005, a contingent of medical students and residents met with top Pennsylvania officials to voice concerns about the shocking number of residents in training who are no longer staying in Pennsylvania to practice.

The data, from 2004 research of the Pennsylvania Medical Society's Health Services Research Institute, showed that the number of young doctors practicing in Pennsylvania has dropped to an all-time low (Graph A). By 2003, only four percent of Pennsylvania physicians were under the age of 35, compared with 12.3 percent in 1990 and 22 percent in 1980.

The statistics clearly show a decline in the numbers of residents choosing to practice in Pennsylvania (Graph B) and an equally troubling decline in numbers of high-risk specialists.

The number of neurosurgeons practicing in Pennsylvania has declined to pre-1991 levels (Graph C).

Graph A



Graph B

The data also shows unprecedented health insurer profits (Graph D) and surpluses (Graph E).

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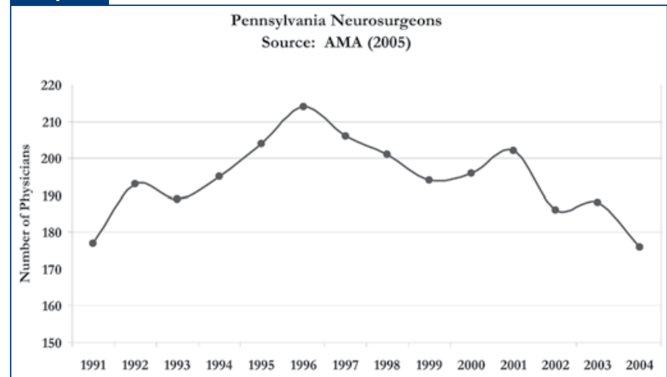
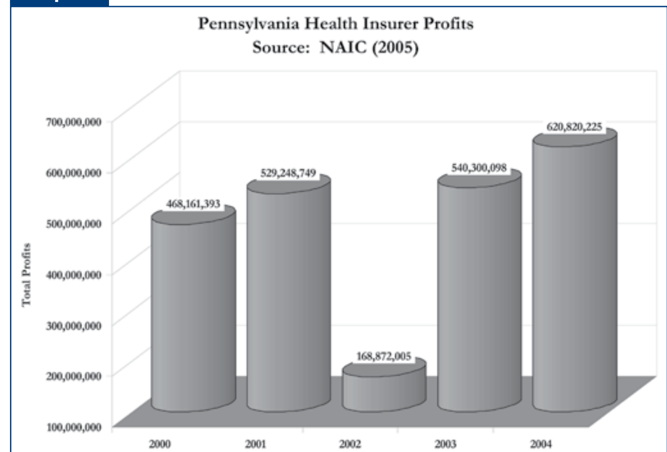
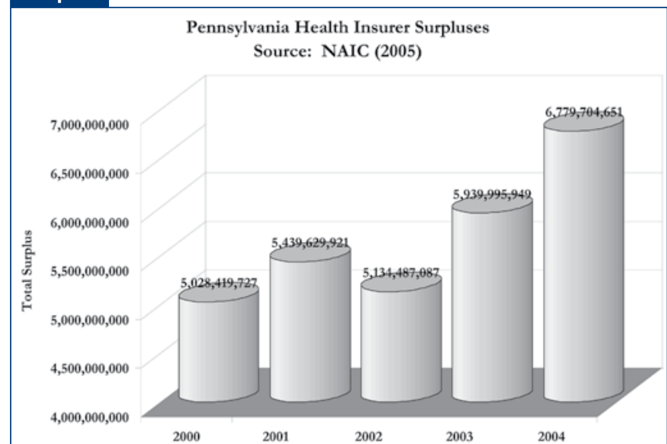
Graph C



Graph D



Graph E



Editor's Column

Electronic Health Records (EHR): Getting it Right with Open Source

Bruce Wilder, MD, MPH, JD, Editor

There is, and should be, no debate about the value of, and the need for, the implementation of electronic health records across the spectrum of health care providers. What is not clear is how this will evolve, and who will control the implementation and development of EHR.

The concept of EHR has been around for a long time, and various attempts at implementation in health care are as old as those in other industries. However, the health care "industry" has lagged far behind others in this regard as computer technology has evolved. Some large health care systems are using fairly sophisticated systems, but even these systems will be looked upon as crude in as few as ten years from now.

The barriers to establishment of industry-wide implementation are well known. The cost, especially to smaller entities, is prohibitive for some. The problem of interoperability has been recognized for some time, and is perhaps exacerbated and perpetuated by large proprietary vendors who are jockeying for control of the EHR market. There continue to be significant concerns about maintaining confidentiality of patient-physician communication and about the security of such information and of other personal information that is acquired in the course of the provision of health care. By the time it was enacted, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which had its origins in the recognition of a need to have portability of health insurance, had morphed into what some see as a distorted and contradictory system that, while ostensibly providing protection of personal health information, validates the release of some personal information to entities that previously were not clearly entitled to it. Although it is explicit in the statute that States may make rules that are more restrictive, one may not assume that States will always recognize the threats to personal privacy that exist, let alone move to correct them. Some exceptions are being made to anti-kickback rules, which would permit larger healthcare organizations to provide assistance for physicians in the implementation of EHR in their practices. While this may be a convenience for the physician in the short term, one should remember that it goes against the policy underlying the anti-kickback rules.

To put it briefly, the health care industry has many unique features that pose problems in the implementation of EHR. In approaching these problems and attempting to find solutions, it is worthwhile to review some history and to question some basic assumptions. Over the years, physicians have seen the erosion of autonomy, and the loss of control of how health care is delivered. This phenomenon has by no means been all bad, because some aspects of health care delivery require a large organization to meet the demands of patient safety, economies of scale, efficiency of health care delivery and conservation of resources, and other matters. On the other hand, matters relating to the protection of physician-patient communications, and the need for developing effective and efficient methods of storage and retrieval of pertinent medical and other information, that can be adapted to the changing landscape of medical technology and methods of health care delivery are best managed by persons and entities (e.g. physicians, nurses, hospitals, outpatient clinics), who interact face-to-face with patients on a daily basis, and not, say, insurance companies (who may, in ten years, be completely out of the picture, if we move to a single-payer system), or pharmaceutical conglomerates.

This is where Open Source comes in.

If we permit the implementation of universal EHR to be controlled by big-money players, it is almost a certainty that we will find ourselves with a system dominated by a few large vendors using proprietary systems that do not always operate in the best interests of patients, and that is clearly the trend. There has been some discussion of Open Source by HHS, and by HL7 (Health Level 7 (**www.hl7.org**)) is an organization dedicated to establishing open standards of interoperability (see below for a discussion on the difference between Open Source and open standards) and it has been met with quick opposition by the proprietary software vendors, including Microsoft, for obvious reasons.

What is Open Source? Basically, Open Source is a licensing model that that differs from the traditional licensing model of copyright. Lets say ABC Software develops a program and wishes to profit from the work that went into producing it. The traditional, copyright model gives the copyright-holder of that software program the exclusive right to copy, sell, or modify it. The copyright-holder can sell a license to use that program, but the license usually prohibits the user from copying or modifying the program. If the user wants to modify the program, he must have the permission of the copyright holder, and that permission may come

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President's Message

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recent repeal. A tiny group of people (probably not larger than our own society) started and carried through this repeal process. With rightness on their side, some cash, media attention, and a large pink pig, they left our Harrisburg legislature quivering in fear for their jobs during the November election. Their actions have led to a rollback of this pay raise. They have even rattled the State Supreme Court and led to the first ever non-retention of a sitting Supreme Court Justice. There is no reason why organized medicine or organized neurological surgeons cannot do the same. Perhaps all it will take is a large pink pig with a headband and an external ventricular drain to get our agenda out in front of the public and put our points across. We certainly have rightness on our side.

In closing, it has been a pleasure to serve as President of the Pennsylvania Neurosurgical Society. I look forward to continuing my education in the Harrisburg political arena.

Daniel M. Bursick, MD
President

Thank Your Legislators!

We urge you to thank your state legislators (both Senators and Representatives) for voting for the one-year extension of the Mcare abatement. In addition to the extension, which runs through 2006, the approved legislation includes a 50% abatements for nursing homes during 2006 and creation of an 11-member commission to analyze ways to pay down the unfunded liability of the Mcare fund.

Negative Forces

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In light of the recent data, many of the concerns of Pennsylvania's medical community have been borne out. While Pennsylvania has made progress in some areas to improve its medical practice environment, more needs to be done. The Pennsylvania Medical Society believes that the commonwealth must take these steps:

- Approve a plan to pay down the unfunded liability of the Mcare Fund with the use of the cigarette tax and auto fund monies to ultimately eliminate the Mcare Fund. This is extremely important if the commonwealth is to attract young physicians and encourage resident physicians to stay here to practice.
- Pass a constitutional amendment and legislation to bring a meaningful cap on non-economic damages to Pennsylvania. This is extremely important in controlling the increasing costs of liability insurance, and vital to the efforts to have commercial carriers reenter the Pennsylvania market.
- Educate the insurers, public, physicians and hospitals on the use of mediation as an alternative to the current court system, and have the Supreme Court adopt an apology rule crafted after legislation already adopted in Colorado.
- Pilot a no-fault demonstration project for medical liability claims, and a demonstration project to pilot an administrative court process, headed by an administrative law judge, to handle liability claims.
- Establish a "deregulation commission" designed to reduce the unnecessary and burdensome regulations on medical practices in the commonwealth, and adopt a culture to encourage—not discourage—medical enterprise. The health care industry is Pennsylvania's largest employer category.
- Approve a wholesome restructuring of the state's Medicaid program. The program is nearing collapse and needs to be restructured using a defined contribution approach, rather than the current defined benefit approach. The commonwealth should obtain a federal waiver to start such a restructuring, as Florida has done.
- Pass fair contracting legislation—House Bill 503, sponsored by the Pennsylvania Medical Society—to level the playing field between physicians and market dominant health insurers and eliminate many of the unfair business practices of large health insurers.
- Improve the health care regulatory and legislative environments to encourage the expansion of medical services in a more patient-centered environment, such as outpatient facilities and the home. The commonwealth should change the financial incentives to encourage more medical management, particularly with chronic disease management and preventive health care.

Only broad reforms such as these will begin to improve the medical practice environment in the commonwealth to welcome new generations of physicians to practice here.

Legislative Report

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H.B. 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.

S.B. 435 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. Third consideration and final passage on December 6, 2005.

Patient Safety

Federal

The House passed **S. 544**, The Patient Safety and Quality Improvement Act of 2005, by a vote of 428-3, on July 27, 2005. This legislation establishes protections for the reporting of medical errors. It does not shield information that is available from medical records. This Bill became Public Law No. 109-41 on July 29, 2005.

State

H.B. 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 Pennsylvania Medical Society House of Delegates passed a resolution on October 15, 2005, that would support this proposed legislation.

Electronic Health Records (EHR)

Federal

S.B. 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, May 10, 2005.

State

S.B. 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. Referred to Committee on Public Health and Welfare on October 17, 2005.

Other

H.B. 134 (Fleagle (R)) Allows the Department of Health to create and maintain a Health Care Advance Directive Registry. Referred to Judiciary on January 31, 2005.

Current versions of bills and bill history in Pennsylvania can be found at **www.legis.state.pa.us***. Status of Federal legislation can be found at* **www.govtrack.us** *or at* **thomas.loc.gov**

Editor's Column

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at a price, which could include all rights to the modification. Thus, a user who makes an improvement in a software program, may gain some benefit from the improvement, but the original developer of the program will reap the profits from the efforts of the licensee. The Open Source licensing model is different and is based upon what is known as the General Public License (GPL), i.e. the source code is available to anyone, and anyone may make, and use and distribute (and even sell) an unlimited number of copies of the program. The only restriction of the GPL is that any user who modifies the program agrees to make the modification freely available to any other user. To put it another way, the people who actually use the program can make whatever changes they wish, but must share those changes with every other user. In other words, the users of the program can adapt it in any way they choose, to suit their own needs. The incentive to modify a program is that the user will be able to improve its own EHR system, without having to have the approval of the copyright holder, which may come at a significant price. Open standards differs from Open Source, in that open standards are publicly available specifications that permit manufacturers (for the purposes of this article, read software developers) to create products that can be integrated so that they work together seamlessly, in short, products that are interoperable (see above discussion on HL7).

There are some drawbacks to using Open Source at the present time, but for the most part, the disadvantages relate to the fact that it has not been widely adopted across the health care industry. It will take a critical mass of users before we experience the true value of Open Source. The debate about adoption of Open Source is now being played out in Massachusetts, where state government has moved to adopt an Open Source document format called Open Document, instead of Word, for all its official records. As might be expected, there is fierce opposition from Microsoft. Moreover, many public and governmental entities are exploring the move to Open Source, perhaps primarily for economic reasons, but there are other considerations. In the healthcare field, control by medical providers, including considerations of confidentiality and security, as well as the actual design of systems that maximizes effective and efficient storage, retrieval, and display of medical data are paramount, and are probably more critical than cost considerations. In my view, it is absolutely critical that control of the development of EHR (as an aside, just type in "EHR" next time you use Word, and see what you get) systems be in the hands of health care providers. Without Open Source this will not happen.

Numerous projects relating to Open Source in medical records are underway (for example, see **www.openehr.org**). Recently, the Veterans Administration released the source code for VistA, its own EHR system. In addition, there are a number of bills in state legislatures, and in Congress, that are designed to facilitate the implementation of EHR systems, but these bills have almost completely ignored the issue of Open Source, most likely because of lobbying interests. In my view, we are at an extremely important watershed with regard to the issue of Open Source in healthcare EHR. While proprietary vendors are free to develop and market their products under traditional copyright protection, medical professional and other public organizations, including government, should recognize the long term benefits of Open Source and promote it now, or a significant opportunity for controlling the way health care is delivered may be lost forever.

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2006 Annual Scientific Meeting

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category received a gift of medical textbooks. Ultimately, attendees were uniformly impressed with the quality of the scientific presentations as well as the hotel facilities and local recreational activities.

The format for the upcoming 2006 meeting will be very similar, except for the addition of an expanded program on Friday, July 14th. This year's theme will be "The Future of Neurosurgery." Along with talks on the future trends in the major subspecialty areas of neurosurgery, we will also hear presentations regarding Maintenance of Certification and pay-for-performance as they relate to neurosurgical practice. For the first time this year, lunch will be provided, prior to a special afternoon session focusing on what may be the future of spinal instrumentation and fusion —motion preservation with dynamic stabilization. Saturday's session will again include oral and poster presentations of current neurosurgical topics. Monetary prizes will be awarded for the best clinical and the best basic science presentation.

This year's keynote speaker will be Dr. Paul B. Nelson, Betsy Barton Professor and Chairman of Neurological Surgery at Indiana University. Dr. Nelson has strong ties to Pennsylvania. He grew up in the State College area, where his father was a member of the Penn State University faculty. Dr. Nelson, himself, was an undergraduate at Penn State University, received his Medical Doctorate from the Penn State College of Medicine and completed his residency at the University of Pittsburgh. After being on staff at the University of Pittsburgh for a number of years, Dr. Nelson moved to Indiana University where he is now Chairman of the Department of Neurological Surgery. On a national level, Dr. Nelson has been active in organized neurosurgical efforts for medical liability reform. In his keynote address he plans to discuss the future of professional liability, especially with regard to upcoming initiatives concerning patient safety and quality of care.

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