Presidential Address

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We have now arrived at that point in the annual meeting when custom and tradition call for the President to address the assembled Congress. In light of our many innovations at this 21st annual meeting, I must say that I toyed with the idea of breaking with tradition here as well; however, my poor judgment has prevailed, and I will proceed. Since this is a new experience for me to give a presidential address, I wanted to share with you some of my thought processes that went into the preparation for such an endeavor. The foremost question, of course, was the subject for the address; a choice that can and did prove quite difficult. I expect a certain amount of empathy from you, since most of you cannot be certain that you yourself won't be in the same position as I during the ensuing years, this being a democratic organization. The subject, of course, must be pertinent and timely. It probably should concern medicine in general and neurosurgery in particular, and should carry a message with broad implications to us all. It should include some important recommendations to the members and perhaps admonishments as well. A bit of prophesying probably would not be out of line.

Naturally, in a situation like this, one turns to the past to see what has been said and done before. Having had an outstanding list of predecessors, I felt a certain confidence in turning to a review of their speeches. John Shillito, in the 1968 Toronto meeting, told us of the outstanding accomplishments of the Congress of Neurological Surgeons (16). He emphasized the international nature of the Congress and further cited our contributions to the education of younger neurosurgeons. The involvement of our members in the committee structure of the Congress was rightfully praised. John pointed out the difficulties encountered in our day-to-day attempts to practice neurosurgery as medicine interfaced increasingly with government and with a clamoring public. Finally, we were admonished to be more flexible in our approach to the practice of medicine and reminded of our basic dedication to the healing art.

Paul Sharkey in 1969, in Boston, discussed with us the dangers of isolating ourselves in our neurosurgical practice to the extent that we excluded our families and our communities (15). He charged some of us with failure to assume our responsibilities in matters outside of, yet pertinent to, the practice of neurosurgery and suggested a revision of our time budget to include time for these other important considerations.

Last year in St. Louis at the 20th annual meeting, John Thompson made

a masterful historical review of the development of neurosurgery and of neurosurgical societies (17). The history of the Congress of Neurological Surgeons was detailed. It was clear that the Congress had come of age among the other societies and had assumed a position of youthful leadership in the neurosurgical world.

From my first association with the Congress, I have continued to be impressed with its steadfastness of purpose, namely, the maintenance of high standards of neurological surgery in the interest of public health and welfare. The Congress has served this goal primarily through the continuing education of neurosurgeons but has not satisfied itself merely with educational endeavors. With enthusiasm and energy, it has sought out problems for study and solution both here and abroad. Its socioeconomic efforts quickly come to mind. The Fee Survey and Utilization Guidelines are outstanding contributions. The Directory and Placement Committees have helped in the distribution and procurement of neurosurgical care. The recent establishment of a Neurosurgical Residency Registry will further help to make neurosurgical service available throughout the world. Despite this effort, I don't think we have done nearly enough; I would like to challenge the members of this organization to be the leaders in an attempt to further upgrade the practice and delivery of neurosurgical care in this country and elsewhere. Fortunately this society, perhaps because of resourcefulness and flexibility, has not become tradition-bound. This is perhaps exemplified by this year's somewhat marked revamping of our meeting format and the major revision of our By-laws, including elimination of the AMA membership requirement. As John Shillito has stated, "We must change and grow and reorganize . . .", and he was quick to insist that it must be the doctors who should be the forerunners in the planning and organization, and I might add, not the politicians, not the nonprofessional administrators, not the do-gooders, not the union leaders, and not the Ralph Naders. It is to this interface between physicians and the public, particularly as it relates to neurosurgery, that I direct my remarks. Part of what I have to say may not be popular. In fact, to some, none of it will be. Nevertheless, there are forces buffeting the medical profession today that should make even the most conservative of us concerned. I need only remind you of some of these problems, since everywhere we turn today, we hear or read of the ugly specter of government's entry into medicine, consumerism, malpractice, doctor shortage and maldistribution, urban and rural health neglect, and so forth.

It is obvious to us all that the medical profession faces difficult times ahead. In recent years, we have been subjected to a seemingly endless stream of criticism from all quarters despite our record of scientific advances. Medical care is not merely a conversation piece, it is the subject of

heated political debate and social controversy (5, 11, 14). To some enterprising politicians, it has furnished the opportunity for a political heyday—Madison Avenue style. The rising costs of medical care, particularly for the hospital segment, the unavailability of care for the poor and the near poor, and the financial failure of Medicare and overall failure of Medicaid have given the social planners ample opportunity again to attempt to socialize medicine in this country.

Medicine has become more and more hospital-based because of the increasingly inverse ratio between the generalists and specialists. The emergency room has become an unsatisfactory family doctor to a large segment of America. Federally financed and organized medical plans have fanned the fires of discontent by creating a new population segment which now clamors for care from an already inadequate and overworked medical force. It is common to read and hear bandied about statistics supposedly illustrating how poorly cared for the health of Americans is. If there is any doubt that the public has become disenchanted with the medical profession and has lost its traditional respect for the doctor, one need only look to the malpractice problem for convincing evidence.

Whether or not these criticisms are, in fact, justified, is a separate question (14); nevertheless, even unfair criticism can be useful because it leads to self-evaluation and prevents complacency. Two points do stand out, however. First, the consumer of health care has clearly staked out his claim to a voice in the health delivery system (6). Second, the concept of the right of every human being to health care has become established (3).

Few would disagree with President Nixon's stated objectives: (1) to provide every American citizen with equal access to adequate medical services, regardless of ability to pay; (2) to increase the supply of medical manpower and facilities to meet the expanded demand; (3) to increase the efficiency and economy with which medical services are supplied to our people; and (4) to accomplish these objectives insofar as possible, within present medical structures and without sacrificing traditional American freedom of choice (1).

Let there be no doubt that the Federal government is standing in the wings ready and willing to enter into the practice of medicine. The only question remaining is in what fashion and to what degree. Already many changes have taken place in an attempt to solve our so-called health delivery system failure. The manpower shortage is being alleviated by programs of physicians' assistants, retrained corpsmen, paramedical technicians, and so forth. Opportunities for entry into medical school have grown markedly with the enlargement of existing schools, founding of new ones, and the shortening of curricula. Barriers for immigration of foreign gradu-

ates have been lowered to further expand our medical manpower pool. Legislation to subsidize medical schools and students is being formulated. Special attempts are being made to recruit the so-called disadvantaged and/or minority students.

The ultimate form that the American health delivery system will take and the means of financing it will not be revealed until the all-powerful Ways and Means Committee makes its move on this issue. The variability of the plans being considered is wide—from total restructuring into a completely socialized system not unlike Britain's or Sweden's—to a system with little change from the present. As you know, the government is pushing the concepts of HMO (Health Maintenance Organization) but claims no intent to create a monolithic system. At the same time, it is obvious that the administration has become enamored with the concept of prepaid capitation payment to medical groups who will in turn provide complete health service. Whatever the ultimate form is, let us hope for the sake of the patient and the physician that it is a pluralistic system. The end result must be judged by two criteria. First, is health service available and is it good? Second, since goods and services have cost, has provision been made for their purchase? If these two criteria are not met, there will be a system failure (8).

Health care is so closely related to socioeconomic conditions that to consider the two separately is ridiculous. Many criticisms of the medical profession stem from the social and economic problems plaguing the United States today, as for example, urban decay, black ghettos, the Vietnam war, inflation, civil rights strife, poverty, campus riots, *ad infinitum*. We are told by William Braden in *The Age of Aquarius* (2) that we are in the midst of a "cultural revolution" or humanistic revolt against technology and against the debatable form of affluence that technology so far has produced in this country. Charles Reich in *The Greening of America* (12) senses a revolution against the so-called "corporate state." He believes this change will lead to "a new way of living," in which man will reject the technological society and assume a new life style based on the philosophy of the absolute worth of every human being. The basic issues in America's insurrection against itself, according to Jean Francois Revel, the French author of "Without Marx or Jesus" (13), who also predicts a revolution in America, are: ". . . radically new approach to moral values; the black revolt; the feminist attack on masculine domination; the rejection by young people of exclusively economic and technical social goals; the general adoption of non-coercive methods in education; the acceptance of the guilt for poverty; the growing demand for equality; the rejection of an authoritarian culture in favor of a critical and diversified culture that is basically new, rather than adopted from the old cultural

stockpile; the rejection, both of the spread of American power abroad and of foreign policy; and a determination that the natural environment is more important than commercial profit." Our young people, including medical students, are very much involved in this revolution and are frustrated by the discrepancies between what they see wrong and what they personally can do to correct it (4). Their basic belief is, however, that human needs must not be subordinated to technologic advance or corporate profits. Revel claims that this is "the first revolution in history in which disagreement on values and goals is more pronounced than disagreement on means of existence."

It is against this difficult background that medicine must shape its future. We must ask ourselves: Can there ever be good health for all without improved housing, improved education, improved economic opportunities and improved living standards? Still, for the doctor, the central mission will always be to maintain health and prevent disease, to diagnose illness and treat it, if possible, to reduce morbidity and mortality, and to ease pain and suffering. The question remains: How can we neurosurgeons further increase our effectiveness?

A couple of years ago, a somewhat obscure *ad hoc* committee was formed by Dr. Paul Sharkey which has proved, at least in my opinion, to be one of the most challenging and provocative of the Congress committees. I refer to the Committee to Study Means of Maintaining High Levels of Neurosurgical Practice. Don't be put off by the name, because this committee has wrestled with most of the problems related to the delivery of good neurosurgical care and has begun to formulate some definite goals and recommendations. At the heart of the matter is nothing different from the basic goals of this Congress; namely, the delivery of high-grade neurosurgical care. General areas of concern were: (1) continuing education, (2) individual reassessment, (3) peer review, and (4) systems of neurosurgical care.

Attempts to improve the Congress' already successful continuing education program may seem redundant; however, a number of ideas have evolved. This year's luncheon discussion groups and workshops are examples. The Continuing Education Calendar, we hope, will evolve into an important list of seminars, postgraduate courses, workshops, etc., of interest to all neurosurgeons. This list, plus the opportunities for sabbatical visits being developed by the Sabbatical Interchange Registry, should provide our members with an excellent mechanism for updating their knowledge and skill.

The question of self-assessment probably gave the committee more difficulty than any other area. This seems to be an emotionally charged question and we could never reach unanimity of opinion. Some favored

self-assessment examinations, either voluntary or compulsory, to be given at stated intervals. Others proposed actual periodic recertification by the American Board of Neurological Surgery. Then, of course, there was also a strong feeling that any type of reassessment was unfair and an imposition on the practicing neurosurgeon. Perhaps it is known to you that Ralph Nader and other consumer groups have strongly advocated periodic evaluation of every physician to assess his competency. The Committee finally recommended that Congress members should be encouraged to enroll in the AMA Continuing Education Award program which recognizes physicians who participate regularly in continuing medical education. This route does not adequately solve the problem since there is no actual evaluation, and, furthermore, those neurosurgeons most in need of updating are the least likely to participate. The committee also recommended that members consider taking the self-assessment examination given by the American Association of Neurological Surgeons' Joint Committee on Education. It seems likely that some type of periodic reevaluation will be instituted in the future. Let us do our level best to keep this on a peer basis rather than in the hands of lay persons or government.

This brings us next to the question of peer review, a subject currently in the limelight (9). Peer review has been defined as a review of a physician's work by another physician of like training and experience. It implies an educational re-examination of a physician by his equals—equals in that they are both practicing physicians in the same area and preferably of the same specialty. Peer review is not new to medicine. It has existed in some form since the ancient days of the profession, as, for example, in the relationship of teacher to student, or attending surgeon to resident, in board examinations, in tissue committees, in mortality and complication conferences, in medical record committees and in medical audits. These were and are self-imposed means by the medical profession to maintain high standards of care (7). We are now called upon to enlarge the scope and improve the methodology of peer review.

There are three facets to peer review: (1) utilization, (2) financial, and (3) performance. Utilization review was the first to be introduced and seems to be a reasonable requirement of value both to the patient and to the physician. I am sure that it is familiar to you all.

Financial or fee review has been more controversial but undoubtedly will become more and more prevalent. There are demands for cost and quality control by a health insurance industry with more than 70 million subscribers and by health plans of organized labor, as well as the programs of local, state and federal agencies. The Usual, Customary and Reasonable fee system spawned the need for this particular type of review. Fees that are considered out of line in any of the three categories, that is, usual,

customary, or reasonable, ultimately are reviewed by a committee of peers. To be effective and logical, the review must be done by peers of the same specialty; that is, neurosurgeons judging neurosurgeons. The Congress Fee Survey has supplied much helpful information in this regard.

A most difficult area is the matter of peer review of performance. This problem is so closely allied to the matter of systems of neurosurgical care that I don't think they can be discussed separately. It is extremely difficult to judge the performance of another physician and specifically, for our purposes, the performance of another neurosurgeon. This may be true even of a surgeon in one's own institution or hospital unless certain predetermined assessment guidelines are established. Some envision the ultimate form of assessment to be made by computer analysis of data fed in from a variety of sources (10). This sort of analysis has been done in Michigan and is useful in detecting deviations from established "norms"; however, judgments on the quality of care rendered require careful consideration by physicians practicing in the same specialty. The goals of peer review are said by a committee of the American College of Surgeons to be: (1) to provide a method for creating public awareness of medicine's efforts to assure high quality health services at reasonable cost; (2) to slow the rate of escalation in health care charges; (3) to stimulate health insurance organizations to provide broader protection for more people; and (4) to retain professional supervision and ethical standards in the fiscal and economic aspects of the physician-patient relationships.

Germane to our discussion is another matter being considered by this same Congress committee; namely, whether the Congress should advocate and promulgate the establishment of neurosurgical units throughout the country. Before you become fearful that the Congress or some other organization is going to tell you where you can practice, let me enlarge on this matter. For some time, it has been customary for neurosurgeons entering private practice to begin by going on the staff of a number of hospitals. In this way, the surgeon becomes known and available to a broad base of referring physicians and is also available to the various emergency rooms. Fortunately, in most instances, the young surgeon becomes busier and busier and finds it necessary to confine his coverage eventually to one or two selected hospitals that seem most attractive to him. For him to continue otherwise would only be to the detriment of his patients and himself, since the coverage becomes too thin and the care of his patients inadequate. Unfortunately, hospital administrators, boards of trustees and medical staff often promote staff opportunities for selfish reasons without consideration of the overall good of the community despite the availability of top-rate neurosurgical care nearby. It is my contention, and I am speaking from a personal viewpoint, that the days of a solo

neurosurgical practitioner trying to cover a bevy of widely separated hospitals should come to an end. I think that this is a variety of itinerant surgery and from that standpoint alone should be condemned. Neurosurgical consultations can be done in outlying hospitals, but the patient should be brought for definitive investigation and treatment to the surgeon's major hospital where the neurosurgical unit is located. Available here should be the best forms of diagnostic aids, the best surgical equipment, the best anesthesia, the best surgical team and intensive care team. In these days of rapid transportation seriously ill patients, including head injuries, can quickly be brought to the neurosurgical unit when necessary. I think that neurosurgeons should group themselves together in major hospitals to facilitate the formation of such units for the investigation and care of neurosurgical patients. They may be associated in practice or only geographically associated. It is inefficient for the neurosurgeon to spend a large segment of his time each day in travel. It is, likewise, not in the best interest of his patients for him not to be quickly available in emergencies. Essential for the formation of these neurosurgical units is the organization of the available neurosurgeons for coverage, education, and peer review. A team of neurosurgical intensive care and operating room nurses, technicians and other ancillary personnel can be developed and kept up to date by in-service training programs and postgraduate courses. This concept of neurosurgical units may be unpopular at first and may meet resistance from individual hospitals; however, I think that if a national society such as the Congress advocated this as a policy, neurosurgeons will be able to effect the change. It will be necessary to convince referring physicians, hospital administrators and sometimes the patient himself, that transfer is in the best interests of the patient.

Neurosurgery, after all, should be considered the second or third echelon of care. If the concept of HMO is adopted, it will be all the more important to have clear lines of neurosurgical referral in your units established since many of these organizations will be established for primary care only.

I personally think that a young man entering practice today should try his best to associate either with a contemporary or with an established neurosurgeon. I do not think ideal a loose association of neurosurgeons who share an office but who each have their own practice in separate hospitals unless there is ample opportunity for joint conference, consultation, and *peer review*. Ideally, some type of peer review could be extended so as to involve neighboring units in the same geographic area.

I would like to challenge our Congress to be formulators in the restructuring of neurosurgical care. Fortunately, we have committees actively considering these matters. Hopefully, we as physicians will be given a voice in the plans for the future. Let us not abdicate our responsibility.

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