2010-2011 Officers

President .......................................................... Narendra Trivedi, M.D.
President-Elect .................................................... Kenneth Y. Pauker, M.D.
Immediate Past President ................................. Linda B. Hertzberg, M.D.
Secretary ............................................................. Earl Strum, M.D.
Assistant Secretary ............................................. Christine A. Doyle, M.D.
Treasurer ............................................................. Peter E. Sybert, M.D.
Assistant Treasurer .............................................. William W. Feaster, M.D.
Speaker of the House of Delegates .................. Johnathan L. Pregler, M.D.
Vice Speaker ....................................................... James M. Moore, M.D.
ASA Director for California ......................... Mark A. Singleton, M.D.
ASA Alternate Director ................................. Michael W. Champeau, M.D.
Chair, Educational Programs Division ............. Adrian Gelb, MBChB
Chair, Legislative and Practice Affairs Division .... Paul B. Yost, M.D.
Vice Chair ....................................................... Stanley D. Brauer, M.D.
Vice Chair ....................................................... Mark I. Zakowski, M.D.

Views expressed are those of individual authors.
# Table of Contents

2  **Editor’s Notes**  Arthur O’Neil McGowan, M.D., Our Own Invisible Hero, Stephen Jackson, M.D.

4  **In Memoriam**  
   • A Tribute to Art McGowan, M.D., Peter McDermott, M.D.  
   • Arthur O. McGowan, M.D., Norman Levin, M.D.

8  **Court Rules Against CSA and CMA on Opt-Out**  Linda B. Hertzberg, M.D.

10  **President’s Page**  Surgery Without Anesthesiologists, Narendra Trivedi, M.D.

14  **From the CEO**  ACOs: Revolutionary Healthcare Model or Repackaging of the Same Old Ideas? Barbara Baldwin, MPH, CAE

17  **On Your Behalf, Legislative and Practice Affairs**  

28  **Talking Points for Responding to New York Times Editorial**  Kenneth Y. Pauker, M.D., Stephen Jackson, M.D.

35  **Peering Over the Ether Screen**  Anesthesiologist Assistants: Right for California? Karen S. Sibert, M.D.

38  **A Blind Horse Upon a Treadmill**  An Opinion, Steve Goldfien, M.D.

44  **ASA Director’s Report**  2010 ASA August Board Meeting Report, Mark Singleton, M.D.

47  **Winter 2011 Hawaii Meeting Brochure**

51  **Keeping Patient Safety First While Responding to Production Pressure**  2010 Claims Rx Publications NORCAL Mutual Insurance

58  **Society of Ambulatory Anesthesia (SAMBA) Consensus Statement on Perioperative Blood Glucose Management in Diabetic Patients Undergoing Ambulatory Surgery**  Commentary, Thelma Korpman, M.D.

64  **Pediatric Anesthesia CME Program**  Module 2  Pediatric Resuscitation, Suzanne L. Strom, M.D.

82  **Arthur E. Guedel Memorial Anesthesia Center**  Ethyl Chloride and the Rapid Induction, Merlin D. Larson, M.D.

87  **In Memoriam: Patrick Sim, M.L.S.,**  Librarian at the Wood Library Museum, Stephen Jackson, M.D.

88  **California and National News,**  Stephen Jackson, M.D.

93  **New CSA Members**

94  **Mark Your Calendar**

96  **Laughing Gas**
June 24 was the final day in the life of Dr. Arthur O. McGowan, one of our specialty’s true heroes. Art, as we liked to call him, suffered a cardiac arrest several years earlier, and the resultant severe hypoxic encephalopathy relegated him in his final years to being a mere shell of the special human being he was to all of us who knew and loved him. For Bonnie, his wonderfully supportive wife and supreme caregiver, June 24 felt like his second passing. Still, what an extraordinarily exceptional life Art did lead! All California physicians have been enriched by his having walked amongst us, by his showing us the way.

To those of us who were well acquainted with Art, he held the stature of our “invisible hero.” Why so? Well, Art, although soft-spoken, was simply a brilliant independent thinker, able to discern and distill the essence of what really matters, then to draw logical and reasoned solutions, and, most importantly, only then to act decisively on the courage of his convictions, seeing them through to their fruition. Yes, with Art, it was deed, not just creed. His superior courage, nobility of purpose, and self-sacrifice empowered him to achieve the goals and objectives for causes he championed on innumerable occasions. Although his “under-the-radar-screen” leadership in guiding our profession through the passage of MICRA legislation to solve the medical malpractice crisis of 1975 is the most widely known of his accomplishments, Art’s contributions to local, state and national medical organizations over the succeeding decades are legendary, many documented in the “In Memoriam” pieces on the pages that follow.

My connection to Art grew out of CSA leadership, but more than anything else, from his being my predecessor Editor of the Bulletin. After he passed the baton to me, he generously and tirelessly served as my teacher, mentor, enabler and confidant; and he remained so until the catastrophic event that effectively took him from us. Indeed, it is Art’s dogged commitment to excellence that I hold up as the role model to which I aspire.
When all is said and done, Art will be remembered by those of us who really knew and admired him mostly for his gentle and reserved nature, his personal integrity and strength of character, his deep-seated value of virtue, his intense sense of fairness, and his determined pursuit of excellence. This was our gift: an immensely good, talented and caring human being. Farewell, our wonderful friend.

I see, in his frank eyes,
The hero’s soul appear...
The light that on the past and distant gleams,
They cast upon the present and the near,
With antique virtues from some mystic land,
Of knightly deeds and dreams.

(from Heroes, by Emma Lazarus)
In Memoriam: A Tribute to Art McGowan, M.D.

By Peter McDermott, M.D., Ph.D., Friend

In 1998, Art McGowan received the CSA Distinguished Service Award for his many years of service to the society, to the specialty, and to the medical profession. I was privileged to present the award, and think it now appropriate to repeat some of the sentiments I expressed on that occasion. No one who knew Art had a bad thing to say about him. So much for negative praise. He was an enormously good and gifted person, and it is useful to review his life and how he got to be such an admired friend to so many of us.

Good midwestern stock and traditional family values went into producing Art. One can imagine him growing up out there in Kansas, blistering in the prairie sun, and “Tom Sawyering” his way through an untroubled childhood. Wafting summer breezes, the smell of wet hay, large skies, family picnics, cousins, lakes and homemade pies, the lazy droning of bees in the refulgent sunshine, the ineffable sadness of distant trains bestowing mournful valedictions in the summer night, but I digress.

Art was a terrific student, a Phi Beta Kappa from University of Kansas, and then in medical school at the University of Kansas, Kansas City, Kansas, a member of the Alpha Omega Alpha. Art’s internship and residency took place at Harbor General Hospital in Torrance, California.

Art subsequently joined the military and was posted to the Irwin Army Hospital in Fort Riley, Kansas. He rose to the rank of Major in the Army—a fact that rankles in the envious soul of this former Captain. During the Cold War, Art was responsible for the successful military defense of Kansas’ Fort Riley.

I always thought that Art was born—metaphorically—in 1975 when he emerged from the obscurity of his first California practice situation to devote himself to a practical solution to the malpractice insurance crisis. Art not only helped organize the physician work stoppage at the beginning of the showdown in Sacramento, but he even quit his practice and became a registered lobbyist! Indeed, his tenure as a lobbyist lasted three long summer weeks during the special session of the state legislature, during which he accomplished a number of significant things: he drew the attention of the California Legislature to the malpractice problem, and was instrumental in
passing the most powerful reform legislation in the history of malpractice insurance in the form of MICRA, the Medical Insurance Compensation Reform Act. A generation and more of physicians have benefited from this, and almost none of them know whom to thank for the savings in real dollars and, more important, the freedom from persecution that previously weighed down so many doctors. Give thanks to Art.

He helped to put this specialty squarely in the vanguard of the medical profession’s engagement with society. Anesthesiology gained stature from Art’s presence and leadership. Give him thanks.

Art’s leadership role as CSA president, as our representative to the California Medical Association House of Delegates, as an innovative and superb Editor of the CSA Bulletin for six years, ASA delegate, and member of multiple committees is a matter of history. He has often been the quiet warrior for CSA, the secret weapon, the “invisible hero” in Steve Jackson’s words.

His love for his loving and supportive wife, Bonnie, and their two wonderful children—Jill and David—of whom he was ever so proud, as well as his grandchildren, was never a secret, and without that crucial bedrock and anchor, Art would not have been Art.

There was a cluster of personal virtues Art possessed that made him special to me and to many. A noisy, back-slapping, gregarious jokester—Art was not. A self-serving opportunist who exploited friends and pursued a personal agenda—Art was not. But because it is never sufficient to define a person by the choices they have not made or by the defects they lack, let us acknowledge his attributes.

Art was unfailingly honest. Not only was he honest, but he held those around him to high standards of honesty. I am sorry if this simple virtue is the first one that comes to my mind, but I find it the prerequisite to goodness in a person, and in Art it was clear and unshakable. Upon further reflection, I think that what I mean to say is that he was “authentic.” Art was a person of genuine character, intellectually admirable and morally exemplary.

His diligence was remarkable. There was “conscientiousness” to Art’s efforts and consistent quality in his results.

Art was wise. He brought good judgment incubated in honest values to his decisions and to the advice he gave to others. He was a counselor, a guide, a beacon. Farewell and love, Arthur O’Neil McGowan.
In Memoriam: Arthur O. McGowan, M.D.

By Norman Levin, M.D., Past CSA President and Friend

On June 24, Arthur O. McGowan passed away and left behind a host of friends and innumerable fond memories. With his passing, the CSA, ASA and medical community lost an outstanding, dedicated and wonderful human being.

I had the pleasure of knowing and being a close friend of Arthur for over 40 years. I first met him during his residency in anesthesiology at UCLA Harbor General Hospital in 1969. Since that time, he had been involved not only in the practice of medicine but also in governmental lobbying, anesthesia politics, and publishing. Our involvement in CSA and ASA activities allowed us to spend many hours traveling together to numerous ASA and CSA meetings, in addition to frequent legislative visits in Sacramento and Washington D.C.

In 1975, during Arthur’s early years in practice, he became politically and intimately involved in the California malpractice crisis in which anesthesiologists were the leaders. As many of you may not know, he worked with a national public relations firm and had given unselfishly of himself by becoming a registered lobbyist in Sacramento.

He lived there during the crisis, spending months away from his family, friends and practice to further the cause for improving the malpractice climate in California. Through the efforts of Arthur and many other individuals, the landmark MICRA legislation, which California physicians have enjoyed for over 35 years, was passed. MICRA has become the prototype for tort reform of which other states have envied and have attempted to establish in order to control the escalating malpractice premium costs. We thank Arthur for the assistance and sacrifices he made in this effort.

Throughout his professional career, Arthur had been involved with anesthesia politics not only at the state level, but the national level as well. At the CSA he held the offices of Speaker of the House, Secretary, President and CSA delegate to the CMA Specialty Delegation. He also chaired and served on numerous CSA committees. At the ASA, he served as a delegate to the House of Delegates, and he was a member of many committees, in addition to making countless trips to Washington visiting legislators concerning issues that would affect anesthesiologists.
Among his many professional accomplishments, Arthur will be remembered most for being editor of the CSA Bulletin. He devoted thousands of hours to the Bulletin and single handedly changed the look, format, and computer programs for printing this widely read informational publication for anesthesiologists. When he became editor of the Bulletin, he fulfilled his lifelong passion, since junior high school, to become a writer and editor for a prestigious publication. We were happy that the CSA was able to fulfill this aspiration. His task as editor of the Bulletin was enormous, and Arthur handled the challenge well. When he retired from being its editor, it took two people to replace him. We thank him for the changes he instituted and the outstanding and excellent job he did as the Bulletin’s editor.

In 1998, Arthur received the prestigious Distinguished Service Award for his outstanding and meritorious contributions to the CSA, to our specialty, and to the medical profession. An honor well deserved.

It is impossible for me to enumerate the contributions Arthur has made to the many lives that he touched. As I mourn his passing, I want to extend my deepest sympathy and compassion to Bonnie, their children and grandchildren. I wish comfort to his family and hope, that in time, the pain of his passing will lessen. Arthur, my good friend, you will be greatly missed.

An Editor’s Valediction For Another Old Friend

Stephen Jackson, M.D., Editor

It falls to me to inform our readers of the “retirement” of our Bulletin’s long-serving Managing Editor, Andrea de la Pena. Andrea has been the silent and vibrant enabling force behind the Bulletin for a decade and a half, serving her editors with excellence: first for Arthur McGowan, and then for Kent Garman and myself. Andrea has been an exceptionally capable, conscientious, dedicated, loyal and knowledgeable professional, and the editorial board and regular contributors acknowledge her constantly outstanding guidance and assistance. I personally will miss her inevitably cheerful pleasantness, “can do” spirit, “always available” work ethic, and intelligent mastery of her position: the success of our publication has, to a great extent, been in her caring hands. For this, Andrea, we sincerely thank you and wish you success and contentment in your future endeavors.
Court Rules Against CSA and CMA on Opt-Out

By Linda B. Hertzberg, M.D., Immediate Past President, Editor of Electronic Media

On October 8, 2010, Governor Arnold Schwarzenegger and the San Francisco Superior Court missed yet another opportunity to ensure the highest standard of care for every Californian during a time when quality matters most—while under anesthesia.

In June 2009, Governor Arnold Schwarzenegger submitted a letter to the Centers for Medicare and Medicaid Services (CMS) requesting that California be allowed to “opt out” of the CMS regulation that physicians directly supervise nurse anesthetists. Last February, the CSA and the California Medical Association (CMA) filed suit against Governor Schwarzenegger in response to the Governor’s letter. The motion filed by the CSA and the CMA to require that Governor Arnold Schwarzenegger withdraw his letter was denied by the San Francisco Superior Court judge in a preliminary ruling. The CSA and CMA are awaiting the final opinion.

The ruling was based on the judge’s opinion that given the absence of a State statute requiring physician supervision of nurse anesthetists who administer anesthesia, federal regulations allow the Governor discretion to conclude that opting out of the Medicare supervision requirement is consistent with State law. The judge stated that with respect to the physician supervision issue, current California law does not directly refer to supervision, and that interjecting a supervision requirement into the law would create ambiguity. The judge went on to state that the Legislature has the ability to impose such a requirement into State law should it wish.

CSA notes that the State’s Legislative Counsel, Attorney General opinions, and prior court opinions came to a different conclusion.

“For the Governor and Superior Court to decide for the people of California that it is perfectly safe to remove the medical and physician component from anesthesia care is absolutely irresponsible,” said CSA President Dr. Narendra Trivedi. “The Governor’s plan goes against the belief of most practicing physicians and jeopardizes the quality of care that citizens of California will receive. The CSA asks the Governor to put patients first and work with physicians to find innovative and efficient solutions to our state’s health care concerns regarding maintaining quality of health care.”
The backdrop of the ruling on the lawsuit is troubling to CSA, especially in light of the recent New York Times editorial of September 7, 2010, “Who Should Provide Anesthesia Care?” Many in the anesthesia community were deeply distressed by the misguided and unfounded claims set forth in the editorial. Response by ASA leadership and others was swift and resulted in the publication of several letters to the editor denouncing the editorial. See “Talking Points” on pages 28-34.

The debate on the role and scope of practice of non-physician providers of health care, not just nurse anesthetists, clearly has national implications; this issue does not simply affect California or other states where an opt-out has been exercised. Those who attended the opening session of the ASA on Saturday, October 16, 2010, heard a compelling talk by Jeff Skiles, co-pilot of US Airways flight number 1549, who, along with Captain Chesley Burnett “Sully” Sullenberger III in January 2009, successfully landed in the Hudson River after a bird strike resulted in both engines failing. Skiles emphasized the importance of training, teamwork, standardized procedures and checklists, and above all experience in airline safety, and by extension in anesthetic care. Since the incident, Skiles has become a tireless advocate in Washington, D.C. for tightening of Federal Aviation Administration (FAA) licensing rules for pilots based on their level of training and experience. He is concerned that the agenda of the airline industry and the FAA will effectively lower the bar in pilot licensing to create an “equilibrium between costs and adverse outcomes.”

The implications here for anesthesiologists are clear. Decades of research and the development of new drugs and procedures by anesthesiologists have resulted in enormous increases in anesthesia safety. Increased safety, however, does not separate the practice of anesthesiology from the practitioner. There is no equivalence of physician and nursing care, in either education or experience, notwithstanding attempts to administratively or judicially effect or legislate this. The practice of the medical specialty of anesthesiology equates to far more than the technical components that nurse anesthetists are trained to perform.

The court’s ruling results from the efforts of nursing unions as well as hospitals and insurance companies to convince legislators, the courts, and the public to expand the scope of practice of nurses through the illusion of cutting costs. The CSA is vehemently opposed to this egregious decision that sacrifices patients’ ability to choose to have a physician involved in their anesthetic care, and the CSA remains resolved in its commitment to ensure patient access to physician-led anesthesia regardless of political or financial pressures.

The CSA and CMA are analyzing the court’s opinion and are exploring all available options for further action, including issuing an appeal.
President’s Page

Surgery Without Anesthesiologists

By Narendra Trivedi, M.D.

Imagine a major airline removing its pilots and assigning the co-pilots to fly 757s around the world. Would you travel on that airline? Even though air travel has become significantly safer, we all want a fully qualified pilot in the captain’s chair—just in case both engines fail and an emergency landing into the Hudson River becomes the only viable alternative. Well, if one would refuse to fly on that airline, why would that same person who requires surgery want to go to a hospital that employs only unsupervised nurse anesthetists?

Within this past year, Governor Schwarzenegger surreptitiously filed a letter with Medicare in an attempt to opt the state of California out of the requirement that nurse anesthetists must be supervised by a physician. While physicians were strongly opposed to the monumental damage to the culture of quality of care for surgical patients, they were, at that point in time, largely powerless to prevent the filing that was strongly encouraged and supported by the nursing unions. Anesthesiologists, like most physicians, are not sophisticated politicians. However, the traditional goal of placing their patient’s best interests foremost has prompted them to take legal action against any scientifically unsupported expansion of the scope of practice of nurse anesthetists. Anesthesiologists are resolute in their stance that a physician must direct and supervise nurse anesthetists. Besides, that is the law in California!

Nurse anesthetists’ leaders have cited a study that was commissioned by the American Association of Nurse Anesthetists, which alleges that nurse anesthetists are the equivalent of anesthesiologists. While nurse anesthetists are to be respected for providing the services they can and do provide under the direction and supervision of physicians, we unequivocally believe that the nature of their training should place limits on their scope of practice. Compared with nurse anesthetists, anesthesiologists receive a vastly more rigorous and intensive medical education and training, one which we are taught throughout to think critically, to diagnose, and to develop the capacity to make medical judgments and decisions. It is this background that anesthesiologists bring to the care of their patients that helps avoid morbidity and lower mortality, so to speak, to land their plane safely in the Hudson.
Anesthesiologists believe that nurse anesthetists should practice within the anesthesia care team mode. Collegially and cooperatively, they should join with Anesthesiologists to find innovative solutions to reduce the cost of health care while improving its quality and access. The safety of patients never should play second fiddle to cost cutting or politicking. One shall not “legislate” a nurse to assume the role of a physician.

Committee on the Future of Anesthesiology

This year I appointed a new committee “the Committee on the Future of Anesthesiology.” I believe that CSA needs to focus much attention on the future of our specialty as healthcare reform proceeds and workforce issues continue. This committee will work to prepare anesthesiologists for future challenges in a rapidly changing healthcare field. It is composed of distinguished CSA leaders who have expertise in this area. This committee’s work will include working with residency program directors to implement innovative changes in residency training programs that will prepare residents for the challenges of healthcare reform.

California Medical Association

The CSA delegation to the CMA Specialty Delegation is based on the number of active voting CSA-CMA members. We currently have two delegate and two alternate delegate positions. The delegates are elected by the CSA Board of Directors for two-year terms and are supported by the CSA. Our current delegation is Narendra Trivedi, M.D., and Peter Sybert, M.D., as delegates, and John MacDonald, M.D., as an alternate delegate. I believe that the CSA's CMA Specialty Delegation is of great enough importance in representing the CSA at the level of the CMA, such that these delegates should be included in the nomination process conducted by our Committee on Leadership Development and Nominations (CoLDaN). I have, therefore, recommended that the CSA bylaws be changed to include CSA delegates to the CMA Specialty Delegation in the CoLDaN nominations process.

Overall, CSA members have taken active leadership roles at CMA. We have four CSA members who serve on the CMA board of trustees: Virgil Airola, M.D., Benjamin Shwachman, M.D., Michele Raney, M.D., and Lee Snook, M.D., as well as approximately 30 delegates and alternate delegates. Under the leadership of Mark Singleton, M.D., three CSA members recently have been elected as alternate delegates for the CMA's Hospital Based Practice Forum. I would encourage all CSA members to become CMA members and take active role in CMA activities.
Membership Activity

Since the Annual Meeting, I have been engaged in several recruitment efforts to increase CSA membership. On July 31, ASA President Dr. Hannenberg and I sent a joint letter to former CSA-ASA members encouraging them to rejoin their professional organizations. So far, about 20 anesthesiologists have renewed their memberships. In addition, letters were sent to about 100 California anesthesiologists who never have joined, but have participated in CSA-CME activities. Furthermore, I believe that another major source of members is the Kaiser Permanente Medical Group. Kaiser Permanente is the largest group of anesthesiologists in California, but only about 40 percent of them are CSA members. I believe that we should aggressively recruit Permanente anesthesiologists to become CSA members. Because of this, a targeted mailing to all non-member Permanente Anesthesiologists is now underway. With great support from CSA past-President, Edgar Canada, M.D., I am working to meet with ASMG leadership to achieve 100 percent CSA membership, as this large and well respected San Diego group already has 100 percent CMA membership. All board members should work aggressively to help increase CSA membership.

Advocacy

On September 1, 2010, I held a fundraiser at my home for Ami Bera, M.D. (CA-3), a candidate for the US Congress from the Sacramento area. Dr. Bera is a former Dean of Admissions at UC Davis School of Medicine and one of the top Democratic challengers in the country. Dr. Michael Champeau and Dr. Jeff Mueller helped to obtain a PAC contribution from ASAPAC to support his candidacy. About 50 physicians and distinguished community leaders attended this very successful event, and Dr. Bera received very generous campaign contributions. I would strongly encourage active participation in political advocacy by CSA members.

Program Directors Group

The California Osteopathic Medical Society invited me to speak to their leadership on July 14, 2010. I met with their leaders and anesthesia residency program director. They are very interested in being active members of CSA. I discussed this with Dr. Gelb, Dr. Wald and other CSA leaders and decided to invite their program director to join the CSA Program Directors Group. I hope to build a closer and stronger relationship with the Osteopathic Society and encourage more D.O. anesthesiologists to become active members of the CSA.
Memoriam to Seymour Wallace, M.D., and Arthur McGowan, M.D.

In the past couple of months, CSA has lost two great leaders and Past Presidents: Seymour Wallace, M.D., (1974-1975) and Arthur O. McGowan, M.D., (1986-87). Both of them had done landmark work on MICRA. Their leadership, vision and hard work dramatically improved the malpractice liability climate for physicians in California.

Finally, I want to encourage feedback from my fellow CSA members. Please contact me with any suggestions you may have for a better CSA. I can be easily reached by email, narendratrivedi@csahq.org, or through our CSA office.

YOUR CSA

CSA Mission Statement
The California Society of Anesthesiologists is a physician organization dedicated to promoting the highest standards of the profession of anesthesiology, to fostering excellence through continuing medical education, and to serving as an advocate for anesthesiologists and their patients.

CSA Then
The California Society of Anesthesiologists, Inc., is the recognized component society of the American Society of Anesthesiologists, Inc., in the state of California. CSA was founded in 1948 and incorporated in 1953 as a voluntary, non-profit association of physicians interested in the practice of anesthesiology.

CSA Today
Today, the elected officers and Board of Directors are individuals dedicated to the preservation of the unique specialty of anesthesiology. CSA works closely with ASA to protect the interests of all anesthesiologists, on a national, state and local level.
one of the many controversial elements of the new Health Care Reform legislation is the establishment of Accountable Care Organizations (ACO). With the projected bankruptcy of the Medicare Trust Fund and steeply increasing health care costs overall, a sense of urgency exists to address the areas of cost, quality and efficiency. Some believe that ACOs can successfully improve quality and efficiency while achieving cost savings within the healthcare system.

The literature on ACOs is extensive with policy briefs, personal viewpoints of supporters and detractors, and even implementation manuals for those ready to take the plunge. The discussion here is only a brief overview of some elements of ACOs that may be of interest to CSA members.

Although many authors describe ACOs as models for community health systems and privately insured patients, the new law, including requirements and incentives, address only Medicare beneficiaries in the fee-for-service system. It could be a harbinger of a future of managed care for all Medicare beneficiaries as noted in a reference to “assigning” beneficiaries to ACOs if they do not select one. One element that has not been addressed in the literature is that under the ACO model, Medicare contracts directly with the provider organizations without the reliance on a health plan intermediary.

Medicare Shared Savings Program

The Patient Protection and Affordable Care Act describes ACOs in Section 3022, entitled “Medicare Shared Savings Program.” Examples of acceptable business models are noted in Section 1889(b):

“The following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:
“(A) ACO professionals in group practice arrangements.
“(B) Networks of individual practices of ACO professionals.
“(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.
“(D) Hospitals employing ACO professionals.
“(E) Such other groups of providers of services and suppliers as the Secretary of Health and Human Services determines appropriate.”

Among the myriad requirements to qualify as an ACO, entities must have a legal structure that is the recipient, manager and distributor of shared savings. They must establish and document quality measures, develop methods of quantifying and reporting clinical processes and outcomes, and report patient and caregiver experience of care, as well as utilization. Many of these factors have been around for years and most continue to defy clear definition and implementation. A simple example is the widespread absence of electronic health records, which continues to be a huge impediment to effective coordination of care.

Payment models for providers include traditional fee-for-service, bundled/episode-of-care payments, and partial or full capitation. However, the new law notes that Medicare payments to the ACOs “shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings…”

ACOs must have a minimum of 5,000 Medicare enrollees, and all benchmarks are measured against that population. Provided that the ACO meets the quality standards (as yet undefined), then the Secretary of Health and Human Services determines the percentage of savings shared with the ACO. Savings are the difference between the estimated per capita cost of care (adjusted for patient characteristics) and actual expenses.

State laws greatly influence the structure of ACOs and how physicians are integrated into the system. Only a handful of states, including California, prohibit lay entities from employing physicians. That doctrine prevents hospitals from requiring hospital-based physicians to become employees.
ACOs may be viewed as an opportunity to reap rewards for managing care across a continuum, from prevention to acute care and caring for those with chronic conditions, providing only necessary care to achieve cost savings, all the while improving quality and patients’ experiences. From another vantage point, it raises alarm among some individuals and groups that they might be dominated by hospitals or entities that will exert control over their practices and incomes. While that could happen, it would require the assent of groups or individuals who agree to the conditions and payment methods for their services. Cooperation and coercion, however, bear a strong resemblance where one “partner” has significant clout over others.

While many elements of ACOs are familiar, the time-worn expression “the devil is in the details” reminds us that what sounds good in concept may not be successful in execution. Who controls the dollars is a significant issue that may impede the formation of ACOs or ultimately could mark their demise.
The dying days of a two-year session display the legislative process at its worst. Examples include

✓ A logjam of bills requiring final action on decisions which have been deferred until the last moment when the sheer volume of information available and decisions required prevents careful scrutiny.

✓ “Gut and amend” opportunities where bills are stripped of content and new provisions slipped in. Again, the time crunch prevents detailed analysis.

✓ Threatened gubernatorial vetoes of legislators’ pet proposals are used to force action on other unrelated issues that otherwise have failed to gain traction on their merits.

✓ Innumerable campaign fundraisers are held by every incumbent running for re-election and seemingly every other candidate for state office in the upcoming Fall election. Well over 100 campaign “events” will have occurred during the last month of the session. We’ve attended our share and fielded calls about many more.

This has been, and will continue to be, the Capitol backdrop until the 2009-2010 regular session has been concluded on August 31 AND a State budget is enacted. Because no 2010-2011 state budget has yet been approved, an extraordinary (in the sense this has never happened before, not in the normal usage of the term) special session will be called to finalize an overdue spending plan.

The projected budget gap as this is written (9/12/10), is somewhere between $19 – 20 billion. The problem that is extraordinary (the normal usage of the
term) is that all the accounting and budget gimmicks employed in past years have been exhausted. Whatever is cut now is going to hurt, and hurt badly, and California still requires a two-thirds supermajority of each legislative house to pass a budget vehicle. Because most of the 120 legislative districts (discussed later in this report) have been gerrymandered either solidly Democratic or solidly Republican, persuading any Republican legislator to vote for a budget that includes any tax increase (or allowing a past tax cut to expire) is almost impossible because it is political suicide for any GOP legislator to consider such action. Forging a compromise is not made any easier by the fact that Controller John Chiang publically announced that State revenues have surpassed projections so he will not have to issue IOUs until October at the earliest. This takes some of the heat off the politicians for a while.

**Legislation of Interest to CSA**

**SB 726 (Ashburn, R-Bakersfield) – Bar against the corporate practice of medicine.** The Senate Rules Committee referred SB 726 to the Senate Business and Professions Committee for a hearing on whether to recommend for or against concurrence in Assembly amendments or to kill it. On August 25, with about one-half hour's notice, we faxed over the CSA opposition letter and, a few minutes later, testified against the bill along with CMA, CAL/ACEP, and several other specialty witnesses. The proponents were there in full force, but our side prevailed. On the motion to recommend in favor of concurrence, the vote was three aye and four no. The bill failed. The author and chief sponsor (American Federation of State, County and Municipal employees) had not intended to take the bill to a hearing at that time; however, Senate Rules informed Senate B&RP that the bill had to be heard within 48 hours of referral or it was dead. Most likely, the proponents would have preferred to wait until closer to the end of session to have the bill heard, but that was not to be the case. Watch for a return of this bill next year.

**SB 1150 (Negrete-McLeod, D-Chino) – Licensing of already accredited outpatient surgery sites.** The initial provisions would have expanded Medical Board of California (MBC) oversight of outpatient settings with detailed requirements for cosmetic surgery, use of laser devices and in vitro fertility clinics. Included were standards for advertising, physician availability, internet posting of an educational fact sheet about cosmetic surgery and inspections, reporting and processing of deficiency corrections by accrediting agencies. A similar 2009 measure was vetoed for reasons unrelated to substance.

During the last few weeks, the Schwarzenegger Administration proposed a “gut and amend” to require Department of Public Health licensure of outpatient surgical settings already accredited under a system overseen by the MBC. The
proposed system of dual regulation would have imposed new license costs, in addition to existing accreditation expenses, and subjected such facilities to state building codes for clinics which are not appropriate to many of these accredited surgical settings that essentially are physician offices. CSA, CMA and several medical specialties raised objections. Thankfully, the bill was held on the Assembly Appropriations Committee suspense file.

**AB 542 (Feuer, D-Los Angeles) – Hospital “Never Events.”** Consistent with provisions of the new federal health reform, this bill moves Medi-Cal towards withholding payment for specified “hospital acquired conditions,” formerly better known as “never events.” Earlier versions of the bill would have extended the “nonpayment” requirement to services provided to patients of private managed care/insurance plans! The bill now is limited to establishing a technical working group to fashion nonpayment controls for Medi-Cal. Amendments that we and malpractice carriers proposed will prevent documentation of these “never events” from being used as a treasure trove in medical malpractice litigation. The bill passed the Senate and is on its way to the Governor.

**AB 583 (Hayashi, D-Hayward) – Informing patients of health care practitioner credentials and capabilities.** Interest was expressed to adapting model state legislation drafted by ASA to California law. To put the issue into proper perspective, California started down this path 35 years ago. In 1975, state hospital licensing regulations were promulgated requiring hospital employees “having patient contact, including students, interns and residents, (to) wear an identification tag bearing their name and vocational classification.”

In 1998, this was expanded and elevated into state law. Health care practitioners, when working, are required by this statute to disclose their name and license credential on a name tag in at least 18 point type. The 1975 regulation and 1998 law are the reason practitioner name tags have been commonplace in California hospitals and other facilities for decades.

In early 2009, CMA received an AMA grant to pursue state legislation to enhance transparency in healthcare. Assembly B&P Committee Chair Mary Hayashi, agreed to author a measure, and AB 583 was the result. As introduced, the bill called for practitioner disclosure of their highest academic degree and, for some physicians who supervise offices other than their primary practice location, their regular schedules. Nurses were specifically exempted from disclosure of their highest academic degrees. Also as introduced, written disclosure by physicians was required of their status as “certified” by the ABMS or ACGME. In June 2009, technical objections to the bill were raised by the Administration. As a result, AB 583 was put on hold for a year.
In June 2010, CSA interest was expressed in having California adopt rules along the lines of AMA/ASA model legislation requiring health professionals to more accurately represent their education, training and license credential to patients. As indicated above, a body of law and regulation to that effect has long existed in this state. At that point, upon closer examination of AB 583, we believed the bill would have undone some of the practitioner identification requirements already in effect.

Our analysis was followed by a series of meetings and discussions with CMA, other specialties and the author's staff. As a result, the bill was re-drafted so as not to weaken existing law and regulations. Still, concerns remained from our office and other medical specialties on items to which CMA and the author remained committed. At that point, suffice it to say, there was no benefit to the “House of Medicine” airing the differences publically, especially in view of the short time remaining in the session.

In its last amended (8/20/10) form, AB 583 leaves existing law in place and adds new requirements of written disclosure at the patient’s “initial office visit” of the practitioner’s license “type,” and “highest level of academic degree.” For physicians, the ABMS/ACGME disclosure mandate noted earlier remains in the bill. Still exempted from the degree requirement are nurses. Exempted from the bill’s entire provisions, but still subject to the existing name tag law, are any providers of medical services who work for Kaiser Health Foundation; any person who works in a general acute-care hospital or a clinical laboratory; hearing aid dispensers, respiratory therapists, veterinarians, pharmacists, and marriage & family counselors.

The ABMS/ACGME requirement is the desired goal of the California Plastic Surgery Society (CSPS), a co-sponsor of AB 583. The aim is to discourage physicians having little or no training in aesthetic surgery from providing such services to unwary patients. AB 583 passed the Legislature and is on its way to the Governor.

**AB 1503 (Lieu, D-Torrance) – Discounted emergency physician fees for emergency medical services rendered to indigent patients.** Throughout the 2009-10 session, advocates for the poor and several labor unions have been seeking a system of discounted physician fees for emergency care rendered to indigents, similar to a 2006 law requiring discounted hospital fees for patients at or below 350% of poverty level. Their argument, in essence, is that only uninsured indigents pay full “rack rate” for medical care, including emergency services, because government programs receive discounts by law, and health insurers and managed care plans negotiate discounts for their subscribers.
The initial version of AB 1503 dealt with payment for emergency services from existing “Maddy” funds maintained at the county level (a source for limited funding for care otherwise not compensated from any other source—amounting to pennies on the dollar – participating counties financing these funds through revenue sources that include penalties on certain criminal and traffic-related violations), and set 350 percent of the poverty level as an eligibility factor for a physician fee discount system. The bill passed the Assembly in 2009 with no opposition. While it was pending before the Senate Health Committee, proponents negotiated the issue with the party most directly affected, the emergency physicians, through their organization, CAL/ACEP. When agreement was reached between CAL/ACEP and the proponents, it would have applied to all physicians who render emergency care in a hospital, including those acting in an “on-call” capacity. As such, it drew objections from CMA and a number of specialties, including CSA. After much discussion and many meetings within medicine and with proponents, a further agreement was reached to limit the discount arrangements in AB 1503 to emergency physicians rendering emergency medical services in a hospital emergency department. This is intended to exclude physicians who render emergency services on an on-call basis. Proponents will try to extend the discount policy to on-call physicians next year. AB 1503 is on its way to the Governor.

Political/Election Update

As touched upon briefly in the section above, the 120 current legislative districts (40 in the Senate and 80 in the Assembly) were gerrymandered either solidly Democratic or Republican during the last reapportionment in 2001. Because politics quite frequently overrules policy considerations in the crafting of laws in California, the elections are very important to everyone who lives or does business in this state.

Special Elections

Concurrent with the June 8 primary election, Assemblyman Bill Emmerson, DDS (R–Hemet) was elected in Senate District (SD) 37. He was supported by CSA in view of his long support for MICRA and other physician issues both as an Assembly Member, a practicing dentist, and earlier as the political action director of the California Dental Association.

Also elected at the same time was Mike Gatto (D-Burbank) in Assembly District (AD) 43 who also expressed support for MICRA and other physician issues during his candidate interviews. He will finish the current term and should be
re-elected for a full term as the Democratic nominee in the November general election.

The run-off in yet another special election took place on August 17 in SD 15 as a result of Able Maldonado becoming Lieutenant Governor. Republican Assemblyman Sam Blakeslee of San Luis Obispo overcame a Democratic voter registration advantage to win over former Democratic Assemblyman John Laird of Santa Cruz. Blakeslee came close to securing the seat in the earlier primary but fell just short of the necessary 50 percent plus one. Holding the seat was particularly important for Senate Republicans because its loss would have put Democrats just one win away from gaining a two-thirds majority with another GOP-held Senate District in jeopardy in November. Without the ability to block budgets, urgency, and tax bills, the Republicans would lose their current leverage on a HUGE range of policy issues.

Primary Election Results

The June 8, 2010, primary election may be best remembered for record high campaign expenditures and record low voter turnout. Negative campaigning, especially via television advertising, long has been believed to repulse voters and depress turnout. The nasty tone of the non-stop, saturation TV spots during the primary campaign may have helped prove the point. That said, existing levels of support for MICRA have been maintained or maybe even strengthened some among lawmakers expected to be in office in 2011. Some highlights:

✔ Primary election results take on a greater significance in California than other states because of gerrymandered legislative districts and term limits. Here term limits remove elected officials from office much faster than do the voters. Even without the defeat of a single incumbent's re-election, 39 state legislative seats will change hands this November. Competition for legislative seats, such as it is, occurs more during intra-party primaries rather than in general elections. The gerrymandered reapportionment of 2001 has effectively limited districts from switching from one party to the other. This could change, at least for state legislative districts, as the decennial redistricting for the 2012 elections will be conducted by a new citizen's commission; that is, unless it is reversed by a new initiative (Proposition 27) on the November ballot.
Both gubernatorial candidates favor keeping the MICRA non-economic damages cap at $250,000. Democratic nominee Jerry Brown, the current Attorney General, signed MICRA into law during the first year of his prior tenure as Governor and sees no need to change it. The Republican nominee, Meg Whitman, whose husband (Griffith Harsh, IV, M.D.) is a Stanford Medical Center neurosurgeon, has expressed opposition to raising the cap.

In the state Senate, the pro-MICRA forces gained at least two votes. The impact in the Assembly may have been limited to a single pick up, but certainly no worse than staying even. An intriguing development has to do with Assembly Speaker John Perez. He recently suggested that one of his Democratic colleagues should rethink the latter’s support for raising the cap. The suggestion was taken to heart. A likely vote for upping the cap has moved away from that position.

Without question, the constant scrutiny of any legislation that remotely impacts MICRA, plus the continuing interaction with legislative candidates, has discouraged moves to undermine the gold standard of medical malpractice law.

General Election Prospects

Besides the Legislature, the “constitutional offices” that have decision-making authority over issues directly affecting CSA, are the Governor, the Insurance Commissioner and, possibly, the Attorney General.

Governor Arnold Schwarzenegger (GAS, as he’s referenced in Administration circles) will be gone. The heady days of his 2003 election are hard to recall in light of his vows (“blow up the boxes,” “cut up the state’s credit card” and “sweep the special interests out of Sacramento”) and today’s realities. No happy ending in this docudrama. So, whose turn will it be to “clean up the mess in Sacramento?” From all indications, the race to replace GAS will be heavily financed and close, barring some unforeseen scandal or major event.

Former eBay CEO Meg Whitman spent $91 million in defeating Insurance Commissioner Steve Poizner to gain the Republican nomination and, since June 8, invested another $28 million, mostly on TV ads attacking Democrat Jerry Brown. She now holds the all-time national record for personally spending the most ($119 million) on one’s own political campaign. Some feel Brown has allowed himself to be defined by the repetitive attack ads while
sitting on his own campaign fund of $23 million until Labor Day when he thinks voters begin paying attention. A contrasting view is that despite the nearly there-month TV blitz, Whitman has not closed the gap in public opinion polls and may be reaching the point of diminishing returns in negative, saturation campaigning.

Also noted have been the surprising defeats of two June ballot measures that were backed by big corporate dollars with no counter campaigns or advertising. PG&E pumped $47 million into Proposition 16, “The Taxpayer Protection Act” to prevent local governments from going into the electric power business. Likewise, Mercury Insurance Company ran a $16 million effort to pass Proposition 17, its “Fair Auto Rates” proposal. Both were promoted by slickly produced, ubiquitous, and unanswered TV spots. Yet both lost, confounding the experts as well as the campaign consultants who doubtless fretted about it all the way to the bank. Another big bucks loser was Chris Kelly, former Facebook General Counsel, who blew $12.5 million in failing to gain the Democratic nomination for Attorney General.

Insurance Commissioner Steve Poizner lost his bid to head the GOP ticket, leaving the office open for a contest between two terming-out Assembly Members. For the Republican nomination, former Assembly Minority Floor Leader Mike Villines of Clovis narrowly edged a politically unknown Insurance Department lawyer, Brian Fitzgerald. On election night, Villines trailed by 8,000 votes but pulled ahead when absentee ballots were counted later. He ran poorly in Los Angeles and Orange Counties apparently due to unrelenting condemnation, on a popular conservative radio talk show, of his 2009 votes for temporary tax hikes that were part of the Governor-approved budget fix. He supports keeping MICRA just as it is.

The Democratic nominee is Dave Jones of Sacramento. He supports raising the MICRA cap. His failed attempt, as Assembly Health Committee Chair, to intervene in The Doctors Company (TDC) acquisition of Southern California Physicians Insurance Exchange (SCPIE) unnecessarily complicated the deal and could have cost many CSA members insured by TDC and SCPIE a lot of money in diminished stock value and higher med-mal premiums.

Attorney General Jerry Brown’s candidacy for Governor has led to two district attorneys vying to become the state’s top law enforcement officer. The long time Los Angeles versus San Francisco rivalry will be a backdrop. Los Angeles County District Attorney Steve Cooley will carry the GOP/LA banner while San Francisco D.A. Kamala Harris is the Democratic nominee.

The State Legislature will continue to have strong Democratic majorities in both the Assembly and Senate. Support for MICRA will remain strong as well.

24 CSA Bulletin
1. The Assembly lineup presently is 50 Democrats, 28 Republicans, one Independent (who votes with the Democrats) and one vacancy (that will be filled by a Republican). The independent is Juan Arambula, a MICRA supporter, who will be replaced by Henry Perea, who also supports MICRA. The vacancy in AD 63 is a safe Republican seat that will be filled by Mike Morrell, also a MICRA supporter.

In jeopardy are two first term Democrats whose victories in traditionally GOP districts were helped by the 2008 Obama turnout.

- In AD 10, southern Sacramento and northern San Joaquin Counties plus some foothill areas, Alyson Huber eked out a win over former San Joaquin County Supervisor Jack Sieglock only after final absentee ballots were counted three weeks post-election day. Sieglock had to pry his name plate off a Capitol office door, but he has a good chance to reuse it after the upcoming 2010 rematch. Sieglock is a MICRA supporter; Huber is not.

- In the East SF Bay, AD 15 had been trending away from the GOP for some years and in 2008 finally elected a Democrat, Joan Buchanan. She is a MICRA supporter as is Republican Danville Mayor Abram Wilson, her opponent in another 2010 rematch. He has a solid chance because of her poor showing in a 2009 Congressional special election and his non-stop campaigning over the past two years.

Three physicians ran for the Assembly. Two won their primary races; the other lost.

- Linda Halderman, M.D., \(\text{(Dr. Halderman generously has written articles on her humanitiation experiences for previous CSA Bulletins -- Editor)}\) by winning the primary in safe Republican AD 29, will be representing the Fresno/Madera area where her earlier surgical practice was not economically viable due to a heavy Medicare/Medi-Cal patient base. She has a Democratic opponent in the general election but the primary victory has locked it up for her.

- Richard Pan, M.D. \(\text{(Dr. Pan, an academic pediatrician at U.C. Davis, has served with distinction as the chair of the CMA's Council on Scientific Affairs -- Editor)}\) won the Democratic primary in AD 5, which is located in traditionally Republican parts of suburban Sacramento and Placer Counties. He faces a difficult challenge in moving this district into the Democratic column. His opponent, attorney Andrew Pugno, is a physician's son who supports MICRA. The wild card in this race is Pugno's highly visible role with Proposition 8, the

Legislative & Practice Affairs (cont’d)
same-sex marriage ban with which he is often associated. This will be one of the most expensive legislative contests.

Donald Kurth, M.D., lost in the Republican primary in AD 63 which is located in the San Bernardino/Riverside area. The victor, Mike Morrell, is a MICRA supporter. This is another safe Republican seat, and Morrell should win easily in November. Kurth’s campaign was hurt by a late negative attack funded by independent expenditures of $150,000 from Blue Cross, Blue Shield, Health Net and the California Association of Health Plans. He had been critical of managed care interference in the physician-patient relationship.

2. The Senate lineup presently is 25 Democrats, 14 Republicans and one vacancy. The vacancy is in SD 1, where Sen. Dave Cox (R-Fair Oaks) passed away in July. It will be filled by a special election that will have its first race (primary) concurrent with the November 2 general election. If a candidate fails to receive a majority (which will most likely happen), then a runoff (general) election will take place between the candidates with the most votes in each of the recognized parties. Because this is a solid GOP district, this race will be decided on November 2. In other primary races:

Juan Vargas, former Assembly Insurance Committee Chair and a MICRA supporter, will return to the Legislature after edging Assembly Member Mary Salas (D-Chula Vista) in SD 40 by just 22 votes out of 48,000 cast. The morning after the election, Salas led by 295 votes and declared victory. Her lead disappeared when absentee and provisional ballots were counted over the following three weeks. She ended a recount after several precincts did not alter the Vargas margin. He will replace Senate Budget Chair Denise Ducheny, who was not considered a MICRA supporter. Add one to the pro-MICRA ranks. The GOP nominee, Brian Hendry, a Chula Vista educator, has little chance.

Assemblyman Ed Hernandez, O.D, of Baldwin Park, a practicing optometrist and MICRA supporter, will succeed Senator Gloria Romero, who was not, in SD 24. Termed out, she lost a bid for State Superintendent of Public Instruction. Another plus for the pro-MICRA forces.

Assembly Member Noreen Evans of the Napa/Santa Rosa area will move to SD 2 to replace retiring Senator Pat Wiggins. Evans has stressed that patient access considerations would be key to her view on MICRA related legislation. Wiggins was considered leaning against our side. The heavy Democratic majority should enable
Evans to easily outdistance the GOP candidate, Santa Rosa CPA Lawrence Wiener.

✅ Assembly Member Anna Caballero (D-Salinas) will face Ceres Mayor Anthony Cannella (son of former Assemblyman Sal Cannella, a Democrat), the Republican candidate, in SD 12. This promises to be one of the more competitive and expensive races on the November ballot. Both are considered to be MICRA supporters. The Democrats would love to pick up this seat which is being vacated by Republican Jeff Denham (who’s moving on to Congress) in order to get closer to a veto-proof 27 vote majority.

Senator Lou Correa (D-San Ana), a MICRA supporter, will be opposed in SD 34 by Anaheim City Councilwoman Lucille Kring, who has been active in Orange County politics for years. The narrow Democratic registration advantage could pose a problem for Correa if there is a strong Republican tide. Campaigns for this relatively competitive seat are always expensive.

**Ballot Measures**

As if voters won’t have enough to deal with a full slate of state constitutional offices, one U.S. Senate race, 53 seats in the U.S. House of Representatives, 80 state Assembly districts, 21 state Senate districts and four state Board of Equalization posts, the November ballot will contain at least nine propositions. Highlights include:

✅ Prop. 19: legalizes recreational marijuana.

✅ Prop. 20: adds Congressional reapportionment to the authority of the citizens’ redistricting commission created by Prop. 11, 2008.

✅ Prop. 23: rolls back AB 32, the state’s landmark greenhouse gas emissions law.

✅ Prop. 24: repeals 2009 enacted corporate tax breaks.

✅ Prop. 25: reduces legislative vote requirement to pass a budget from two-thirds to a simple majority.

✅ Prop. 26: increases legislative vote requirement to impose state levies and charges (fees) from a simple majority to two-thirds.

✅ Prop. 27: eliminates citizens’ redistricting commission created by Prop. 11 of 2008.
Talking Points for Responding to New York Times Editorial

By Kenneth Y. Pauker, M.D., President-Elect, Associate Editor, and Stephen Jackson, M.D., Editor

The provocative New York Times (NYT) Editorial entitled “Who Should Provide Anesthesia Care” has stimulated considerable discussion, and will be cited in future discussions involving health care planners, legislators, regulators, and the public. The editorial is replete with inaccuracies, speculations, unsupported judgments, and misleading statements at a time when clarity and transparency — not obfuscation — are needed. The superficial research and subsequent flawed judgment comprising this editorial tarnishes the reputation of the NYT.

For generations we have counted on the NYT tradition of “All the News That’s Fit to Print.” Sadly, with this editorial, the NYT has allowed itself to be manipulated by those who distort and “spin” actual facts for their own political agenda.

Below are “Talking Points” to serve as a resource for those among us who will be addressing this opinion piece and the many issues raised in it. The points are presented as a phrase-by-phrase dissection of this poorly constructed editorial. In addition, some of the published and unpublished Letters to the Editor submitted to the NYT may be found on the CSA web site.

• “Who should provide anesthesia care?” Medical care is still an art as well as a science, although that crucial fact is awkward to plug into a mathematical formula for planners to assess quality and efficiency. Physicians are well-educated professionals who apply the art and science of medicine to their patients on an individualized basis. As such, they are not cogs or tools, mere technicians, or “providers.” Anesthesiologists practice medicine. We do not provide anesthesia care.

• What is “close medical supervision?” It is assuming ultimate responsibility and making sometimes difficult medical judgments while supervising or directing an anesthesiology resident, anesthesiologist assistant, nurse anesthetist, student anesthesiologist assistant, or student nurse anesthetist. Competent nurse anesthetists usually do not need to have their hands held, but when true expertise in problem solving with respect to patient care becomes necessary (this is not a rare event), then in
the name of patient safety, almost all are grateful to have a physician make the ultimate judgment as to how to proceed. After all, anesthesiologists rely on their education and training as physicians to resolve unexpected as well as anticipated medical problems in the peri-operative period.

- The issue that the editorial seeks to address has, in fact, been smoldering for decades, and has not “recent[ly] emerged.” The concept of “opting out” of the long-standing federal requirement for there to be physician supervision of nurse anesthetists caring for Medicare patients was first promulgated in the last days of the Clinton administration, when the President (whose mother was a nurse anesthetist) opted every state out. President Bush, as a compromise, modified this regulation to permit, under certain conditions, each individual state to “opt out.” In 2009 California became the 15th state to make this declaration, despite this action being in stark violation of California law. The matter is by no means settled, and is now before the courts in California.

- “Potentially important to patients?” Because flying in commercial aircraft has become so safe, should we economize by using “junior pilots?” How often does a flock of birds get sucked into a jet taking off, and how much training is needed to land such a plane? Advances in anesthetic care, driven solely by the scientific advances of anesthesiologists, have made surgical procedures much safer and more comfortable. Is the public ready to accept the risk to themselves from nurses who do not have to answer to physicians in critical situations? Nurse anesthetists who later have become physician anesthesiologists echo Dr. Jane Fitch’s rationale: “I got frustrated… I just didn’t know enough” to tell whether a patient was ready to undergo surgery safely. “There is no comparison” between what she knew then and what she knows and can do now. Anesthesiologists draw upon the full breadth and depth of their education, training, and experience when they must act under conditions that are challenging to the well being of their patients.

- “Studies — hotly disputed?” There is no discussion as to why anesthesiologists find these studies methodologically inadequate, and their conclusions unsupported and disturbingly disingenuous. Nurse anesthetists funded these “studies”: the “researchers” who authored the Health Affairs article were paid by the American Association of Nurse Anesthetists, surely an insurmountable [not, as stated in the editorial, a “potential”] conflict of interest in light of the fact that the conclusions argue for an economic advantage to the study’s sponsor. In recent years, we have seen repeatedly that being at “respected organizations” does not necessarily equate to ethical conduct or competence.
In examining in greater detail some of the flaws in these “studies,” it is notable that the conclusions are derived from “administrative data,” and are essentially unadjusted for risk. First, nurse anesthetists are much more likely to care for healthy patients, while anesthesiologists typically render anesthesia to the sickest patients, even for those having the simplest of surgical procedures. Second, there is no determination as to whether deaths are from surgery or anesthesia. Third, there is no discussion of the frequency of expected deaths versus actual deaths, but rather, only a coarse examination of gross data from one state to another. Fourth, in an “opt-out state,” there is no clear separation of cases by nurse anesthetists acting alone from those participating in the anesthesia care team model with anesthesiologists supervising and directing the care of the patient. Fifth, the determination of the reporting codes underlying the data upon which these studies are based is inconsistent, using different rules and methods from location to location, and frequently may be influenced by financial incentives.

Administrative data, mostly generated from billing records, are useful for forming hypotheses, but not for scientific proof. Data can be deployed to “prove” most anything, and the studies cited in the editorial are that in spades. In order to develop an evidence-based understanding of the differences between types of practitioners, one needs substantially more clinical data from actual patient care, assuredly not billing data that are notoriously inaccurate and incomplete. Moreover, because anesthesiologists tend to care for sicker patients than do unsupervised nurse anesthetists, the expected mortalities in less complex patients cared for by nurse anesthetists should be less. Yet, the mortality data are comparable, suggesting better outcomes when anesthesiologists render care. Furthermore, there are many intra- and post-anesthetic complications besides death that must be analyzed to make any logical statements about “equivalence” [in the words of the editorial, “no significant difference”] of care.

“Not too much difference in the amount of training in administering **and monitoring** anesthetics?” Nonsense! An anesthesiologist receives a minimum of 12 years of education and training! Four years of college leading to four years of medical school versus three to four years of nursing school does, indeed, provide anesthesiologists with, in the words of the editorial, “a big advantage… in their much longer and broader medical training that… better equip them to handle complex cases and the rare emergencies that can develop from anesthesia.” Then, four years of specific post-doctoral physician training with
progressively more independence and more difficult surgical cases (including neonatal), pain management and critical care, in stark contrast to nursing experience in the ICU plus a mere two years of nurse anesthetist training. There is a meaningful difference between how doctors and nurses are trained to think, and the basis upon what this thought is based. Consider, for example, the complexity of diagnostic reasoning and the biases introduced by Type I reasoning (intuitive judgments and pattern recognition) versus the refinements of Type II reasoning (“reflection in action”). Indeed, this qualitatively different method of thought is relevant in a field that is only partly technical and increasingly cognitive.

** The failure of the authors of the editorial to realize that “monitoring” is but one aspect of “administering anesthetics” is in itself revealing of their lack of understanding of the subject they so ill-informatively address.

• **“Miniscule risk?”** When an adverse event does occur, no matter how unlikely, those patients so affected deserve the most educated, qualified, and experienced practitioner to rescue them. Isn’t that what you would want? Playing with probabilities may seem like a sensible approach across a population of patients, but in a specific instance with a specific patient, all of that population risk is focused upon that one individual patient.

• **“California’s move is being challenged… on procedural technicalities?”** In California, the “opt out” of the Medicare mandate for physician supervision of nurse anesthetists was undertaken in flagrant violation of state law, which explicitly requires such supervision. To characterize this as a “procedural technicality” trivializes an illegal and irresponsible act by Governor Schwarzenegger.

• **“The state’s [California] reasoning, which appears sound?”** There has been no consultation with the state’s medical board about problems of access and quality, as the federal regulations for opting-out require. In fact, there is no data that problems exist with anesthesia care or access. Rather, some hospitals may see an opportunity for financial advantage by employing unsupervised nurse anesthetists, and business interests surely have lobbied the Governor, spinning the facts to support their arguments. The opt-out has the appearance of being politically motivated, done by a lame duck governor furious with California physicians for opposing his version of health care reform (with a doctor “tax” he called a “fee”), and particularly angry with anesthesiologists.
for contesting regulations about chiropractic spinal manipulation under anesthesia for his chiropractic friends.

• “**Savings to the health care system if nurses delivered more of the [anesthetic] care?**” As physicians, anesthesiologists not uncommonly help to prepare patients for surgery by diagnosing and evaluating various complex medical conditions, which often require a weighing of competing priorities. Cardiologist, pulmonologist, neurologist, nephrologist, hematologist, hepatologist, and endocrinologist—an anesthesiologist is in essence many physicians all at once, and may be called upon to make judgments as to how to make patients ready for surgery and anesthesia, to determine when they are ready, to intervene medically intra- and post-operatively as required, and serves as the last remaining physician advocate to keep the patient out of harm’s way. Often, medical consultations can be foregone, saving untold resources, while a nurse anesthetist would be incapable of the required diagnostic skills. Avoiding complications, both intra- and post-operatively, is a highly prized and effective method for saving health care costs.

• The only mention of “substantiation” for “savings” is the report by the Lewin Group which “judged nurse anesthetists acting without supervision as the most cost-effective way to deliver anesthetic care,” a fatally flawed study in how it addresses quality and cost differences, and one that was funded by the AANA, the ugly head of conflict of interest arising once more. It is notable that nurse anesthetists generally work eight-hour work shifts, and thus 24-hour staffing would require multiple personnel. Furthermore, anesthesiologists work far greater hours and fund their own practice overheads, liability and disability insurances, and retirements, all facts that substantially explain a difference in salaries. In actual fact, the payment by insurance carriers, including Medicare, for a particular case is the same for a nurse anesthetist as for a physician. Hence the cost for a physician or a nurse anesthetist is essentially the same.

• “**Costs absorbed by various institutions and public programs?**” It is true that it costs more to educate an anesthesiologist than a nurse anesthetist, but the same can be said of an internist compared to a nurse practitioner, a surgeon to a non-physician first assistant, and a senior commercial pilot to a junior flight officer. The federal and state governments do not nearly fully pay for the costs of educating physicians, who, on average, graduate medical school with $100-200,000 in debt. Repeal of the egregious Teaching Rule for anesthesiology residents has permitted better funding for anesthesiology teaching programs, but this
federal support represents a long overdue and unfulfilled obligation to pay more equitably for the care of Medicare/Medicaid patients who, for decades, were given a free ride. Furthermore, the federal and state governments continue to fail to pay their fare share of charges for anesthesiologists: Medicare still now pays at 33 percent of usual contracted insurance rates, comparing poorly with the 80-120 percent paid for other specialists and primary care physicians.

• Indeed, the costs of training ultimately are absorbed into the system, but to this tally one should consider adding the items of anesthesiologists’ longer working hours, more cost effective rendering of anesthetic services (minimize unnecessary consultations and avoid intra- and post-operative complications), and scientific innovation that improves quality of care. Just what is the price tag for safety? Are informed patients willingly going to accept the concept of the government demanding increased value for Medicare when the ultimate plan is to control costs, and the methods for determining quality are based upon flawed administrative data?

• Medicare beneficiaries prefer a physician anesthesiologist rather than a nurse anesthetist by a wide margin. Most patients are given neither the choice nor the correct information (including qualifications) about who would be responsible for their anesthetic. Indeed, if the misguided contention that nurse anesthetists are much less expensive for the health care system were correct, then how does one explain:

“that even countries with single-payer, government-run health systems (Canada, Western European nations) have not replaced physician anesthesiologists with nurses. There is simply too little to be gained in cost reduction and too much to lose in patient safety.”

In summary, physician direction and supervision of nurse anesthetists, as with any other physician and nurse-extender, creates the highest culture of safety for our healthcare system. Anything less is a subtle and insidious rationing of healthcare, and to suggest otherwise without credible scientific data is disingenuous.


3. Jane Fitch, M.D., formerly a nurse anesthetist, is Chair of the Department of Anesthesiology at the University of Oklahoma.
Talking Points (cont’d)


If you are an anesthesiologist in California, either you work in an anesthesiologist-only practice, or you work as part of an anesthesia care team where you may supervise residents, nurse anesthetists, or both. However, if you practice in Georgia, the District of Columbia, or 16 other states, you have another option: working in an anesthesia care team that includes anesthesiologist assistants, or AAs.

In California, many anesthesiologists are unaware that the profession of “anesthesiologist assistant” even exists, or that there is a potential option for employing physician extenders in anesthesia practice other than nurse anesthetists (NAs). Certainly there are no AAs currently working in California, because the state of California has not authorized AA practice, and no effort to introduce AA licensing legislation has been initiated to date. Could California anesthesiologists benefit from AAs practicing in our state?

The ASA firmly supports the anesthesia care team concept and the addition of AAs as team members. The AA profession was founded over 40 years ago by academic anesthesiologists who wanted to create a new master’s-level educational program in anesthesia. With this degree, graduates are ready to work as mid-level anesthesia providers under anesthesiologist supervision. The education prerequisites are comparable to those for admission to medical school—a bachelor’s degree with specified basic science courses, and the GRE or MCAT examination—so AA graduates can readily make the transition to medical school for further training if they wish. The first year of AA education is didactic, followed by a year of clinical operating room experience in different rotations. Upon graduation, students receive a master’s degree and must pass a national certifying examination. Seven accredited AA training programs exist in the U.S., and over 200 AAs graduated this year.

In states where AAs have the right to work, they must practice under the oversight of state medical boards, whereas nursing boards govern NAs. Otherwise, AAs’ function and scope of practice in essence are identical to those of NAs. They work as part of the anesthesia care team, with specific duties defined by the supervising anesthesiologist. AAs and NAs have equal recognition from the Centers for Medicare and Medicaid Services (CMS) as “nonphysician anesthetists”, and insurers similarly pay for their services. In terms of skills and competencies, there appears to be no
significant difference between NAs and AAs. Today AAs may practice legally in any VA hospital or Department of Defense facility in the U.S.

The major difference between AAs and NAs is philosophic: AAs define themselves literally as “anesthesiologist assistants,” who practice exclusively under the medical direction of anesthesiologists, just as a physician assistant (PA) works under the direction of a surgeon or a family physician. To date, there never has been an instance of an AA seeking to practice without anesthesiologist supervision. In contrast, an NA may practice under the supervision of any physician, and the AANA actively promotes independent practice without physician oversight.

Governor Schwarzenegger signed an “opt-out” letter in June 2009 with the apparent intention of permitting California NAs to practice without physician supervision. While the CSA has filed suit to challenge this action on the grounds that it violates state law, the San Francisco Superior Court recently ruled against the CSA's motion to require the Governor to withdraw the letter. This was cause for celebration among NAs, though most others believe it threatens safe anesthesia care for Californians. Furthermore, there is a nationwide trend for NAs to obtain “doctor of nursing” degrees and insist upon being addressed as “doctor”, which many see as a further attempt to undermine the distinction between anesthesiologists and NAs.

AAs, on the other hand, “are inherently tied to the medical practice of anesthesiology, and are therefore supporters of anesthesiologists and their issues,” says Ellen Allinger, a certified AA and past president of the American Academy of Anesthesiologist Assistants. “All AA educational programs must have a board-certified anesthesiologist as a director, and AAs practice only under the anesthesia care team model. This is a vast difference between AAs and nurse anesthetists.”

“AAs are a better match for us,” says Dr. Steven Goldfien, past president of the CSA, a member of the ASA Committee on the Anesthesia Care Team, and former Chair of the ASA Committee on Anesthesiologist Assistant Education and Practice. Dr. Goldfien would like to see one of the California universities establish an AA education program as an ideal way of bringing AAs into California. In an AA training program, students work without prior licensure just as medical students do, under 1:1 supervision by an anesthesiologist. An accredited AA program affiliated with a major California university could boost public awareness of AAs and pave the way toward AA licensure.

Currently, twelve states allow AA practice under statutory authority and another six under delegatory authority. The difference is this: under
statutory authority, the state medical or allied health board licenses AAs. Under delegatory authority, AAs practice under the auspices of a licensed physician who is entitled to delegate tasks to allied health providers, and usually no license is issued. Although delegatory authority may be easier to accomplish initially, it has proved vulnerable to legal challenge from NAs, and AA leadership clearly prefers the licensure route.

What are the obstacles to obtaining licensure for AAs in California? Perhaps foremost is the inevitable opposition from the California Association of Nurse Anesthetists. Although AAs do not exist in sufficient numbers to threaten their livelihood, NAs fiercely oppose their right to work. Media campaigns against AAs in other states, as Ms. Allinger dryly notes, have been “unencumbered by the truth”. They have attempted without proof to portray AAs as insufficiently educated and a threat to patient care. Nationally, NA professional organizations are well funded and supported by their members; moreover, nurses as a group enjoy the respect and sympathy of the public.

Within the CSA, support for AA licensure thus far has not been universal. Some members fear that it would be inevitable for AAs to want independent practice just as NAs do. Some California anesthesiologists currently work with NAs in academic departments, public institutions or in Kaiser hospitals, and they worry that the introduction of AAs could cause unhappiness and disruption in their workplaces.

Nonetheless, CSA leadership is extremely concerned that the anesthesiologist-only practice model, prevalent in California, will become economically unsustainable. Dr. Ken Pauker, CSA president-elect, agrees that the economic climate and health care reform threaten traditional practice. “It’s far better for our patients’ safety to have supervisory anesthetic care than a lesser alternative,” he says. But the process of getting AAs the right to work in California won’t be quick or easy. The first step, according to Dr. Pauker, would be to make sure that there is strong, unified support from CSA members for AA licensure.

The AAs themselves remain hopeful that someday they will be allowed to work in California. “I’m a California native,” says Shane Angus, an AA who is on the teaching faculty of Nova Southeastern University in Florida. “I’d come back to work here in a minute.”

For further information on AAs and on the ASA’s official position regarding their practice, visit the ASA website. The CSA also recommends the article “Anesthesiologist Assistants vs. Nurse Anesthetists…What Are the Differences?” by Dr. Jeffrey Plagenhoef, which can be accessed at: http://www.asahq.org/Newsletters/2008/02-08/plagen02-08.html.
A Blind Horse Upon a Treadmill

An Opinion by Steve Goldfien, M.D.
Former CSA President

The word contempt, in modern usage synonymous with disdain, disrespect, scorn, and condescension, would seem to describe President Obama’s feelings for the medical community during the battle over health care reform. His repeated allusions to doctors lining their pockets by providing unnecessary or inappropriate care certainly created a feeling of righteous indignation among physicians, but doctors seemed to have missed the more important, though less apparent, implication of the President’s words. In 18th century parlance contempt simply connoted something unworthy of serious consideration, something safely disregarded. The “something” in this case would have been organized medicine’s advice on how best to improve our health care system. The behavior of the President seems to imply that he found physicians more useful as whipping boys than allies. Contrast this with physicians’ own view of their role in this process, as expressed in a statement by then AMA President James Rohack in July 2009: “We know our position at the center of the health-reform debate is both an honor and a serious responsibility.” How can we then reconcile these divergent perspectives? If physicians were so central to the process, then why were they misled, insulted and marginalized while their top priorities of Sustainable Growth Rate (SGR) and tort reform went unfulfilled? And given their deprecation by political leaders, why didn’t they fight back, publicly oppose the Congressional plan, and attempt to defeat it outright?

Broadly understood, this treatment of physicians demonstrates that the medical profession now lacks the political power to influence events in Washington, and as a consequence no longer can maintain control over the profession of medicine. As physicians have come increasingly under the thumb of government and big business, their ability to practice according to their ethics, education and training, to ensure that patient needs are put first—ahead of profit and political expediency—is being lost. This change threatens the very soul of the profession and provides the impetus to seek a better understanding of why this has happened and what, if anything, can be done to reverse it.
Medicine as a profession was once the most powerful the country had ever seen. Headed by the 600,000-strong AMA, it enjoyed guild-like levels of professional autonomy at the time Medicare was passed. This was reflected in the freedom physicians had to choose and educate future doctors, conduct the research that advanced their varied specialties, control their work environment, and manage their own financial affairs. This is the essence—the who, what, when, how, and how much of any profession—and physicians had secured it all through a successful relationship with government in which they were valued as a powerful and respected partner. In return, Americans enjoyed the best medical care in the world. The power of the profession at that time is on display in this dramatic point and counterpoint:

From a packed Madison Square Garden in 1963, President Kennedy spoke to the nation urging the passage of legislation creating a federal health care program, the precursor to Medicare. Not allowed to respond that evening, then AMA President Edward Annis had the audacity to rent the Garden the very next night, and, before a sea of empty chairs, warn the public of the skyrocketing costs and government interference in their care that would surely come if the President’s plan were approved. The medical profession, supported by the public and confident in its political power, went head to head with a popular President, and won! Little did they know, as they celebrated their victory, just how short-lived it would be. <http://www.youtube.com/watch?v=vFesycofKk4>

 Barely two years later, and this time despite their objections, the Medicare Bill was passed, making the Federal government responsible for the medical care of the elderly. As predicted by Dr. Annis, rising costs soon turned a health care system, a national treasure in the private sector (albeit with some notable blemishes), into a financial cancer in the public sector. Venerated before they were sending their bills to Washington, physicians now came under attack from Washington’s cost-cutters and their minions in the press. Adulation became accusation as the popularity—and then the power—of the medical profession were systematically undermined by incessant charges, often unsubstantiated, of inferior care and high cost. Once the populace accepted the image of the rich country-club doctor, mistake-prone and unconcerned with the public welfare, then politicians could attack physicians with impunity, knowing that protestations of unfair treatment would fall on unsympathetic public ears. This loss of prestige and public trust weakened the negotiating power of the profession just as the federal government entered a period of massive expansion in size and power.

Over time, physicians came to avoid direct appeals to the people, but rather to rely on the ability of consultants and lobbyists to convince lawmakers that treating physicians fairly was necessary for public welfare. Although not without its successes, this policy reflected—and was limited by—a dearth of real political
power. Lacking a strong base of public support, physicians were simply an elite minority in a democracy, a source of money when budgets were stretched, and dependent for fair treatment on the virtuous behavior of those with real political power.

Now fast-forward from 1963 to 2009: the government is proposing the largest entitlement expansion since Medicare, and physicians will be in the eye of the storm. Public concern grows as details become known. The people not only expect physician opposition, but a sizable majority hope it will tip the scales and force a true bipartisan effort at reform. Polls that confirm the public’s profound trust in physicians show an equally profound distrust of government. So energized are their patients that public protests break out in every state. In three major elections Democrats are voted out of long held seats, one in Massachusetts apparently for the express purpose of bringing the whole process to a halt. The stage is set for organized medicine to act.

But Dr. Annis and the AMA of 1963 are long gone, his defense of the principles underlying private sector health care forgotten, the happy symbiosis that once bound the public to its physicians but a distant memory. Rather than oppose government expansion into the private sector, the AMA actually proclaims its support publicly, its leadership working behind the scenes to mitigate the damage, “keeping a seat at the table,” physician income its top priority, fearful of alienating those who control that income, praying that the bill will die at the hands of others, but hoping to be justly rewarded for being “team players” should the bill pass. Many try to warn the AMA leadership off this catastrophic strategy, that the real fight is about control and not payment. But this time there will be no partnership with the public, no warning of increased costs, decreased quality, rationing, and government interference in the doctor-patient relationship. Instead, organized medicine is sitting on the sidelines with promises of SGR reform, taking a “recommended with reservations” attitude, “keeping our ammo dry” until long after that ammo is of any use. By refusing to fight a blatant government takeover of the health care system, by failing to join the public and defeat the bill outright, by ignoring strong opposition from the physician community, the AMA failed the profession, and the doctors knew it. Worse, it failed the people, and the people knew it.

Medicine has reached a crossroads. The profession is rapidly being enclosed in what Max Weber called “the iron cage of bureaucratization.” Price–controlled, micromanaged and hounded by regulators, the end–game approaches as the Centers for Medicare and Medicaid Services (CMS) moves to control the provision of medical care through its Value Based Purchasing (VBP) program. If physicians continue on this course, then they soon may find themselves unable to function as professionals.
Under our current model of medical professionalism physicians use their specialized education to address, as best they can, the unique problems of every individual. Flexibility, discretion and experience play a key role in the translation of imperfect knowledge into the optimum treatment for each patient. Standards and guidelines, when needed, are developed under the auspices of professional medical organizations, in a democratic fashion, by experts working with the latest medical knowledge and welcoming input from a wide range of sources, including rank and file practitioners. Discretion and flexibility are built in while high sounding but inappropriate notions such as “zero tolerance” are eschewed. As part of the private sector, these organizations can react quickly to changes in medical knowledge so that practice guidelines will remain relevant and useful.

Inside the “iron cage,” standards of care are set by government regulators within CMS who also monitor compliance as a condition of payment for services. Expert opinion and scientific knowledge may be sought but only at discretion. The process is slow, not easily adapted to changes in medical knowledge, and far less insulated from those with political or financial agendas. “Zero tolerance” and “equality” are the real standards of care, rules must be followed precisely, documentation perfect, and no one is allowed better care than anyone else. This bureaucratic model is necessarily inferior to professional care because the patient-specific information and medical knowledge available to the bureaucrat cannot be as accurate, up to date, or expertly used as that available to the physician in the room or at the bedside. The danger for medical professionalism and the health of the public is now reaching critical levels because legislators and regulators in Washington now believe they can implement the bureaucratic model. By creating a system to gather the necessary data, they believe that they can control the doctor-patient relationship, improve the quality of care and save money, all at the same time.

Under the rubric of VBP, CMS has created a multi-pronged plan to control the provision of medical care. It begins with the creation of the Personal Health Record. This is the repository of patient-specific health information for every individual, and to which the government will require unfettered access in the name of proving the best care to which each person is entitled. To determine what care is indicated, data is being gathered on current health care practice through the submission, soon to be mandatory, of an ever-growing number of physician and hospital performance measures or “quality indicators.” Comparative Effectiveness Research will allow them to prioritize treatments on cost, in theory increasing value by getting the highest “quality” for the lowest cost. The program would be impossible without digitized data, so adoption of the Electronic Health Record (EHR) is of the highest priority. According
to House Speaker Pelosi, 19 billion dollars are being devoted to spur both its adoption by skeptical health care providers and to convince the public that the EHR is key to safety and quality in their medical care. Finally, but just as critical to the success of the project, private sector registries, like the Anesthesia Quality Institute of the American Society of Anesthesiologists, are being “certified” to gather all this data and make it available to CMS in the correct electronic form.

Despite the grand pretences evident in CMS’ own description of its plan, it is a delusion to think that lay bureaucrats, or even a centralized panel of expert physicians from academia and professional medical societies, can use these mountains of data to replace the doctor in the room. Biologic diversity and limitations in medical knowledge mean that medicine is still as much art as science, that actual experience in care remains critical to success. The real effect of VBP will be to transform our health care system into one in which the care received is based not on the good of the individual, rather on the “greater good” of the society. When physicians are relegated to serving the “greater good,” to satisfy the public’s “right” to health care, to be treated as commodities by the government and industry, then they no longer are professionals, but simply, to quote Abraham Lincoln, “a blind horse upon a treadmill… all the better for being blind, that he could not tread out of place or kick understandingly.”

It may be time for physicians to consider that their professional societies, having failed to protect their interests during health care reform, and having jumped on board the VBP bandwagon, are failing in their primary duty—to preserve the profession as a profession. Without power over how they practice and what care they provide, physicians can neither provide the high quality care the public expects, nor fulfill their ethical obligation to put the interests of their patients first, nor keep the details of their patients’ health care confidential and treat them as individuals. The causes of this failure are many, but all stem from the federal government’s urgent need to control the cost of its promise of unlimited medical care to those in the Medicare program—a pledge that will become all the more difficult when 30 million uninsured are added to the burden. If physicians are to reinvigorate their profession, then they must focus on regaining their professional power, something they will never be able to do so long as they remain economically dependent on the federal government. To change this, they must strive to eliminate federal price controls on physician fees and to regain the right to privately contract with any patient, including those in government programs. Just as importantly, they must work to break the power of CMS over the doctor-patient relationship by supporting legislation to prohibit the federal government from regulating the practice of medicine, a power that by right and tradition belongs to the individual states.
A Blind Horse (cont’d)

Achieving these goals will be a daunting task, but the alternative is a health care system marked by mediocrity, rationing and the stifling of innovation. With careful preparation, re-education of the public, reform of the Congress, and steadfast determination, a way forward can be found. The time for change is now, while the public is up in arms over the cost and intrusiveness of the federal government. The House of Medicine must join with the people and support those legislators who will help them reign in the federal government, freeing them once again to practice as the professionals they are. Only when such people once again lead this country will America and its medical profession regain their health.

Excerpt from Arthur O. McGowan, M.D., CSA President’s Address to the House of Delegates, July, 1987…

“The subject of Medicare physician reimbursement is going to remain a matter of major concern for years to come. The need for hard work by the individuals in our Society and the rest of medicine will continue far into the future. Difficult confrontations lie ahead of us, and we must persist in what we feel is truly right. We must continue to insist that quality health care be available for our patients. Government is treating health care as a commodity, and they are looking solely at the cost. In their desire to spend less, they will squeeze every possible sector to curb costs. This approach leads to shortcuts, cookbook medicine, and decreased quality of care, short-changed patients, and a degradation of American medicine. These are the end results that we must prevent. Hopefully, reasonable men and women will listen to what we have to say. Thus far they have, and we must continue to make this possible.”

Hal Scherz, M.D., Wall Street Journal, September 1, 2010…

“Section 1311 of the new health care legislation gives the U.S. Secretary of Health and Human Services and her appointees the power to establish care guidelines that your doctor must abide by or face penalties and fines. In making doctors answerable in the federal bureaucracy this bill effectively makes them government employees and means that you and your doctor are no longer in charge of your health care decisions. This new law politicizes medicine and in my opinion destroys the sanctity of the doctor-patient relationship that makes the American health care system the best in the world…ObamaCare will bring major cost increases, rising insurance premiums, higher taxes, a decline in new medical techniques, a fall-off in the development of miracle drugs as well as rationing by government panels and by bureaucrats.”
The Annual Meeting of the ASA Board of Directors (BOD) was held in Chicago on August 21 and 22, 2010. In addition to myself, other CSA members present included President Narendra Trivedi, M.D., Immediate Past President Linda Hertzberg, M.D., Speaker Johnathan Pregler, M.D., Assistant Secretary Christine Doyle, M.D. (who is also Chair of ASA’s committee on Electronic Media and Information Technology), Assistant Treasurer William Feaster, M.D., ASA Alternate Director Michael Champeau, M.D., ASA Assistant Secretary Linda Mason, M.D. and ASA Committee On Economics Chair Stan Stead, M.D. Our CEO Barbara Baldwin was also in attendance, as usual, enabling her to have significant face-to-face interactions with ASA staff and attending the CSA Western Caucus, BOD review committees and formal ASA BOD meeting. The participation of our CEO at the ASA BOD meetings does, in my view, provide CSA with an important measure of informed interaction and gives a significant advantage to our CSA staff that the majority of state component societies do not enjoy.

The many reports and action items that made up the Board Handbook for this meeting were divided between the four usual review committees according to the categories of administrative, professional, scientific, and financial affairs, and all were presented for consideration and testimony. The ASA Board’s recommendations on these items will be presented to the ASA House of Delegates in October along with those recommendations acted upon at the March interim meeting, and many additional reports not previously presented to the BOD. The HOD may, of course, approve or disapprove the BOD’s action on any of these items. Here are some of the issues from the August BOD that may be of interest to CSA members:

- The Administrative Council recommends a Bylaws amendment that would permit the ASA President to lodge a complaint against a member convicted of a felony and such a complaint to be forwarded to the Judicial Council. Most of us were surprised to hear that there were ASA members in apparent good standing who have serious criminal convictions. This is not a statistic that enhances the public image of our society. Current bylaws require that a complaint against such individuals must be filed by another member in
order to initiate a judicial process leading to expulsion from the Society. No one has ever done this!

- The BOD disapproved a recommendation from the New York component society to modify language approved at the March BOD meeting defining how a member is allowed to designate their component society membership. *This is not much of an issue for large western states, but in the Northeast, especially, where people may live in one state and work in a number of others, it can be.*

- The BOD disapproved recommendations from multiple directors, including me and Dr. Champeau, regarding ASA endorsement of Candidates for AMA Offices and Positions. *This arose from widespread concern regarding AMA policy and public statements during the national debate over national healthcare reform. The discussion over this issue has none-the-less raised awareness and recognition of the importance of transparency and trust in the actions of our AMA delegation.*

- The BOD recommends authorization of the Administrative Council (AC) to pursue a plan for site selection and construction of a new building, or an existing building, for a new ASA Executive Office. The HOD will be asked to delegate final authority for selection of a new site or building, purchase, supervision, and negotiation of financing to the AC. This will be subject to a budgetary limitation of $20 million. *The ASA staff has outgrown its current housing in Park Ridge. An adjacent unimproved property parcel was purchased last year, and a detailed analysis of various alternative uses for this property, and how best to address the need for additional office space for ASA headquarters, has been presented to the BOD. This project will be ongoing.*

- The report of the committee on ethics, which was critical of Dr. Hannenberg’s letter to the ABA urging withdrawal of its statement on an ABA diplomate’s involvement in criminal executions, was referred back to the committee. *This report contained additional recommendations defining the expertise and qualifications for members of this committee. Testimony was heard that the president-elect should be allowed judgment and latitude in committee appointments.*

- The committee on economics amended the ASA Statement on Reporting Pain Procedures in Conjunction with Anesthesia, in response to reports of payors inappropriately bundling the placement of epidurals and peripheral nerve blocks for postoperative pain control into the payments for surgical anesthesia services, which is contrary to CPT guidance, Correct Coding Initiative (CCI) and Medicare contractors’ instructions. *Included in the amended language is: “Time for a post surgical pain block that occurs*
after induction and prior to emergence does not need to be deducted from reported anesthesia time.”

- The Advisory on Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners, developed by an ad-hoc committee, and based in large part on the CSA guideline, was approved. *This Advisory can be found on the ASA website.*

- The Committee On Occupational Health recommended revision of the ASA Recommendations for Infection Control for the Practice of Anesthesiology, in order to conform to current guidelines from CDC. The BOD amended this revision, and this statement was approved: “Do not administer medications from a syringe to multiple patients, even if the needle or cannula on the syringe is changed. Needles, cannulae, and syringes are sterile, single-use items. Do not reuse for another patient.” *The additional phrase “or to reaccess a medication or solution” was disapproved.*

- The Committee On Pain Medicine recommended revision of the ASA Statement on Anesthetic Care during Interventional Pain Procedures, which was approved by the BOD with the addition that this statement applied to adults. The following sentence was added to this document: “The use of general anesthesia for routine pain procedures is warranted only in unusual circumstances.” *Although this was approved without comment, practices which routinely provide anesthesia for pain procedures should be aware of this language.*

**HOLD THESE DATES!**

**CSA Annual Meeting and Clinical Anesthesia Update**

**May 13-15, 2011**

At the Fairmont San Jose in downtown San Jose

Topics include:

- Management of Massive Hemorrhage in Obstetrics
- Joint Commission and CMS-Medication Management and Other Compliance Challenges
- Adult Congenital Heart Disease: Meeting the Challenge
- Trauma Anesthesia Update
- Videolaryngoscopy: Should It Replace Direct Laryngoscopy?
- Common Infant Emergencies and Problems: What Do I Need to Know?

Learn more and register at [www.csahq.org](http://www.csahq.org)
California Society of Anesthesiologists
Winter Hawaiian Seminar
January 24 – 28, 2011
Hyatt Regency Maui Resort & Spa
Ka’anapali Beach, Maui

Topics include:

- Managing regional anesthesia complications
- Do anesthetics make you stupid?
- Labor & delivery management of the morbidly obese parturient
- Perioperative stroke in general surgery — no one told me it’s so common!
- Postoperative nausea and vomiting — yes, there are new strategies
- Perioperative fluid management: voodoo or science?
  …and much more!

Faculty

Adrian W. Gelb MBChB
Program Chair
Professor of Clinical Anesthesia
UCSF School of Medicine

Peter J Davis, M.D.
Professor of Anesthesiology
Critical Care Medicine & Pediatrics
University of Pittsburgh
School of Medicine

Tong-Joo Gan, M.D., MHS, FRCA
Professor of Anesthesiology
Duke University School of Medicine

Edward R. Mariano, M.D., MAS
Chief, Anesthesiology Service
VA Palo Alto Health Care System
Associate Professor of Anesthesia
Stanford University School of Medicine

Joy L. Hawkins, M.D.
Professor/Residency Director
Department of Anesthesiology
University of Colorado Denver
School of Medicine

Faculty Disclosures

Faculty who participate in continuing medical education activities sponsored by the CSA are required to disclose any relevant financial interest or other relationship with the manufacturer(s) of any commercial product(s) discussed in a continuing medical education presentation(s). Disclosure of faculty and provider relationships will appear on our Web site or in the conference syllabus.
Educational Information

The California Society of Anesthesiologists is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians.

The California Society of Anesthesiologists Educational Programs Division designates this educational activity for a maximum of 20 AMA PRA Category 1 Credits™. Physicians should claim only credits commensurate with the extent of their participation in the activity.

Hotel Rates

CSA rates based upon single or double occupancy (not including tax):

<table>
<thead>
<tr>
<th>Room Type</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terrace View (limited availability)</td>
<td>$232</td>
</tr>
<tr>
<td>Golf/Mountain View</td>
<td>$289</td>
</tr>
<tr>
<td>Deluxe Ocean View</td>
<td>$317</td>
</tr>
</tbody>
</table>

Family Fun at the Hyatt Regency Maui

There is so much to do at the Resort, including:

- Two free-form pools divided by waterfalls, 1/2 acre with lava tube slide and rope bridge with an outdoor whirlpool and interactive children’s pool
- 1,800-feet of white-sand beachfront at hotel
- Spa Moana and Moana Athletic Club, Hawaii’s only oceanfront, 15,000 square foot full-service spa, salon and fitness center
- Kaanapali Golf Courses: two 18-hole courses, adjacent to the hotel with free shuttle; Kapalua Golf Courses: two 18-hole courses, 15 minutes from hotel;
- Wailea Golf Courses: three 18-hole courses, one hour from hotel
- Tour of the Stars astronomy program
- Wildlife, art and garden tours, hula lessons, lei making, aqua aerobics
- Scuba, windsurfing, kayaking, surfing
- Hula Girl and Shangri La Catamaran Sails - available for private charters or daily
- Camp Hyatt offers a fun activities program for children 5-12.

Auto Rental

CSA members can get great deals on car rental with Alamo Rent-A-Car. Call Alamo at 800-732-3232 and request Group ID #7013800 for discounted rates.
Registration
Mauna Lani Bay Hotel and Bungalows

Name _________________________________________________________________________

MD    DO    CRNA    AA    RN    PA    (Please circle one)

ABA # _________________________________________________________________________

(for CME reporting)

Address _______________________________________________________________________

City/State/Zip __________________________________________________________________

Phone (      ) _____________________________ AANA Member No. ________________

E-mail _________________________________________________________________________

<table>
<thead>
<tr>
<th></th>
<th>Before Dec. 29</th>
<th>After Dec. 29</th>
</tr>
</thead>
<tbody>
<tr>
<td>CSA Member</td>
<td>$595</td>
<td>$645</td>
</tr>
<tr>
<td>Non-CSA Physician</td>
<td>$695</td>
<td>$795</td>
</tr>
<tr>
<td>CRNA, AA, RN, PA</td>
<td>$695</td>
<td>$795</td>
</tr>
<tr>
<td>Resident (verification from</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training Chief required)</td>
<td>$350</td>
<td>$380</td>
</tr>
<tr>
<td>Retired CSA Member</td>
<td>$350</td>
<td>$380</td>
</tr>
</tbody>
</table>

A continental breakfast for registered attendees is included in the registration fee. Breakfast is served 7-8 a.m., Monday – Friday. Weekly guest breakfast passes may be purchased at the CSA’s cost. Hotel restaurants may feature more menu options and lower pricing. Sorry, daily purchases are not available.

Guest Breakfast Fee: $200 per adult, $100 children ages 3-12 years (under 3 yrs no charge)

Please provide the names of all guests for whom you are purchasing breakfast passes:

1 ____________________________________________________________________________

2 ____________________________________________________________________________

3 ____________________________________________________________________________

Guest Meal Total $ _________

GRAND TOTAL $ _________

No refunds for cancellations after December 29, 2010
Please charge my: ☐ MasterCard ☐ Visa

Card # ____________________________ Exp. Date __________________

I authorize the California Society of Anesthesiologists to charge my account for the registration and any indicated guest fee.

Signature: _______________________________________________________

Register online at www.csahq.org  OR
Mail with check payable to:
California Society of Anesthesiologists
951 Mariner’s Island Blvd., Suite 270, San Mateo, CA 94404
800-345-3691  FAX: 650-345-3269

Americans with Disabilities Act (ADA): If you require special services to fully participate in the program, please include a written description of your need with your registration by December 29, 2010.

Refund Policy
• Prior to December 29, 2010
• Requires written request
• $75 charge will be retained to cover administrative expenses

Target Audience
This program is designed to educate and/or refresh the knowledge of practicing anesthesiologists, nurse anesthetists, anesthesia assistants, anesthesia residents and students and other health professional in the practice of anesthesiology.
Keeping Patient Safety First
While Responding to
Production Pressure

Production pressures are the “overt or covert pressures and incentives on personnel to place production, not safety, as their primary priority.”¹ A variety of organizational, systematic and personal factors may be contributing to production pressures in a particular healthcare environment, including unrealistic workload planning, inadequate staffing, disorganization, duplicative efforts, delegation problems, personal financial needs and a culture that does not value safety over production.² Clinicians and staff adapt to production pressures in a variety of ways, including:³

- Deviating from procedures and practice guidelines that are designed to promote quality and safety.
- Completing tasks too quickly and without an adequate amount of attention to quality and safety.
- Working when fatigued.

Any of these coping mechanisms can increase the risks of patient injury and medical liability exposure.

Although much of the responsibility for production pressure risk management falls on the shoulders of healthcare administrators and managers, there are a variety of strategies individual providers can use to meet production expectations while minimizing patient safety and professional liability risks. In addition to providing information for administrators and managers, this publication provides production pressure risk management strategies for individual providers, including: how to recognize when production pressure has reached a dangerous level and how to adjust the circumstances, how to maintain quality while satisfying production demands, and how to become a more efficient communicator during patient encounters.

This article is adapted from the September 2010 Claims Rx publications and is reprinted here with permission by NORCAL Mutual Insurance Company. http://www.norcalmutual.com/publications/claimsrx.php
Production Pressure and Surgery

Production pressure can result in a variety of adverse circumstances in the surgical arena, including, but not limited to:

- Inadequate preoperative work up and evaluation of a case.
- Failure to cancel or reschedule a case when it is reasonable and necessary to do so.
- Surgery on the wrong site or the wrong patient; or performance of the wrong surgery.

Case One - Failing to Reschedule a Procedure

The following case shows how production pressure contributed to an anesthesiologist’s decision to allow a procedure to go forward, when it should have been cancelled.

Allegation: If the procedure had been rescheduled, the patient would have had a better outcome.

The Event

The patient, a 420-pound, 40-year-old male, was scheduled to undergo laparoscopic gastric banding at a surgical center (Center) on a Friday, but because of scheduling problems, the case was moved to a Saturday. On Saturdays, the Center scheduled only one anesthesiologist and no anesthesiology technicians. On this particular Saturday, the scheduled anesthesiologist was recently hired.

In addition to being morbidly obese, the patient had diabetes, hypertension and obstructive sleep apnea. During the pre-procedure anesthesia examination, the patient informed the anesthesiologist that he had undergone a liposuction procedure in the recent past, and that there had been no anesthesia problems. Because of the patient’s preexisting conditions, the anesthesiologist assigned an ASA score of 3. The anesthesiologist obtained an informed consent for general anesthesia and post-operative analgesia.

The patient was taken to the operating room, where in addition to the surgeon and anesthesiologist, a scrub nurse and a circulating nurse were present. The difficult-airway cart was outside the operating room in the hallway. After the monitors were placed, the patient received preoxygenation through a face mask. The anesthesiologist attempted rapid sequence induction but, because of the patient’s size, had difficulty ventilating him through a mask, as well as moving his head to get good position and visualization.
When the anesthesiologist passed the laryngoscope, one of the patient’s teeth became loose and his gums began to bleed. The blood covered the oral pharynx. The anesthesiologist suctioned the blood but still could not see the vocal cords. Within a minute of the onset of bleeding, the oxygen saturations dropped to 80%. The anesthesiologist was able to place a laryngeal mask airway (LMA), and the saturations slowly increased from a low of 70% to 90%. The anesthesiologist placed an endotracheal tube into a fiber optic scope and passed it down the LMA. After an initial increase, the oxygen values dropped again, indicating that the endotracheal tube was not in place.

At this point, the anesthesiologist and the surgeon agreed to cancel the surgery. The anesthesiologist removed the endotracheal tube, leaving the LMA in place because of the damage to the tooth. He turned off all the gases and thereafter administered flumazenil to reverse the Versed and wake the patient. The patient began to wake and resumed breathing on his own; however, he quickly became very agitated—kicking, flailing and pulling at the LMA. The anesthesiologist removed the LMA and placed a non-re-breather (NRB) facemask, but the patient’s agitation continued. He pulled off his monitors and facemask, causing the tubing to become disconnected from the oxygen source. Because of the patient’s size, the surgical team was unable to restrain him adequately. After struggling for a few minutes, the patient slowly became less agitated, and the team was able to reconnect the oxygen and monitors. They then discovered he had no pulse. Chest compressions were started and the LMA was placed. The patient returned to sinus rhythm with a normal blood pressure and saturations.

Unfortunately, the patient had suffered an anoxic brain injury. He was later found to be unresponsive to pain and his pupils were sluggish. As recovery was deemed doubtful, the family decided to withdraw life support and the patient expired. The family filed a medical liability lawsuit against all of the providers involved in the decedent’s care. Because of lack of standard of care support, the case settled.

**Discussion**

Although the anesthesiologist recognized prior to surgery that the intubation could be challenging given the patient’s comorbidities, he felt that he could accomplish it safely. In retrospect, however, the anesthesiologist acknowledged that because of the absence of additional anesthesiologists or anesthesia technicians and the fact that the surgery was not urgent, he should have insisted on postponing the surgery.

The anesthesiologist was a recent hire, and he wanted to appear capable and make a good impression. Despite the challenging circumstances, he did not
he knew that rescheduling would result in a loss of income for the Center and the surgeon, and he did not want to be held responsible for those losses. All of these issues contributed to his decision to continue with the surgery.

**Inadequate Staffing**

Experts felt that the pre-anesthetic evaluation was adequate but not ideal. Had it been performed earlier, providers might have been able to plan more appropriately for the patient. For example, the ability of the surgical team’s ability to restrain the patient physically might have been taken into consideration. When he needed to be physically restrained, the team struggled to accomplish this in a timely manner. Also, the anesthesiologist later noted that many of the problems he encountered with the patient could have been alleviated through the assistance of another anesthesiologist or an anesthesiology technician.

**Inadequate Preparation**

Production pressure can adversely impact a provider’s preparation. In this case, the surgical team (and the anesthesiologist in particular) was unprepared to intervene and/or rescue the patient if it became necessary. Preparing for the anesthetic includes assembling necessary equipment and medications and preparing checklists of important equipment. In this case, the anesthesiologist did not have specialized intubation equipment prepared for immediate use and had left the difficult-airway cart in the hallway. He felt part of his inability to respond to the emergency was his unfamiliarity with the operating room. Experts were critical of his lack of preparation.

**Risk Management Recommendations**

Patient safety must trump production. Many steps can be taken to encourage a culture of safety, including:

- Evaluate the workplace for systems and factors that affect workload and production pressures. Ensure that scheduling and facility planning optimize staff resources. Many times, there are more factors affecting patient safety than simply the number of people scheduled. Consider the fact that clinicians and staff have different levels of skill, knowledge and experience.
Keeping Patient Safety First (cont’d)

• Empower frontline staff and clinicians to halt a procedure when production pressure threatens patient safety.
• Remind clinicians and staff of the importance of a culture of safety.

Although this anesthesiologist’s desire to go through with the procedure is understandable, and there was certainly a chance that nothing would go wrong, proceeding with the surgery turned out to be the wrong choice and resulted in a devastating outcome.

Case Two - Wrong Site Surgery

Allegation: The surgeon operated on the wrong knee.

The Event

A 70-year-old female patient presented to an orthopedic surgeon with complaints of knee pain. The surgeon’s diagnosis was “bilateral knee pain, most likely early osteoarthritis.” He ordered an MRI of the left knee to rule out meniscal pathology. The MRI showed a complex lateral meniscus tear of the left knee. He recommended an arthroscopic partial lateral release and lateral partial meniscectomy of the left knee. Surgery was scheduled to take place a few weeks later — specifically at 4 p.m., the last surgery of the day.

The day the patient presented for surgery was extremely busy. Because of staffing shortages and the orthopedic surgeon’s schedule, procedures were behind schedule. Although the patient had been scheduled for a 4 p.m. procedure, it was almost 5 p.m. by the time the surgeon met with the patient to go through the consent process. The patient signed a consent form for left knee arthroscopy and wrote “Yes” on her left knee. After the patient’s left knee was marked, the anesthesiologist performed a femoral nerve block on the left knee.

Nurse #1 prepared and draped the right knee. (There had been a right-knee arthroscopy in the surgical suite immediately before the surgery at issue.) The operative time-out (surgical pause) was performed by Nurse #2 after the orthopedic surgeon performed his first incision. As part of the time-out, Nurse #2 stated, “Right-knee arthroscopy.”

When the surgery on the right knee was completed, the orthopedic surgeon realized that the surgery was supposed to have been done on the left knee. When the drape was removed, the “Yes” was clear on the patient’s left knee. The patient claimed medical negligence and battery, as she had never consented to surgery on her right knee. The case was settled.
Discussion

According to surgery center policy, the operative time-out was to be performed before any incisions were made, and the person performing the time-out was to read from the consent form. The fact that the nurse stated “right-knee arthroscopy” indicates that she did not look at the consent form during the time-out, as the consent form indicated a left knee procedure. Even though he had performed a block on the left knee earlier, the anesthesiologist did not recognize the error. Even though he had worked up the left knee for surgery, the orthopedic surgeon did not recognize the error. When questioned as to why protocol had not been followed, no one on the team could supply a reason other than being in a hurry to complete the procedure. According to one nurse, it was not uncommon for this particular surgeon to start procedures before the protocol had been completed.

Risk Management Recommendations

- Analyze work systems and workflows to identify the circumstances that cause increased production pressure. In this case, the surgeries were scheduled too tightly, and the surgery center was chronically understaffed.

- Develop methods, policies and procedures for managing workload. If surgeries are scheduled at a rate that compromises patient safety, then this practice must change.

- For many reasons, surgery schedules sometimes back up or run late. It is incumbent upon surgeons and administrators to be honest, ethical and realistic with scheduling and to be willing to make adjustments to the schedule when needed. If this means rescheduling non-emergent cases, then that is what should be done.

- Perform all required safety checks as they are designed. The entire operating room team is responsible to ensure this occurs and members of the team must not allow one member to alter or avoid the protocol.

- Production pressure is not an excuse to skimp on patient safety measures. All members of the surgical team must remain vigilant and support other team members in complying with patient safety protocols.
Late-Afternoon Surgeries

Various studies have shown that adverse events are more likely to occur during late-afternoon surgeries. Clinicians and staff must learn to recognize when fatigue is beginning to affect their ability to remain alert during surgery and to take advantage of short-term interventions to maintain alertness. Howard, et al. suggest the following interventions to combat fatigue during late-afternoon surgery:5

- Understand how sleep deprivation and circadian rhythms can affect alertness in the late afternoon.
- Develop alertness strategies such as naps, short exercise periods and good sleep habits. Healthy sleep is 7 to 7.9 hours per night. Exercise, even for a short period of time, can increase blood flow to the brain.

The foregoing interventions are mostly reactionary, which is not ideal. All members of the healthcare team, including administrators and managers, are encouraged to develop policies and procedures that manage patient flow, on-call hours and interdepartmental communication in ways that reduce surgical team fatigue.

References

There seem to be inconsistencies regarding diabetic management in the ambulatory surgery center. The dreaded cancellation by the anesthesiologist because of a high blood sugar looms over the heads of the surgeons and is not consistent from anesthesiologist to anesthesiologist. And, if the decision is made to proceed with the case, then appropriate management becomes the issue. There is good reason for this lack of clarity. The literature on perioperative glycemic control for diabetic patients undergoing ambulatory surgery has been sparse and of limited quality. The SAMBA consensus panel attempted to fill this void by providing recommendations based on general principles of blood glucose control, drug pharmacology, data from the inpatient surgical population and clinical judgment. What follows are 11 clinical questions considered by the SAMBA consensus panel when developing the consensus statement on perioperative blood glucose management in diabetic patients undergoing ambulatory surgery and the recommendations that ensued:

1. What information specifically related to glycemic control should be obtained in the diabetic patient?
   - HbA1c (if available) and fasting blood glucose levels.
   - Ability of patients to reliably test their glucose levels, and the frequency of these measurements.
   - Type, and dose and time of antidiabetic therapy.
   - Frequency and manifestations of hypoglycemia and level at which hypoglycemic symptoms occur.
   - Hospital admissions due to glycemic issues.
2. How do we manage preoperative oral antidiabetic and non-insulin injectable therapy?
   • No oral antidiabetic drugs on the day of surgery.
   • Not necessary to discontinue such therapy on the day prior to surgery.
   • Patients do not develop hypoglycemia with oral antidiabetic drugs except on rare occasions with sulfonyleureas, meglitinides, and non-insulin injectables. Most first generation sulfonyleureas are no longer used. Second generation sulfonyleureas include glyburide, glipizide and glimepride. They act by increasing the release of endogenous insulin and enhancing insulin receptor function by binding to ATP-dependent potassium ion channels in pancreatic beta cells. The duration of action is variable, but typically less than 24 hours. Meglitinides (repaglinide and nateglinide) act by stimulating insulin secretion by binding to ATP-dependent potassium ion channels in pancreatic beta cells. Non-insulin injectables include exenatide and pramlintide. Exenatide mimics incretins, the peptides that are secreted when a person eats, by enhancing insulin function, and it can be used in combination with a sulfonylurea or metformin. Pramlintide is a synthetic version of amylin, a peptide secreted along with insulin when a person eats, and it may be indicated for a type 2 diabetic who requires insulin.
   • Lactic acidosis is rare with metformin except in patients with renal dysfunction, hepatic compromise, or use of IV contrast. In these situations it may be discontinued one to two days prior to surgery. Metformin is a biguanide that decreases hepatic glucose output and increases insulin action.


4. Is there a preoperative blood glucose level above which one should postpone elective surgery?
   • Postpone surgery if there are significant complications of hyperglycemia (dehydration, ketoacidosis, hyperosmolar non-ketotic states).
   • It may be okay to proceed with surgery in patients with preoperative moderate hyperglycemia if there is adequate long-term glycemic control.
   • In chronically poorly controlled diabetics, the decision to proceed is made in conjunction with surgeon, taking into consideration
the presence of other comorbidities as well as the potential risks of surgical complications.

5. What is the optimal intraoperative period blood glucose level?
   • If diabetes is well controlled - 180 mg/dl or less.
   • Chronically elevated glucose levels should not be decreased acutely in the perioperative period.

6. How do we maintain optimal blood glucose levels?
   • Subcutaneous rapid-acting insulin analogs are used to achieve target levels.
   • There is not enough evidence to recommend a dosing schedule to optimize the blood glucose levels.
   • The “Rule of 1800 or 1500” can estimate the expected decrease in glucose for each unit of insulin administered. For example, if the patient’s total daily insulin dose is 60 units, then one unit of administered insulin would reduce the blood glucose level by 25-30 mg/dl (that is, 1500/60 = 25 or 1800/60 = 30).

7. What are the other considerations specific to glycemic control in diabetic outpatients?
   • Have patient bring insulin(s) to the facility.
   • Travel to and from the facility with hypoglycemic treatment.
   • Aggressive PONV prophylaxis is strongly recommended, but dexamethasone can elevate blood glucose levels.

8. What is the optimal perioperative glucose monitoring?
   • Check blood glucose on arrival to facility, and again prior to discharge.
   • It is not necessary to check glucose intraoperatively for procedures lasting less than two hours. However, such monitoring can be performed every 1-2 hours for longer procedures, and this determination also should take into account the type and amount of insulin that the patient has received.
   • More frequent checks should be considered if insulin was received in the morning and/or if the preoperative admitting glucose level was in a lower range.

9. How should we identify and manage perioperative hypoglycemia?
   • “Alert” value for hypoglycemia is less than 70.
• Administer 15-20 gm glucose if the patient is symptomatic. Repeat this dose until the blood glucose rises and symptoms resolve.

10. What are the discharge considerations for diabetic outpatients?
• Observe if perioperative insulin was given until possibility of hypoglycemia is ruled out.

11. What advice should we give to patient for glucose control after discharge home?
• Check glucose levels frequently if fasting.
• Transition to daily preoperative antidiabetic regimens should be delayed if normal caloric intake is delayed.
• Carry hypoglycemia treatment while traveling to and from the facility.

These consensus guidelines are broad enough to support the viewpoints of competent practitioners on both ends of the spectrum. Not only does it provide some rationale to the most conservative practitioner’s management, but it also supports the position of the most liberal practitioner that rarely cancels a case. Of course, underlying this discussion is the fact that outpatient surgery is a tiny moment in the lifelong disease that is diabetes. During the perioperative period there is limited opportunity to cause significant harm. Nonetheless, the avoidance of even short periods of hypoglycemia or significant levels of hyperglycemia should be the goal for the management of the diabetic patient. Along this line of reasoning, the answer to question #4 dealing with the issue of cancellation is practical, yet addresses the issue of safety. Finally, no guideline consensus statement, or any part of it, is a substitute for good clinical judgment.

References


### Managing Preoperative Insulin Therapy

<table>
<thead>
<tr>
<th>Insulin Regimen</th>
<th>Day Before Surgery</th>
<th>Day of Surgery</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin pump</td>
<td>No change</td>
<td>“Sick day” or “sleep” basal rates</td>
<td></td>
</tr>
<tr>
<td>Long-acting peakless insulins</td>
<td>No change</td>
<td>Give 75-100% of morning dose on arrival to ambulatory surgery facility</td>
<td>• Reduce nighttime dose by 25% if history of nocturnal or morning hypoglycemia.</td>
</tr>
<tr>
<td>glargine (Lantus)</td>
<td></td>
<td></td>
<td>• Glargine/detemir has an onset in 2-4 hours, no peak, and duration of 20-24 hours.</td>
</tr>
<tr>
<td>or detemir (Levemir)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intermediate-acting insulins (NPH)</td>
<td></td>
<td>50% of usual morning dose</td>
<td>• See comments for long acting insulins.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed combination insulins</td>
<td>No change</td>
<td>50% of usual morning dose of intermediate-acting component.</td>
<td>• Aspart protamine 70/30 is available only in combination. On morning of surgery give 35% of total AM dosage as NPH insulin.</td>
</tr>
<tr>
<td>Short and rapid acting insulin</td>
<td>No change</td>
<td>Hold the dose</td>
<td></td>
</tr>
<tr>
<td>Non-insulin injectables</td>
<td>No change</td>
<td>Hold the dose</td>
<td></td>
</tr>
</tbody>
</table>
We fight frivolous claims. We smash shady litigants. We over-prepare, and our lawyers do, too. We defend your good name. We face every claim like it’s the heavyweight championship. We don’t give up. We are not just your insurer. We are your legal defense army. We are The Doctors Company.

The Doctors Company built its reputation on the aggressive defense of our member physicians’ good names and livelihoods. And we do it well: Over 82 percent of all malpractice cases against our members are won without a settlement or trial, and we win 87 percent of the cases that do go to court. So what do you get for your money? More than a fighting chance, for starters. To learn more about our medical professional liability program and the other benefits that have made us the nation’s leading writer of anesthesiologists, call (800) 352-0320 or visit us at www.thedoctors.com.
Pediatric Anesthesia CME Program

Module 2

This is Module 2 of CSA’s Pediatric Anesthesia Continuing Medical Education Program (CME). To receive CME credit, submit your registration page, answers to the questions, and the evaluation to the CSA office by mail or fax (650) 345-3269. Your CME certificate will be mailed to you. Alternatively, the full text of each module will be accessible through the CSA Web Site, www.csahq.org, in the Online CME Program section. Instructions to complete Module 2 online are given in the information pages. After completing the assessment, print your CME certificate. Members will need their usernames and passwords to do the modules online.

The following Important Information about Module 2 must be read and acknowledged before proceeding to the rest of the module. Check the acknowledgement box on the registration page.

Faculty/Disclosures

All faculty participating in continuing medical education activities sponsored by the CSA are required to disclose any real or apparent conflict(s) of interest related to the content of their presentation(s) or any of the industry sponsors of the meeting. In addition, speakers must disclose when a product is not labeled for the use under discussion or when a product is still investigational.

Suzanne L. Strom, M.D.
Assistant Professor
Residency Program Associate Director
Director of Medical Student Simulation
University of California-Irvine

Dr. Strom has no relevant financial relationships with any commercial interests.

Mark A. Singleton, M.D. (Editor and Chair of the Pediatric Anesthesia CME Program) Dr. Singleton is a pediatric anesthesiologist in private practice in San Jose, CA and Adjunct Clinical Professor of Anesthesiology at the Stanford University School of Medicine. He is currently chair of the ASA committee on pediatric anesthesia.

Dr. Singleton has no relevant financial relationships with any commercial interests.

Estimated Time to Complete the Module: One hour
Pediatric Anesthesia (cont’d)

Availability

Module 2: Pediatric Resuscitation
Release Date: September 30, 2010
Expiration Date: September 30, 2013

CME Sponsor/Accreditation
The California Society of Anesthesiologists (CSA) is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians. The CSA Educational Programs Division designates this pediatric anesthesia program for AMA PRA Category 1 Credit(s)™ (1 credit per module). Physicians should claim credits commensurate with the extent of their participation in the activity.

Fees, Target Audience, Evaluation
The modules are free to CSA members. Nonmembers pay $30 for each module. Each module is worth one AMA PRA Category 1 Credit™. This program is intended for all licensed physicians, including residents. An evaluation of each module of this series is offered after the test questions.

Privacy Policy
CSA has a privacy policy that is a general policy for information obtained regarding all online interactive pages, including online CME activities. To review this policy, please go to www.csahq.org/privacy.vp.html.

Objectives
Upon completion of this activity, participants will be able to:

1. Discuss relative risk of serious events and factors associated with cardiac arrest based on the ASA Closed Claims Database and Pediatric Perioperative Cardiac Arrest registry.

2. Identify key similarities and differences between Advanced Cardiac Life Support and Pediatric Advanced Life Support with regard to techniques and equipment.

3. Describe appropriate Pediatric Advanced Life Support protocol and drug dosing for pulseless arrest, tachycardia, and bradycardia algorithms.

4. Describe appropriate Neonatal Resuscitation Program protocol and drug dosing.

5. Discuss treatment of local anesthetic toxicity with intralipid in pediatric patients.
Pediatric Resuscitation

By Suzanne L. Strom, M.D.
Assistant Professor, University of California-Irvine

Dr. Strom is an Assistant Professor at University of California-Irvine. Prior to her current position, she was a fellow in Pediatric Anesthesiology at University of California-Los Angeles. She is a Residency Program Associate Director and teaches residents with pediatric and adult patient populations. Her academic interest is in simulation-based education for anesthesiology residents. She also is the Director of Medical Student Simulation, where she has developed high-fidelity simulation-based curriculum for both basic science courses and clinical rotations including physiology, pharmacology, intensive care, anesthesiology and surgery. She is a member of the Society for Pediatric Anesthesia and also the Society for Education in Anesthesia, where she is a member of the Simulation Committee and Milestones Committee.

Introduction

The practice of anesthesiology in children is commonly a rewarding and straightforward endeavor for prepared, well-trained personnel. However, evidence proves the stakes are high, and sometimes the worst complications occur in the healthiest children. Therefore, it is imperative that knowledge of pediatric resuscitation techniques are available to every anesthesiologist whose scope of practice includes children or obstetrics, in which case resuscitation of the newborn may be required.

Much of our knowledge about the risk of anesthesia in pediatrics comes from information contained in the ASA Closed Claims Database. While there are limitations to the methodology of applying closed claims data to clinical practice, the information contained in the most recent examination of the data from 1990-2000 gives us important perspective.¹ Despite a significant decrease compared to the previous decades, death and brain death remained the dominant injuries in pediatric anesthesia malpractice claims in the 1990s. This pattern of injury is much more serious compared with adult claims. Of the 532 pediatric patients (less than 16 years) malpractice claims from 1973-2000 reviewed in total, 77 percent were patients with ASA physical status 1–2, which highlights the need for readily applicable resuscitation skills even when caring for healthy children. In earlier decades, respiratory events resulted in the most liability in pediatric anesthesia malpractice claims; however, in the 1990s, cardiovascular events (26 percent) outnumbered respiratory events (23 percent).

In 1994, The Pediatric Perioperative Cardiac Arrest (POCA) Registry was formed to determine the clinical factors and outcomes associated with cardiac arrest in anesthetized children. The initial findings of the registry (1994-1997)² suggested that anesthesia-related cardiac arrest occurred most often in patients less than one year of age and in patients with severe underlying disease. Mortality following anesthesia-related cardiac arrest was 26 percent. Patients having emergency surgery or with severe underlying disease were most likely to have
a fatal outcome. Medication-related problems were identified as the most frequent cause of anesthesia-related cardiac arrest. From 1998 to 2004 there was a decrease in medication-related arrests from 37 percent to 18 percent. Cardiovascular causes of cardiac arrest became the most common (41 percent of all arrests), with hypovolemia from blood loss and hyperkalemia from transfusion of stored blood the most common identifiable cardiovascular causes. Despite the inherent biases involved in the reporting of events to a registry and the subsequent analysis, data such as this suggest that education about resuscitation is essential.

The American Heart Association (AHA) periodically reviews, updates and changes the scientific evidence behind its Emergency Cardiovascular Care (ECC) resuscitation algorithms and guidelines. A survey of members of the Society of Pediatric Anesthesiologists (SPA) about knowledge of the current (2005) AHA Pediatric Advanced Life Support (PALS) revealed that of the 51 percent of members who responded, 89 percent knew the correct initial dose of epinephrine for asystole, 44 percent knew the subsequent management for asystole if the initial epinephrine dose was ineffective, 49 percent knew the defibrillation sequence to treat pulseless ventricular tachycardia (VT), and 73 percent knew the medication sequence to treat pulseless VT. This CME module is designed to highlight both the changes to the current PALS and Neonatal Resuscitation Program (NRP) guidelines and the current algorithms. It is not designed to replace PALS and NRP certification, which should take place through accredited AHA programs.

**Pediatric Advanced Life Support**

The ECC guidelines were most recently updated in 2005, but a newer version is expected to be released soon. The current recommendations about PALS compression rates and ventilation ratios are the same as for Advanced Cardiac Life Support (ACLS). The compression rate is 100/minute and the depth should be approximately 1/3 to 1/2 of the anterior-posterior diameter. Ventilation rate should be delivered 8 to 10 per minute. A cycle of cardiopulmonary resuscitation (CPR) is 30 compressions: 2 ventilations. The newest guidelines for both ACLS and PALS also stress the importance of effective compressions with minimal interruptions for defibrillation and rhythm check. Each shock should be followed immediately by CPR. The current PALS drug dosages have undergone minimal changes.

Use adult paddles for defibrillation on children greater than 10 kg if they fit on the chest wall and there is at least 3 cm between the paddles. Use infant paddles for infants weighing less than 10 kg. The guidelines also suggest that automatic external defibrillators (AEDs) can be used in children in ages 1-8 with a pediatric attenuator system, which are pediatric pads that decrease the delivered energy. If no pediatric pads are available, then use a standard AED with sensitivity and specificity for pediatric shockable rhythms.
Pulseless Arrest (Figure 1)

Similar to ACLS, the Pulseless Arrest Algorithm is divided into arms for shockable ventricular fibrillation (VF)/Pulseless VT and non-shockable pulseless electrical activity (PEA)/Asystole. For VF/Pulseless VT, provide CPR while obtaining a defibrillator. Give one shock of 2 J/kg, followed immediately by five cycles of CPR before a rhythm check is performed. The second shock is 4 J/kg, followed by a dose of intravenous (IV) or intraosseous (IO) epinephrine given during the compressions. The dose of epinephrine is 0.01 mg/kg (0.1 mL/kg 1:10,000) IV/IO or 0.1 mg/kg (0.1 mL/kg 1:1,000) endotracheally with a maximum of 1 mg IV/IO and 10 mg via endotracheal tube. The successive shocks are always 4 J/kg, and epinephrine is repeated every 3-5 minutes.

Following epinephrine, give antiarrhythmics such as amiodarone (5 mg/kg IV/IO) or lidocaine (1 mg/kg IV/IO) if amiodarone is unavailable. Magnesium (25 to 50 mg/kg IV/IO with a maximum dose of 2 g) should be considered for torsades de pointes.

With VF/Pulseless VT occurring in only 20 percent of pediatric arrests in the hospital setting, asystole and PEA are far more common. The algorithm arm for asystole/PEA involves only CPR and epinephrine. The dose for epinephrine is the same as for VF/pulseless VT, and it can be administered every 3 to 5 minutes. Perform a rhythm check every five cycles of CPR, or every 2 minutes with two rescuers.

Bradycardia with a Pulse

Bradycardia is commonly caused by inadequate oxygenation and ventilation in children, so PALS emphasizes the importance of supporting the airway and ventilating with oxygen, while attaching an electrocardiogram monitor and defibrillator, and then reevaluating if the bradycardia is causing hemodynamic compromise. If cardiovascular compromise persists and the heart rate (HR) is less than 60 beats per minute (bpm) with poor perfusion, then start chest compressions at 100 bpm. If symptomatic bradycardia persists, then give epinephrine boluses every 3 to 5 minutes at the same dose as in the Pulseless Arrest Algorithm: 0.01 mg/kg (0.1 mL/kg 1:10,000) IV/IO, or 0.1 mg/kg (0.1 mL/kg 1:1,000) via endotracheal tube. This dose of epinephrine should be repeated every 3 to 5 minutes. An infusion of epinephrine or isoproterenol can be administered if only transient response is noted with boluses. If it is determined that the bradycardia is due to increased vagal stimulation or primary atrioventricular block, then give atropine 0.02 mg/kg, repeating this does if necessary, with a minimum dose of 0.1 mg and a maximum total dose of 1 mg. Transcutaneous pacing may be lifesaving if the bradycardia is due to complete heart block or sinus node dysfunction unresponsive to oxygenation,
ventilation, chest compressions and medications. Should a pulseless arrest occur, then proceed to the Pulseless Arrest algorithm.

It may be necessary to seek and treat factors other than hypoxia or ventilation problems that might be contributing to the bradycardia such as: hypovolemia, hypo- or hyperkalemia, hypoglycemia, metabolic acidosis, hypothermia, tension pneumothorax, cardiac tamponade, increased intracranial pressure, cardiac tamponade, and coronary or pulmonary thrombosis.

Tachycardia (Figure 2)

The PALS tachycardia (like ACLS) algorithm is initially divided into narrow- and wide-complex tachycardia. However, it has fewer drug options than ACLS and converging final treatment arms. If the patient has pulses but is having hemodynamic instability from tachycardia, then first ensure adequate oxygenation and ventilation. Next, attach monitors and the defibrillator to determine if the QRS duration is less than 0.08 second (narrow-complex tachycardia) or greater than 0.08 second (wide-complex tachycardia). For narrow complex rhythms, a 12 lead ECG monitor is recommended for differentiation between sinus tachycardia and supraventricular tachycardia. For sinus tachycardia, search for and treat reversible causes.

For supraventricular tachycardia, attempt vagal stimulation unless the patient is very unstable or it will delay chemical or electrical cardioversion. Chemical cardioversion with adenosine should proceed if the vagal stimulation was ineffective. Administer adenosine in children using two syringes attached to a stopcock so that 5 mL of normal saline can immediately follow the adenosine administration. The dose of adenosine is 0.1 mg/kg with a maximum of 6 mg. The second dose is doubled with a maximum dose of 12 mg. Unlike ACLS, no third dose is given. If the patient is very unstable or the adenosine was not effective, then perform synchronized cardioversion with 0.5 to 1 J/kg. If this is ineffective, increase to 2 J/kg. Consider administering an antiarrhythmic before the third shock. Give either amiodarone or procainamide slowly as an infusion and consult experts. The dosing for amiodarone is 5 mg/kg over 20 to 60 minutes and the dosing for procainamide is 15 mg/kg over 30 to 60 minutes.

Wide-complex tachycardia with poor perfusion is most likely ventricular in origin but may be supraventricular with aberrancy, and in either case it should be treated with synchronized electrical cardioversion with 0.5 to 1 J/kg. If it does not delay cardioversion, then a dose of adenosine may be given first in order to determine if the rhythm is SVT with aberrancy. If unsuccessful, then administer a second shock of 2 J/kg. If this is unsuccessful or if the tachycardia recurs quickly, then give amiodarone or procainamide as in the narrow-complex algorithm before the third shock. Lidocaine has been removed from the tachycardia algorithm.
Figure 2. Tachycardia (reprinted with permission of the 2005 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, Part 12: Pediatric Advanced Life Support Circulation. 2005;112:IV-173-IV-187) © 2005 American Heart Assoc., Inc.
Neonatal Resuscitation Program (NRP) (Figure 3)

As anesthesiologists in a perinatal unit, we should understand that approximately ten percent of newborns require assistance to start breathing at birth, and one percent needs extensive resuscitative efforts.\textsuperscript{8} While initial steps at stabilization often are successful, one should be familiar with the current NRP guidelines. The algorithm proceeds in 30-second intervals.

Beginning with anticipating the need for resuscitation, first ask the following four questions:

1) Was the baby born after a full-term gestation?
2) Is the amniotic fluid clear of meconium and evidence of infection?
3) Is the baby breathing or crying?
4) Does the baby have good muscle tone?

If the answer to any of these questions is “no,” then the infant should receive initial steps in stabilization:

1) provide warmth
2) place into the sniffing position
3) clear the airway (endotracheal intubation may be considered)
4) dry
5) stimulate

After these initial maneuvers are completed, then, when indicated, ventilation, chest compressions, and administration of epinephrine and/or volume expanders may become necessary (see below).

Traditionally, all meconium-stained infants had endotracheal intubation with suctioning immediately following birth. However, randomized controlled trials have shown that this practice offers no benefit if the infant is vigorous.\textsuperscript{9,10} The NRP defines a vigorous infant as one who has strong respiratory efforts, good muscle tone, and a HR greater than 100 bpm. Conversely, revised recommendations no longer suggest pausing routinely after delivery of the shoulders for oropharyngeal and nasopharyngeal suctioning in meconium stained infants because this was not found to be efficacious. If the [infant] is not vigorous, then they should receive endotracheal suctioning.\textsuperscript{7}

The above-described evaluation and initial steps in stabilization can take place for up to 30 seconds, and then one must evaluate HR, respirations, and color. If the infant is breathing, and the HR is greater than 100 bpm, and the infant is pink, then observational care may proceed.
Figure 3. Neonatal Resuscitation Program (reprinted with permission of the 2005 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care, Part 13: Neonatal Resuscitation Guidelines Circulation. 2005;112:IV-188-IV-195) © 2005 American Heart Assoc., Inc
If the infant is breathing and the HR is greater than 100 bpm, but the infant is cyanotic, then give supplemental oxygen. If this successfully eliminates cyanosis, then observational care may proceed.

Within the ensuing 30 seconds, if the infant remains apneic or gasping, or the HR remains less than 100 bpm, or the infant continues to have persistent central cyanosis despite administration of supplementary oxygen, then start positive-pressure ventilation. The primary measure of adequate ventilation is prompt improvement in heart rate. Ventilation is the most effective action in neonatal resuscitation.

If the HR is less than 60 bpm despite adequate ventilation (endotracheal intubation may be considered) with supplementary oxygen for 30 seconds, then start chest compressions. Compressions should be delivered on the lower third of the sternum to a depth of approximately one-third of the anterior-posterior diameter of the chest with the two-thumb, encircling-hands technique. The ratio of compressions to ventilations is 3:1, with 90 compressions and 30 breaths to achieve approximately 120 events per minute in order to maximize ventilation at an achievable rate. Note the difference in both compression rate and the ventilation-to-compression ratio when compared with ACLS and PALS. Reassess respirations, HR and color every 30 seconds; then continue coordinated chest compressions and ventilations until the spontaneous HR is greater than 60 bpm.

The standard approach to resuscitation is to use 100 percent oxygen. NPR notes that some clinicians may begin resuscitation with an oxygen concentration of less than 100 percent—or even room air—and suggests that evidence supports either of these practices as reasonable. However, it must be emphasized that if one begins resuscitation with room air, then supplementary oxygen should be available to use if there is no appreciable improvement within 90 seconds after birth. Conversely, concerns about potential hyperoxic injury should limit the use of excessive oxygen, especially in the premature infant.

There is insufficient evidence to support the routine use of the LMA as the primary airway device during neonatal resuscitation in the following settings: meconium-stained amniotic fluid, when chest compressions are required, in very low birth weight babies, or for delivery of emergency endotracheal medications. However, a randomized controlled trial found no clinically significant difference between the use of the LMA and endotracheal intubation when bag-mask ventilation was unsuccessful.\textsuperscript{11}
Pediatric Anesthesia (cont’d)

While ventilation is required for apnea and HR less than 100 bpm or unresolved cyanosis, the guidelines do not require intubation for ventilation. However, intubation may be indicated in the following situations:

- When tracheal suctioning for meconium is required
- If bag-mask ventilation is ineffective or prolonged
- When chest compressions are performed
- When endotracheal administration of medications is desired
- For special resuscitation circumstances, such as congenital diaphragmatic hernia or extremely low birth weight (less than 1000 g)

Given that ventilation is the most effective action in neonatal resuscitation, drugs are rarely indicated in resuscitation of the newly born infant. However, if the HR remains less than 60 bpm despite adequate ventilation with 100 percent oxygen and chest compressions, then administration of epinephrine or volume expansion, or both, may be indicated. Past guidelines recommended that initial doses of epinephrine be given through an endotracheal tube because the dose can be administered more quickly than when an intravenous route must be established. However, given the lack of data on endotracheal epinephrine, the IV route should be used as soon as venous access is established. The recommended IV dose is 0.01 to 0.03 mg/kg per dose. While access is being obtained, administration of a higher dose (up to 0.1 mg/kg) through the endotracheal tube may be considered. The concentration of epinephrine for either route should be 1:10,000 (0.1 mg/mL). The recommendations stress the avoidance of higher IV doses because animal\textsuperscript{12-13} and pediatric\textsuperscript{14} studies show exaggerated hypertension, decreased myocardial function, and worse neurologic function after administration of IV doses in the range of 0.1 mg/kg.

One should consider volume expansion when blood loss is suspected or the infant appears to be in shock and has not responded adequately to other measures. Deliver a 10 mL/kg dose of an isotonic crystalloid for volume expansion.

Naloxone is not recommended during the primary steps of resuscitation\textsuperscript{15} but should be given IV or IM instead of endotracheal administration if needed. The recommended dose is 0.1 mg/kg, although no studies have examined the efficacy of this dose in newborns. The recommendations suggest that naloxone should be avoided in babies whose mothers are suspected of having had long-term exposure to opioids because one case report showed an association with seizures when naloxone was given to a baby born to an opioid addicted mother.\textsuperscript{16}
Lipid Rescue for Local Anesthetic Toxicity

Because the POCA registry suggests that medication-related issues are frequent causes of arrest, it is prudent to discuss the role of lipid therapy in local anesthetic (LA) toxicity. One cannot completely eliminate the risk of local anesthetic toxicity. Tachycardia is not a perfect indicator of an intravascular injection of bupivacaine with epinephrine, occurring in only 83 percent of intravascular injections during general anesthesia. In the initial POCA registry search, all of the cases of cardiac arrest following intravascular injection of local anesthetic during caudal anesthesia had a documented negative aspiration and a negative test dose.

Intravenous lipid emulsion has been shown to be effective for resuscitation of cardiac arrest due to bupivacaine toxicity in animal studies and case reports in humans. Studies in isolated rat heart preparations concluded that lipid treatment promotes the loss of bupivacaine from the myocardium and accelerates the recovery from bupivacaine-induced asystole. The adult literature suggests that 1.5 mL/kg of 20 percent lipid emulsion should be administered over one minute followed by a maintenance infusion rate of 0.25 mL/kg/min and repeated boluses every 3 to 5 minutes until the circulation is restored. Maximum total dose has not been established but is suggested to be 8 ml/kg. To date, there are only a few published pediatric reports with this intervention, but success was achieved with a single injection of 20 percent lipid emulsion in an infant with 2 ml/kg and in a 13 year old with 3 mL/kg. Therefore, the dose of lipids in children remains tentative. However, there is a growing consensus that 20 percent lipid emulsions should be immediately available in any location where regional anesthesia is performed to permit rapid treatment of cardiac toxicity.

References


Pediatric Anesthesia (cont’d)


Pediatric Anesthesia (cont’d)


Questions

1. According to the Pediatric Perioperative Cardiac Arrest (POCA) Registry, the mortality rate for perioperative arrest is 26 percent.
   a. True
   b. False

2. In the ASA Closed Claims Database, pediatric events occurred in ASA status 1-2 patients which percentage of the time?
   a. 22
   b. 55
   c. 66
   d. 77

3. In PALS, the correct initial treatment for pulseless electrical activity (PEA) is which of the following?
   a. Defibrillation at 2 J/kg three consecutive times
   b. Defibrillation at 2 J/kg once
   c. Defibrillation at 4 J/kg once
   d. Epinephrine 0.01 mg/kg IV/IO

4. In PALS, what is the next treatment for wide complex tachycardia with pulses and poor perfusion that responded only briefly to synchronized cardioversion with 1 J/kg then 2 J/kg?
   a. Unsynchronized shock
   b. Amiodarone 5 mg/kg IV push
   c. Amiodarone 5 mg/kg over 20—60 minutes
   d. Vagal maneuvers
5. In PALS, what is the correct sequence of medications for a patient receiving CPR who is in pulseless ventricular tachycardia (VT)?
   a. Epinephrine, amiodarone, epinephrine
   b. Epinephrine, vasopressin, amiodarone
   c. Epinephrine, lidocaine, amiodarone
   d. Epinephrine, adenosine, epinephrine

6. In PALS, what is the correct sequence of defibrillation in a patient with pulseless VT?
   a. Defibrillation at 1 J/kg three consecutive times followed by 5 cycles of CPR
   b. Defibrillation at 2 J/kg three consecutive times followed by 5 cycles of CPR
   c. Defibrillation at 1 J/kg once followed by 5 cycles of CPR, then defibrillation at 2 J/kg once and 5 cycles of CPR
   d. Defibrillation at 2 J/kg once, followed by 5 cycles of CPR, then defibrillation at 4 J/kg once and 5 cycles of CPR

7. In PALS, for a patient receiving CPR for asystole who did not respond to the initial dose of epinephrine 0.01mg/kg, what is your next treatment?
   a. Defibrillation at 2 J/kg once
   b. Defibrillation at 4 J/kg once
   c. Epinephrine 0.01 mg/kg IV/IO
   d. Epinephrine 0.1 mg/kg IV/IO

8. According to the NRP guidelines, a neonate who is meconium-stained needs to be suctioned endotracheally immediately after birth.
   a. True
   b. False

9. In the NRP guidelines, if the heart rate is less than 60 bpm following 30 seconds of positive pressure ventilation, which of the following is the next step?
   a. chest compressions at 100 compressions/min
   b. chest compressions at 120 compressions/min
   c. epinephrine 0.01 mg/kg IV
   d. epinephrine 0.1 mg/kg intratracheally

10. The current suggested dosing for lipid rescue with 20 percent intralipid in adults is a single bolus 1.5 mg/kg. The dosing has not been firmly established in children but it has been used successfully.
    a. True
    b. False
Pediatric Resuscitation

By Suzanne L. Strom, M.D.
Assistant Professor, University of California–Irvine

This second module in the Pediatric Anesthesia Bulletin and Online CME Program is now available in this issue. You may complete the module by taking the assessment and faxing a copy to the CSA office at 650.345.3269., or you may go online and take the module in the Online CME section of the CSA Website (http://www.csahq.org).
Registration

Complete this form, the test, and the evaluation, and mail or fax to the CSA office at 951 Mariner’s Island Boulevard #270, San Mateo, CA 94404 or FAX to 650-345-3269. The CSA CME Bulletin courses also are available on the CSA Web Site at www.csahq.org.

Pediatric Anesthesia CME Course, Module 2
Available November 15, 2010, to November 15, 2013

Name _______________________________________________________________ M.D. D.O.

Address _______________________________________________________________________

City/State/Zip __________________________________________________________________

Phone (      ) ____________________________________________________________________

E-mail _________________________________________________________________________

❑ CSA Member (No Fee)  ❑ Non-CSA Physician $30

Total $_______________

Please charge my: ❑ MasterCard ❑ Visa

Card # ____________________________ Exp. Date __________________

I authorize the California Society of Anesthesiologists to charge my account for the registration.

Signature: _____________________________________________________________________

OR

Mail with a check made payable to California Society of Anesthesiologists

❑ I acknowledge I have read the Introductory Information about Module 2.
A review of anesthetic techniques during the 1920s reveals that operating room efficiency and production pressures were just as much of a concern then as it is now. One example during that era was the widespread use of ethyl chloride, an agent that allowed the surgeon to start the case soon after the patient was brought into the operating room.

Rapid turnover in the operating room was emphasized in the article “The Guillotine and Ethyl Chloride” by CR Sandiford and JC Clayton in the July 28, 1928, issue of the British Medical Journal. In this article, the authors described their rapid ethyl chloride anesthetic for tonsillectomy. Two operating room tables with separate nurses were set up in the same operating room. As one child was being taken out of the room, another one was brought in and placed on the other clean table. One surgeon and one anesthetist worked a case and then moved to the other setup as the emerging patient was being lifted out of the room.

The ethyl chloride induction consumed approximately 30-40 seconds, and the surgeon was able to perform bilateral tonsillectomies and adenoidectomy in another 30 seconds. The surgeon’s tool was the guillotine knife. No attempt was made to cauterize or pack the bleeding tonsillar fossa. The total time for each procedure was estimated to be approximately two minutes so that 30 cases could be performed each hour!

Bleeding that led to airway compromise was treated by lifting the legs and suspending the child upside down until the airway cleared. Apnea or failure to emerge from the anesthetic was treated by splashing a bucket of ice water on the child’s face “with care to first close the external auditory meatus.” One key to the entire process was a good orderly who knew how to position the patients properly during transport (see Figure 1 on the following page).
Ethyl chloride was one of the many alternatives to ether and chloroform during the early 20th century. It was a failure as an anesthetic, but it took several decades before the dangers of the drug were realized. The highly volatile liquid was sprayed directly into a closed system (see Figure 2 on the following page), and a deep and profound anesthetic developed within less than a minute, often accompanied by “stertor” and opisthotonis. For unknown reasons, this type of rapid induction as a prelude to ether maintenance became routine practice, even though it was often described as dangerous by most textbooks of that era. Arthur Guedel was noted to be a master of the rapid ethyl chloride induction but was not immune to the serious complications that followed. In a letter to Ralph Waters dated 1928 he described the following case:

T and A. Girl age 6. Apparently in good health. Ethyl chloride for about half a minute or until the rough edge of consciousness was taken off. Lumbard’s stuff. Then ether for two minutes and suddenly a dead child. Port mortem picture of chest (X-ray) showed large thymus. Would say about the size of a twenty-five cent bottle of fountain pen ink. One here before me now. At any rate it was a much-enlarged thymus.

Status lymphaticus (enlarged thymus) was frequently used to explain anesthetic tragedies. There was an all out attack on lymphoid tissues in the first half of the 20th century. By 1950, there were over one million tonsillectomies performed in the United States. Thymus tissue was sometimes treated with radiation to shrink the gland prior to general anesthesia. Guedel was not the only one to fall back on this diagnosis to cover up toxic deaths from uncontrolled delivery of potent agents like ethyl chloride. Osler's Modern Medicine, published in 1925, has a section on status lymphaticus that describes the risk of death during anesthesia in subjects with this syndrome. A series of influential papers in the late 1950’s eventually debunked the entire concept of status lymphaticus, leaving our specialty without this convenient excuse for intraoperative deaths.
Figure 2: The mask was held over the face with the left hand. After a few breaths, the glass ampoule containing ethyl chloride was snapped open with the right hand. At a vapor pressure of 1064 mm Hg (68 degrees F) the liquid would rapidly vaporize. The glass ampoule is shown in A and positioned into the rubber tube as shown in B. Cotton padding prevented glass from entering the bag. Some air could enter the system around the mask. Image modified from J. W. Gwathmey, Anesthesia, 1914, page 274.

When looking back today on the method by which ethyl chloride was delivered, it becomes apparent that these anesthetists would not have been able to manage the many variables that controlled alveolar concentration such as temperature, quantity of ethyl chloride vaporized, minute ventilation, oxygen concentration, carbon dioxide rebreathing, and absorption of gas by the rubber bag. If an anesthetist were fortunate to give the agent without killing the patient, then it would be an early example of the adage: “better to be lucky than good.” Imagine coming out of training and entering a practice that condoned these methods to provide rapid turnovers! Ethyl chloride also commonly was used to speed up ether anesthetics, and in this capacity it was also a dangerous agent (see above case report).

Death during ethyl chloride anesthesia was difficult to quantify. Flagg, Gwathmy, Lundy and Clements all considered the drug to be dangerous and to require great clinical skill to deliver. Many anesthetists thought that they had that unique skill, including Guedel and his trainees. George Alexander H. Barton stated in his book “A Guide to the Administration of Ethyl Chloride,” that it was a dangerous agent but should not be abandoned. His estimates of death from ethyl chloride ranged from 1 in 3,000 to 1 in 200,000. This agent was on the decline even prior to the introduction in the mid 1930s of thiopental, a drug that solved the delayed inductions that accompanied mask ether inductions.
Guillaume Rouelle, Antoine Lavoisier’s chemistry teacher, first synthesized ethyl chloride in the 18th century from hydrochloric acid and ethyl alcohol:

\[ \text{C}_3\text{-C}_2\text{-OH} + \text{HCl} \rightarrow \text{C}_3\text{-C}_2\text{-Cl} + \text{H}_2\text{O}. \]

The compound is essentially ethyl alcohol with the OH radical replaced by chloride. It was not used medically until the mid nineteenth century when Marie Flourens discovered its anesthetic properties in dogs. Shortly afterward, J. F. M. Heyfelder used it clinically in humans, but his demonstration reported on its dangerous properties, and its use was initially overshadowed by ether and chloroform.

After the demonstration of ether spray-induced local analgesia by Benjamin Richardson in 1866, the more favorable properties of ethyl chloride spray for this purpose were soon appreciated. Local anesthesia with cocaine was introduced in 1884, but ethyl chloride-induced topical anesthesia was promoted as an alternative to cocaine.

The re-introduction of ethyl chloride general anesthesia was an accident. Although several methods of providing analgesia for dental procedures had been developed by the 1890s, one technique was to spray ethyl chloride onto the gums prior to extractions or restorative work. A dentist named Carlson from Gothenburg, Sweden observed that this maneuver would often induce general anesthesia and reported on his observations in 1894.

Coincidentally Carlson’s report came at a time when the safety of chloroform was beginning to be seriously questioned. Several deaths by that time had been attributed to fulminating liver failure following chloroform. Its more rapid decline, however, followed the manuscripts of Levy that reported on its peculiar propensity to induce cardiac arrhythmias. Ethyl chloride filled the gap that chloroform had previously provided. Its rapid onset of action led to its use (together with trichlorethelene) as one of the first patient-controlled analgesics (Figure 3).

**Figure 3:** Patient Controlled Analgesia. When the patient squeezed the bulb (H), more liquid would vaporize. This apparatus was used for both ethyl chloride and trichlorethelene. Image modified from Scher, Dental Record, 1946, p 217, and Forman, Anesthesia and Analgesia 1942, Nov, p 318.
Other disasters with the drug deserve mention. Ethyl chloride spray has been promoted as a topical local anesthetic for well over a hundred years. However, for this purpose it is only marginally effective, and when compared with bicarbonate-diluted lidocaine, it has no advantages. The compound is an ozone depleting gas and has been used illegally as a “popper” with lethal consequences. The spray has been labeled “The Duster” by the drug sniffing community and “lanca perfume” by celebrants during Carnival in Brazil. Several case reports confirm that these uses can be fatal.

Operating room efficiency is a frequent topic of hospital committees, and time spent during the anesthetic induction often is part of the discussion. Developing a reputation as a quick and efficient worker is one of the few ways that anesthesiologists can distinguish themselves, at least within certain segments of the hospital staff. The chair of a large hospital in New York City recently confided interesting information about how he previously had evaluated the members of his large department. He thought that the surgeons could be called upon to evaluate the anesthesiologists. The reasoning was that the surgeons observe the anesthesiologists every day, so that they should be able judge the care they provide. The evaluations from the surgeons fell neatly into two groups: the anesthesiologist was either fast (good) or slow (bad). Obviously, these evaluations were useless, and this became clear enough when the “fast” workers would pass on inadequately prepared cases to other anesthesiologists, thus improving their averages at the expense of the others. Furthermore, there was always the possibility of severe complications from providers that continually tried to minimize the time between induction and incision time. We might take the historical example of ethyl chloride and use it to bolster our belief that undue pressures to begin a case can have undesirable consequences.

---

**CSA Needs Your Home Address and Your Zip+4!**

If you have not given us your home address, please update your information online at www.csahq.org under Members Only/Member Profile Update, or call the CSA office at 800-345-3691. The CSA database offers CSA the ability to give members contact information for their legislators. Because legislative districts are determined by home address, your zip+4 is essential to provide you with this information.

**Have You Changed your E-mail Address Lately?**

Please send CSA an e-mail with your new e-mail address or go online at the CSA Web Site, www.csahq.org, to update your profile if you wish to receive up-to-date information. The monthly Gasline newsletter is sent by e-mail only.
In Memoriam:
Patrick Sim, M.L.S.,
Librarian at the Wood Library-Museum

By Stephen Jackson, M.D., Editor

The American Society of Anesthesiologists lost a dear friend, Patrick Pui-Kam Sim, M.L.S., on October 14, 2010, just short of the day that he was to be honored by the Patrick Sim Forum on the History of Anesthesiology at this year’s ASA Annual Meeting. For nearly four decades Patrick was Librarian (and later the Paul M. Wood Distinguished Librarian) at the Wood Library-Museum of Anesthesiology (WML) in Park Ridge, Illinois. He retired on March 31, 2010. His encyclopedic knowledge of anesthesia history, combined with his gentle spirit and enthusiasm for learning, has been the guiding spirit behind many historians and their projects. A friend to all, Patrick had overseen the tremendous growth of the WLM into a world-class specialty library and museum housing an extensive and unique collection of artifacts related to the history of anesthesiology. Patrick was truly beloved the world over for his gentle and generous spirit, and his humble and selfless devotion to anesthesia history and the WLM. Patrick was a long-time friend of mine, as he was to so many anesthesiologists, and I will miss my extended phone calls with him as well as his smiling and welcoming persona at the Annual Meetings.

I would like to quote the beautiful tribute of Kathryn McGoldrick, M.D., Co-Chair of the WLM Publications Committee, shortly before his passing:

Patrick is such a thoughtful, knowledgeable, yet humble colleague, and graceful friend that it is challenging to pinpoint the traits I most admire and love in his character. After much reflection, I have decided to highlight his wisdom and kindness. Patrick is the hub about which many lives revolve, a pillar of unobtrusive support, insight, and goodness to any and all who need his personal or professional assistance. Patrick is not only universally admired and respected: he is truly beloved by all who are blessed to be part of his world.
California and National News

California Nurses Association (A Union) Kills Nursing Reform Bill: In 2009, the ProPublica non-profit, investigative journalism watchdog group along with the Los Angeles Times investigated the California nursing profession. It found that “the Board charged with overseeing California’s 350,000 registered nurses often takes years to act on complaints of egregious misconduct, leaving nurses accused of wrongdoing free to practice without restrictions. It’s a high-stakes gamble that no one will be hurt as nurses with histories of drug abuse, negligence, violence and incompetence continue to provide care across the state. While the inquiries drag on, many nurses maintain spotless records. New employers and patients have no way of knowing the risks.” This report led the “Governator” to replace most members of the state Board of Registered Nurses (BRN which oversees RNs) and order a review of patient safety controls for all licensed health professionals by the Department of Consumer Affairs. This led to Senator Gloria Negrete-McLeod (chair of the Senate Business and Professions and Economic Development Committee) introducing SB 1111, a proposal for broad revision of the disciplinary processes for virtually all categories of healing arts licentiates, and specifically requiring employers to report RNs who are guilty of misconduct to the state nursing board. The California Nurses Association (CNA) crushed this bill in committee. “The parallels with the California Teachers Association could not be more precise. Both the nurses union and the teachers union depict themselves as noble defenders of the public. The reality is that they are bare-knuckled special interest groups that use their clout to keep incompetents—and worse—on the job.” It seems doubtful that the vast majority of CNA members want their union to protect dangerous RNs from practicing.


California Nurses Association (CNA) Blocks Use Of Out-Of-State Volunteer Health Professionals To Provide Free Care To Indigents: In light of the first Newsbrief found above in which the CNA opposed legislation stiffening regulation of RNs, the action by the very same CNA to prevent the use of out-of-state volunteer health professionals to provide free care to indigents seems more than a bit hypocritical and hollow. In fact, an updated ProPublica (see above) report revealed that the Board of Registered Nurses found that 3,500 California RNs previously had been punished for misconduct by other states, some even having their licenses revoked, while nonetheless retaining their unblemished California RN licenses! Yet, this same CNA union recently blocked
Assemblywoman Karen Bass’s proposed legislation to permit out-of-state volunteers to provide free care for indigents because, they cite, the lack of an oversight licensing body. The Tennessee-based, non-profit Remote Area Medical (RAM) organization has offered to staff large free clinics across the nation, therein showcasing the need for health care among the uninsured. The CNA claimed that the relaxing of state licensure requirements would be a threat to the quality of health care. Earlier this summer, Illinois passed a law to facilitate RAM to bring volunteers from any state to serve patients in Illinois. RAM, utilizing temporary licentiates, actually filled The Forum in Inglewood in 2009 as its volunteers rendered almost $3 million of eye exams, mammograms and pap smears to 700 patients per day. However, earlier this year at another similar RAM event, hundreds of people were turned away for lack of health professionals, despite a doubling of room capacity. Dental care for the poor is another major need, especially since it was deleted from the Medi-Cal program. Note that there does, however, still exist an approximately 90-day process for obtaining temporary licensure for such volunteers in California.

*Culled from multiple sources including a report by Christina Jewett at http://californiawatch.org/watchblog*

**Lawmakers in Most States Have Little Control Over Healthcare Premiums:** As health care insurance premium hikes are in double digits, in some cases approaching 40 percent, the state regulators who are expected to serve as protectors for the public often can do little to control these rates. In many states the health insurance industry largely controls the regulatory process as they are heavy campaign contributors to those key legislators who are in positions of power to influence government oversight of premiums and review of state insurance regulations. Over $42 million have been contributed by insurance companies and HMOs to state legislators since 2003. Consumer advocates and administration officials are attempting to encourage new state efforts to overcome this unlevel playing field, especially because the new federal healthcare law failed to give the federal government any meaningful power to regulate premiums, traditionally a state responsibility. Indeed, the oversight battle is at the state level. Of course, the insurance industry lobbyists are concerned that state regulators want to have the power to block rate hikes deemed unreasonable and unjustified by the states. Oregon is a prime example of a state with such authority (called “prior-authority approval”) to determine the fate of proposed rate hikes, and indeed, has denied or modified 20 of 71 proposals in the individual and small group markets. Only 19 states have such authority, and although some other states can review premiums in limited circumstances, most have minimal legal authority to challenge the insurance companies. In California, Democratic Assemblyman Dave Jones is making his third attempt in five years to get passed a bill to give the insurance commissioner...
“prior-authority approval.” His last failed attempt was in 2007 when blocked by four members of the Senate Health Committee, these four culprits having received more money from the state’s largest health insurers and their trade associations than any other state senators in the preceding six years! In fact, the California Department of Insurance belatedly permitted Anthem Blue Cross and Blue Shield of California a 13.4 percent to 18.5 percent average increase in premiums for individual policy holders only after these insurers had requested as much as a 39 percent increase. However, Blue Cross and Blue Shield later were forced to rescind that unimaginable amount when they were found (and admitted) to having made “errors” in their calculations. California law mandates that insurers can increase rates as long as 70 percent of premiums are spent on medical care, but even the figure of 70 percent is unconscionable low and needs to be increased toward the 90 percent level. Recently, the hand-tied Department of Insurance allowed Health Net to raise premiums by an average of 16 percent for their 38,000 individual policy holders, and Aetna an average of 19 percent for their 65,000.

Adapted from an article by Noam Levey, Los Angeles Times, August 12, 2010

Medical Liability Claim Frequency: A 2007-2008 Physician Snapshot: This “snapshot” of physicians’ experiences with medical liability claims, derived from the American Medical Association’s Physician Practice Information survey, describes differences according to a physician’s specialty, age, gender and practice arrangement. 42 percent of physicians had a medical liability claim filed against them at least once in their career; more than 20 percent were sued two or more times. 15 percent of young physicians (under 40 years old) and 60 percent of older (over 55 years old) reported claims, verifying the fact that older physicians have greater “exposure,” having practiced longer. However, in any single year, being sued is a rare event, only 5 percent of the surveyed physicians being sued in a given year. As expected, there also was wide variation across specialty, the greatest incidence being in general surgery and ob/gyn, nearly 70 percent of those physicians having been sued at least once, and 50 percent at least twice. Anesthesiology was not looked at specifically. Pediatricians and psychiatrists had the lowest incidence of claims. Of interest, before they turn 40, over 50 percent of ob/gyns already have been sued. 90 percent of general surgeons over 55 years old have been sued, and even among pediatricians, by the time they reach 55, over half have been sued. A gender difference was noted; twice as high in men than in women. However, this can at least partially be explained by male physicians being more concentrated in the specialties with the highest levels of claims and female physicians in those with the lowest levels. Moreover, women are newer entrants into the medical workforce, nearly one-third of men - but only 15 percent of women—being over 55 years old. Finally physicians who have an ownership
interest in a practice are more likely to be sued, but this may reflect the legal concept of vicarious liability and the Doctrine of Respondeat Superior, suggesting that some of the claims stem from care provided by employees.  

*American Medical Association Economic and Health Policy Research, August, 2010*

**Cash-Poor Governments Dumping Public Hospitals:** Anticipating increasing debt and expected new federal health care law-mandated costs, numerous local governments are dropping public hospitals that tend to serve as the caregiver net of last resort. If these facilities are to be remaining open, for-profit chains are among the potential buyers, but, of course, if they, in turn, cannot make a profit, then they will close unprofitable services, fail to infuse needed capital, or simply close down. Over 20 percent of the nation’s 5000 hospitals are government-owned, many in serious debt due to a rise in uninsured patients (industry closures), cuts in Medicare and Medicaid reimbursements, elevated health care costs, and payments on construction bonds sold in better financial times (also note that many have credit ratings that, in a tight credit market, impede their ability to borrow money). Furthermore, as many government-owned hospitals are solo operations, they don’t benefit from economies of scale, nor are they likely to manage to their financial advantage the new federal health care law that mandates certain information technologies, quality accounting, bundled payments and care coordination.  

*Adapted from article by Suzanne Sataline, Wall Street Journal, August 30, 2010*

**Department of Insurance Seeks $10 Billion Fine from PacifiCare:** California regulators are imposing fines of up to $9.9 billion from health insurer PacifiCare over allegations that it mismanaged and misplaced medical claims, “lost” thousands of patient documents, was negligent in paying physicians what they were rightfully owed, and failed to respond to complaints about their unlawful actions. These acts were found to have occurred after UnitedHealth Group Inc. (our nation’s largest health insurance company by revenue) purchased PacifiCare, having violated state law about one million times from 2006 to 2008. Probably the largest fine sought against a health insurer, the Department of Insurance’s general counsel said “this is about the intentional disregard for the interests of doctors, hospitals and patients in California, and the pursuit of cutting costs at any means possible. It is a story of intense corporate greed.”  

*Adapted from article by Duke Helfand, Los Angeles Times, September 7, 2010*

**Physician Participation in Lethal Injection and an Inadequate Supply of Sodium Thiopental:** New regulations promulgated by the California Department of Corrections and Rehabilitation and approved by the Office of Administrative Law, although not requiring a physician to administer
the lethal injection “cocktail,” would require a psychiatrist to certify (evaluate and declare) that an inmate is mentally competent to undergo execution (now that’s quite an “undertaking”). This disregard of the widely accepted ethical imperative against physician participation in execution represents a direct violation of the AMA, CMA and ASA ethical stances, yet such physician participation has been included in new CDCR regulations despite the strongly worded formal objections of organized medicine. In 2006, AB 1954, sponsored by the CMA, prohibited state or local government agencies from using a physician to participate in an execution. However, the bill was enmeshed in the controversy over capital punishment and experienced a rapid demise. And, now we have been informed that sodium thiopental, once one of the most readily available and most utilized anesthetic drugs, and one that is integral to the state-established lethal injection process, no longer may be available in amply supply, at least until 2011! As anticipated, the legal wrangling will continue well into the future.

ABA Numbers for Reporting CME credits!

CSA will report CME credits earned to the American Board of Anesthesiology. These credits will be counted as Lifelong Learning and Self-Assessment activities toward your Maintenance of Certification in Anesthesiology (MOCA) requirement. In order to report these credits, anesthesiologists need to provide their ABA number. To obtain an ABA number, visit www.theABA.org and create a personal portal account.
New CSA Members

A list of new CSA members is set forth below by membership category.

**Active Members**

Aakash V. Agarwala, M.D.  
William P. Akrawi, M.D.  
Norman M. Aleks, M.D.  
Hemanth A. Baboolal, M.D.  
Mary Beth Bewersdorf, M.D.  
Shawn F. Bullock, M.D.  
Jeffrey P. Chisdak, M.D.  
Rhodel G. Dacanay, M.D.  
Alimorad G. Djalali, M.D.  
Brian D. Dula, M.D.  
Barton B. Fischer, M.D.  
Edward B. Fohrman, M.D.  
Mitchell S. Friedman, M.D.  
Debra H. Gambrell, M.D.  
Benjamin Jensen, DO  
Clinton F. Kakazu, M.D.  
Sherif H. Kandil, M.D.  
Jack S. Kao, M.D.  
Brian O. Keyes, DO  
Omar Khawaja, M.D.  
Omid Khodadadi, M.D.  
Abraham M. Kiani, M.D.  
Stanley G. Koh, M.D.  
Mona K. Kotecha, M.D.  
Edward Kwon, M.D.  
Ryan E. Lauer, M.D.  
Janet Y. Lin, M.D.  
Gagan Mahajan, M.D.  
Lisa E. Matos, M.D.  
Dharmesh S. Mehta, M.D.  
David Ng, M.D.  
Hanh T. Nguyen-Clark, M.D.  
Jorge L. Palacios, M.D.  
Shaival M. Patel, M.D.  
An N. Pham, M.D.  
David L. Salinger, M.D.  
Jed Shay, M.D.  
Todd W. Smith  
William A. Spina, M.D.  
Sepehr S. Tabibzadeh, M.D.  
Antonius Y. Tan, M.D.  
Candice A. Tay, M.D.  
Katherine P. Tobin, M.D.  
Loc H. Tran, M.D.  
Haitao Yang, M.D.  
Rensheng V. Zhang, M.D.  

**Resident to Active Members**

Cheryl R. Chen, M.D.  
Daniela S. Karagyozyau, M.D.  
Michelle M. Petrie, M.D.  
Kimberly Robbins, M.D.  

**Affiliate Members**

David C. Asseff, M.D.  
Corey C. Downs, M.D.  
Gagan Mahajan, M.D.  
Joseph R. Palma, M.D.  
Phillip Geiger, M.D.  
Gail B. Lew, PharM.D.  
Min-Ung Pak, M.D.  
Huy Phun, M.D.  
Claudia Praetel, M.D.  

**Resident Members**

Kevin P. Blaine, M.D.  
Harmony Carter, M.D.  
Daniel M. Choi, M.D.  
Brandon Davalle, DO  
Joseph R. Palma, M.D.  
Katie J. Roddy, M.D.  
Shawn R. Vedamani, M.D.  
Kenneth L. Wayman, M.D.  

**Retired Members**

Paterno A. Almendral, M.D.  
Steven D. Brauser, M.D.  
William H. Gausman, Jr., M.D.  
Cyrus Pirnazar, M.D.  
Francisco C. Rico, M.D.  
Anne B. Wong, M.D.  
Suzanne M. Quenneville, M.D.
Mark Your Calendar

2010

Dec 10-14  64th Postgraduate Assembly in Anesthesiology
Marriott Marquis Hotel, New York, New York.
Contact NYSSA at 212-867-7140; www.nyssa-pga.org

2011

Jan 7-8  California Society of Anesthesiologists Board of Directors Meeting
Westin South Coast Plaza, Costa Mesa, California

Jan 24-28  2011 CSA Winter Hawaiian Seminar
Hyatt Regency Maui Resort & Spa, Poipu Beach, Maui
http://www.csahq.org/up-more.php?idx=39

Apr 8-9  California Society of Anesthesiologists Board of Directors Meeting
Westin South Coast Plaza, Costa Mesa, California

May 13-15  CSA Annual Meeting & Clinical Anesthesia Update
Fairmont San Jose, San Jose, California
http://www.csahq.org/up-more.php?idx=40

Oct 15-19  2011 ASA Annual Meeting
Chicago, Illinois

Oct 24-28  2011 CSA Fall Hawaiian Seminar
Grand Hyatt Kauai Resort & Spa, Poipu Beach, Kauai
http://www.csahq.org/up-more.php?idx=41

Congratulations to our iPad winner,
Ronald E. Lazar, M.D., of Redlands, California.
And many thanks to all who participated
in the Bulletin Survey and our drawing!
ASA Delegates and Alternates to the American Society of Anesthesiologists

Terms begin at the close of the annual CSA meeting at which they were elected.

<table>
<thead>
<tr>
<th>Delegates</th>
<th>Alternate Delegates</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Edgar D. Canada, M.D.  (11)</td>
<td>Jonathan F. Barrow, M.D.  (11)</td>
</tr>
<tr>
<td>5. Christine A. Doyle, M.D.  (12)</td>
<td>Uday Jain, M.D.  (11)</td>
</tr>
<tr>
<td>22. Earl Strum, M.D.  (13)</td>
<td>Vacant</td>
</tr>
<tr>
<td>23. Peter E. Sybert, M.D.  (11)</td>
<td>Vacant</td>
</tr>
<tr>
<td>24. Narendra Trivedi, M.D.  (12)</td>
<td>Vacant</td>
</tr>
<tr>
<td>25. Samuel H. Wald, M.D.  (13)</td>
<td>Vacant</td>
</tr>
<tr>
<td>26. Paul B. Yost, M.D.  (12)</td>
<td>Vacant</td>
</tr>
<tr>
<td>27. Mark I. Zakowski, M.D.  (11)</td>
<td>Vacant</td>
</tr>
</tbody>
</table>

IN MEMORIAM

John W. Black, M.D.  San Diego, CA
Robert G. Byers, M.D.  Yuba City, CA
Joel F. Fine, M.D.  Los Angeles, CA
W. Robert Hagerman, M.D.  Norco, CA
Arthur J. Martinson, M.D.  Alhambra, CA
Arthur O. McGowan, M.D.  Lakewood, CA
William J. Siering, M.D.  Nevada City, CA
Edithmae E. Taylor-Braslow, M.D.  Indian Wells, CA
Seymour Wallace, M.D.  Los Altos, CA
Leslie C. Watson, M.D.  Long Beach, CA

Upon notice that a CSA member is deceased, a donation is sent to the Arthur E. Guedel Memorial Anesthesia Center in their memory.
LAUGHING GAS
So, You Think That English Is Easy?

→ The bandage was wound around the wound.
→ The farm was used to produce produce.
→ The garbage dump was so full that it had to refuse more refuse.
→ Because there is no time like the present, she thought it was time to present the present.
→ When shot at, the dove dove into the brush.
→ He did not object to the object.
→ The insurance for the invalid was invalid.
→ They weren't close enough to the door to close it.
→ The buck does funny things when the does are present.
→ The wind was too strong to wind the sail.
→ We had to subject the subject to a series of tests.
→ How can I intimate this to my most intimate friend?
→ She shed many a tear when she saw the tear in the painting.
→ A bass was painted on the head of the marching band's bass drum.
→ He could lead the cross country team if he would get the lead out.
|----------------------------|---------------------------------|-----------------------------|--------------|-------------------------------|--------------|-------------------------|--------------|-------------------------|-------------------------|
CSA Continuing Medical Education

Free CME Program for CSA Members
CSA CME Critical Care Program, Modules 1-8
CSA CME Obstetric Anesthesia Program, Modules 1-4
CSA CME Pain Management and End-of-Life Care, Modules 1-12
CSA CME Pediatric Anesthesia Program, Module 1-2
CSA Bulletin and CSA Web Site (www.csahq.org)

January 24-28, 2011
CSA Winter Hawaiian Seminar
Hyatt Regency Maui Resort & Spa
Ka’anapali Beach, Maui

May 13-15, 2011
CSA Annual Meeting &
Clinical Anesthesia Update
Fairmont San Jose
San Jose, California