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Editor’s Notes

Incivility—A Destructive Force in Politics as well as in Medicine

By Stephen Jackson, M.D., Editor

A short time ago, I had the pleasure of attending the peripatetic biennial meeting of the international Laurel and Hardy appreciation organization (the “Sons of the Desert,” named after their arguably most famous film) right here in Sacramento. As with all of aficionado attendees, I am enthusiastic about preserving the memory of Laurel and Hardy and their films, hoping that their comedic genius might be savored by future generations. On the opening day of this festive meeting, the entire throng of over 300 loyal fans posed for a commemorative photograph on the steps of the State Capitol. At that moment, it occurred to me that the jury was out on whether the biggest jokes in Sacramento that day resided within the Capitol building or on those steps. I could visualize Stan and Ollie shaking their heads in lamentation and almost hear them chiding our legislators with an authority untainted by historical perspective: “Here’s another fine mess you’ve gotten us into.”

The persistent inability of our elected state officials, collectively and accountably, to enact responsible legislation—with the goal of achieving economic viability and social stability for our endangered state—is of grave concern to most Californians. Moreover, there is an analogous situation at the federal level, a state of affairs that is not new to our nation’s politics. Indeed, Ron Chernow\(^1\) recounts how our founding fathers used “vehement” disagreements and “vitriolic rhetoric” to advance conflicting political philosophies, they too undermining civil and respectful public discourse with their deplorable oratory. Undeniably, much of today’s paralytic problem appears to flow from the highly partisan behavior of our elected lawmakers who comprise our state and federal legislative bodies, which, in turn, have become highly polarized within a milieu of unceasing contentiousness and outright animus. Unfortunately, unlike most of our founding fathers—the passionate spearheads of the American Revolution and framers of our Constitution—few of our present day elected officials could be lauded for their “erudition, integrity and philosophical genius.” The prevailing winds of incivility and the absence of a fundamental and firmly grounded will to compromise heighten the probability that elected legislators and leaders will fail to advance the issues vital to the well-being of their constituencies.

The uncivil behavior of our legislators—their failure to engage in respectful and civil discourse—has elevated the level of partisanship to dysfunctional heights.
Furthermore, legislators’ *incivility* to each other not only reflects, but sadly, also amplifies what appears to be a progressive *incivility* amongst American citizens themselves, their own unwillingness to listen respectfully to each other, and to consider each other’s opinions. After all, *civility* has its root in the Latin word for “citizen” (*civis*), and implies a *shared sense of identity*, a notion that one often would be hard pressed to find or experience within our dysfunctional social fabric.

As civil is the root word for civilization, it connotes an advanced stage of social development. *Polite* describes someone with good manners at all times, someone who always follows the rules for proper behavior. *Courteous* adds to polite the idea of showing thoughtful or considerate attention to the feelings and wishes of others. *Civil* connotes being just polite enough not to be rude, and therefore, *civility* in this editorial will refer to behavior somewhat less than polite or courteous, thereby setting the social behavior threshold somewhat lower in terms of what one might expect would be requisite for mutually beneficial social actions with other people in one’s work environment.

Civil behavior increases social capital, which is the fountainhead of interpersonal trust, sense of obligation, strength of norms, and unrestrained informational pathways that accrue from robust relationships among members of a community. Social capital produces communities of cooperation, fosters communication, enhances achievement of common goals, and facilitates successful realization of complex and dynamic relationships.

According to former Iowa Congressman (and current head of the National Endowment for the Humanities) Jim Leach, “The times require a new social compact rooted in mutual respect and citizen trust. At its core, civility requires respectful engagement: a willingness to consider other views and place them in the context of history and life experiences.” Incendiary words matter, and labeling a political foe as a “socialist, liberal or left winger,” or “conservative or right winger,” is not an argument, but rather a label that serves as an inadequate and inappropriate substitute for thought. Leach states that the words we use can “clarify or cloud thought and energize action, sometimes bringing out the better angels of our nature, sometimes baser instincts. When coupled with character assassination, polarizing rhetoric can exacerbate intolerance and perhaps impel violence.” Moreover, reporter Mark Bernstein comments that this approach to politics results in an “insidious … tactical refusal to engage those with differing opinions in a search for the common good.” Indeed, civility should not be incompatible with partisanship. He further reports that our current two-party system “seems to exist in different worlds.” For example, he cites that each federal legislator receives closed-circuit television feeds of the proceedings on the floor of Congress from their own caucus, the practical result being that they are not viewing the same debate!
Daily, Americans are barraged by a system of balkanizing, foment-goading media and communication vehicles that tend to promote and heighten intolerance of differences of opinion rather than serving to catalyze informed, reasoned and civil discourse. You always can locate only the news that you want to hear (as an example, Fox News or MSNBC), news that reinforces your own system of beliefs rather than educating you about the thoughts of others. Our politicians, no less our citizens, should be listening with respectful consideration to the possibilities of the viewpoints raised by those with whom we know we disagree, even on a visceral level. Politicians should be ethically bound to seek the pathways of compromise—perhaps even arriving at a consensus—rather than those of divisiveness and vilification, lest our country suffer even further indignities.

As anesthesiologists, we know full well that incivility does rarely rear its ugly head in the medical workplace in the guise of the abusive and/or disruptive physician. Abusive behavior is characterized by the treatment of others harshly, cruelly and unremorsefully, while disruptive behavior is the moniker for interference with the integrity and continuity of functions necessary for the provision of quality of care. The importance of respect and civility in promoting good patient care is a foundation of the American Medical Association's Code of Medical Ethics and the American Society of Anesthesiologists Guidelines for the Ethical Practice of Anesthesiology. Of course, room must be preserved for the appropriate and civil use of “innovative disruption”; that is, the deployment of disruption as a means of pursuing improvement, where there is a role for the maturation of new ideas to replace those that previously have not been productive. Uncivil behavior subverts the ethical obligation of healthcare professionals to consistently place the interests of their patients foremost because it interferes with the normative processes of collegiality, cooperation, communication and teamwork. Incivility sabotages the viability of an effective and efficient institutional culture of safety and quality care.

The elimination of abusive and disruptive behavior in politics, just as in medicine, should be pursued vigorously. Without a wellspring of civility, the “well-being” of our great democracy is in jeopardy.

3 It is important to appreciate that physicians may participate in business arrangements that hospitals might view as unfair or unwanted competition, and such professional competition and animosity has, on occasion, created incentives for hospital administrators to use the disruptive/abusive label inappropriately in a ruse to try to remove such competitors from the medical staff. Physicians should not be labeled as abusive and/or disruptive if they violate onerous, overly broad or sham “codes of conduct” that are created to squelch medical advocacy, target competitors, or otherwise have no nexus to improving patient care.
I am honored to serve as your 63rd President of the California Society of Anesthesiologists. With your help and support, I believe we can make this a year of great achievements for the medical specialty of Anesthesiology and for the CSA. We will be faced with many challenges in the upcoming year: Every day California’s budget looks worse; the national economy is still unstable; and the implications of healthcare reform by President Obama are of increasing concern.

Though federal healthcare reform legislation has been signed, it is becoming evident that we can influence and modify certain aspects of this reform if we stand up for what is right: right for our patients, right for our members, and right for our country. Therefore, we must make advocacy the top priority for the next year. Advocacy will allow us to build relationships with legislators and assist them in modifying the reform bill, to improve the care we provide to our patients, and to address the issues facing our members. Someone has to take the lead in designing revisions to President Obama’s healthcare bill: CSA and California anesthesiologists are qualified, positioned and need to do this.

There have been times in the last 20 years when medical specialties faced challenges to their practices. Some of these specialties just “hoped” for change led by someone else, rather than working hard to address those challenges. As a result, some of these specialties, like pathology, are no longer major players in modern health care.

Another specialty that just hoped for a better tomorrow is Cardiac Surgery. With the invention of angioplasty, stent placement and many new advances in technology, cardiac surgery volumes have significantly declined. Cardiac surgeons did not take the lead to use these new advances to their advantage; they were committed to the status quo. Now, many cardiac surgeons are struggling, looking for work, and performing general surgical cases to maintain their income. We must learn from these specialties that have suffered because they didn’t prepare themselves for new challenges. We must prepare ourselves for the challenges of the future and push for any change that is within our power to change.
We must not ask ourselves if we can do it or if we should change with the times. Rather, we must ask “How can we do it?” We must come out of the four walls of the operating room and explore opportunities to expand our role in other areas of patient care.

If we believe that nothing is going to change in our practice, we are kidding ourselves. Some challenges are already knocking at our door. Five years from now, we may not be able to collect full payments for giving a milligram of Versed for a cataract surgery or a simple podiatric procedure. With the skyrocketing costs of healthcare, practices such as this are unsustainable. Already, there are institutions using nonphysician practitioners to render this care. But, we should not let these inevitable changes discourage us, much less stop us. Instead, we must explore ways to expand our practice. We must enhance our knowledge, our training, our experience and our expertise in the field of perioperative care. We must invest our time in research so we can find new areas in patient care that can improve the lives of patients and also provide us with a unique set of skills. Specialties such as radiology, cardiology and vascular surgery have used new advances, new methods and new technologies to sustain their practices and incomes in the rapidly changing health care world. We must learn from their experience to make a better future for our specialty.

I have come to the realization that CSA needs to do more than just solving yesterday’s problems and today’s challenges. Therefore, I ask you to join me in embarking on a journey to a better future for our specialty. It will involve continuous work but will have profound rewards. I have dedicated the year of my Presidency to the theme, the “Future of Anesthesiology.” Together, we can prepare anesthesiologists for challenges of changing health care. Among other things, we must work with residency program directors to explore various options to prepare a new generation of anesthesiologists to expand the scope of their training for a better future. Some of this work is already underway.

You may ask: Can we do it? Can we successfully fight for our specialty? I believe we are beyond asking these questions. We must do it, and we must do it now—because if we fail, then our patients, our community, and our profession will suffer. So, I urge all of you to join me and your CSA in working together to guide health care policy and develop a plan for the better future of American health care and the pivotal role to be played in that future by Anesthesiology.

At this time, I would like to thank the distinguished leaders of the CSA, those CSA past presidents who have encouraged, guided and mentored me to be ready for the presidency. I offer very special thanks to Drs. Steve Goldfien, Eddie Canada, Steve Jackson, Linda Mason, Dan Cole, and Virgil Airola. Special
thanks also are due to ASA Assistant Treasurer Dr. Jim Grant for his friendship and leadership.

There are two very special individuals who have helped me learn how to handle the challenges and problems faced by CSA and a major part of the reason that today I feel confident and ready for this job. Over the past two years they have become trusted friends, and I would like to thank Drs. Michael Champeau and Dr. Linda Hertzberg.

I would like also to thank my partners at Permanente Medical Group who have always been my strong supporters. I would like to thank all my Permanente friends of many years for their support and encouragement.

Finally I would like to thank my family members who are in the back of the room: My dad, who has been a great inspiration and a role model for me all my life. My wife Trupti and my two sons, Akash and Nick, have always been there for me—supporting, advising and obviously critiquing me. Without them, I could not succeed in life. Thank you.

I want to thank all of you once again for giving me this great responsibility. I promise I will take this responsibility seriously and work hard to meet or exceed your expectations. Now, let’s get ready and work together so that we can achieve these goals and make 2010-2011 the best year for CSA yet, and make CSA a leader in organized medicine.

Address of CSA President Linda B. Hertzberg, M.D., to the 2010 CSA House of Delegates

Thank you for the opportunity to address the 2010 House of Delegates. It has been a privilege to serve the California Society of Anesthesiologists for the past year. Near the end of my speech before this HOD last year I said, “I am looking forward to a challenging and energetic year working on behalf of the members of the CSA.” Little did I realize how prophetic those words were and how challenging this year would become. For the next several minutes I hope to share a few thoughts with you about the past year and the future of our Society.

When my daughter was in high school, my sister and her children came to visit our family in Fresno. At one point we drove up to the Bay Area. As anyone who has lived in Central California knows, to get from Fresno to other major metropolitan areas of California requires driving through acres and miles of farmland. My niece, a typical resident of suburban New Jersey, kept asking where we were because there did not appear to be any major buildings, towns,
President’s Page (cont’d)

or other points of reference. After receiving what she considered to be a series of unsatisfactory answers to her questions, she finally announced, “We are nowhere!” That became the theme for the rest of the car trip. So where is the CSA now? Are we nowhere? Well, we certainly are not where we anticipated we would be one year ago when my presidency began. The road has taken many detours that we did not imagine last May. The medical and political landscape we now inhabit may well seem unfamiliar relative to where many of us have lived our professional lives.

At this time last year, major national health care reform was under discussion in Washington, D.C. No one could have anticipated the twists and turns of the legislative and political process leading up to the enactment of major health care reform legislation earlier this year. The position of the AMA in supporting the legislation as written was particularly problematic for many physicians both inside and outside of organized medicine and anesthesiology. This proved to be no less controversial within the CSA and ASA. There were many who believed that there was little to love in any of the health care proposals that we saw last summer and autumn. Within both the CSA and ASA there was a movement to oppose staunchly any of the legislative options. ASA chose instead to work to de-link payment methodology for anesthesiologists in the so-called “public plan” from the already undervalued anesthesia Medicare rates. This became THE message that the ASA asked its members to carry forward in contacts with members of Congress late last year. This strategy proved controversial within the CSA because a vocal group of the membership believed that we still would be headed for a total government takeover of the health care system, no matter what payment system was agreed upon.

Ultimately CSA leadership chose to support the ASA strategy going forward. The CSA stayed with the ASA on this course throughout the ongoing political drama leading up to the House of Representatives enacting, in March 2010, a Senate-approved health care reform bill and its companion reconciliation act. That bill was opposed by the ASA and other major specialty societies, but endorsed by the AMA. Not addressed by the Congress in this legislation (despite promises to the contrary) was the flawed Sustainable Growth Rate (SGR) formula used by CMS to update Medicare payment rates to physicians on an annual basis. Organized medicine and the ASA are now left in the unenviable position of continually asking for deferral of the 21 percent payment cut mandated by the SGR formula this year. In the meantime, the ASA is attempting to have anesthesia codes revalued by Secretary Sibelius, as this appears to be allowed under the new legislation. This week you received information from the ASA about contacting your Congressmen and asking
them to sign the bipartisan “Anesthesiology Medicare Payment Letter.” I urge you to follow up on this request.

For many of our members who have practices with large proportions of patients with Medicare or other government-based payers, the path forward is alarming because the successful outcome of either of these initiatives is by no means certain, and is dependent upon the actions of politicians and bureaucrats. The costs of doing business as medical professionals do not go down, while payments to physicians are cut and paperwork and documentation demands increase. Are we nowhere? Well, we are certainly not where we had hoped to be at this time a year ago with health care reform. The impact of the health care reform bill on our professional lives and the care of our patients is uncertain and the road ahead is unclear. We still may be wandering in the hinterlands for a while.

Next on the list of places we did not intend to visit this year is Governor Schwarzenegger’s opt-out of the CMS requirement that nurse anesthetists be supervised by physicians. If health care reform put the CSA and its members in the midst of the California hinterlands, then the opt-out left us wondering whether it was the Governor or the CSA that was in the wrong state.

You have all received numerous messages from the CSA this year about the opt-out and what the CSA is doing about it. I am assuming that this HOD is particularly well informed on this subject and will therefore emphasize only a few points.

The most likely reasons for the opt-out center around retaliation for CSA’s opposition to the Governor’s push to tax physicians 2 percent of their gross revenue as part of his ill-fated 2007 Health Care Reform plan, and also CSA’s leading role to stop a rule to legalize Chiropractic Manipulation Under Anesthesia (MUA). Governor Schwarzenegger’s support for his long time friends who are now appointees on the Chiropractic Board, and their efforts to bend state rules has been well publicized over the past several years. The only other explanation for the opt-out that we were able to obtain is that it reflects the Governor’s consistent encouragement of physician extenders. That said, efforts to expand non-physician scopes of practice, whether proposed by the Governor or others, have gone down to legislative defeat since he has been in office. With an opt-out, he is able to expand scope of practice without a legislative process.

In regard to the specific CMS requirement that an opt-out be consistent with state law, California law explicitly limits CRNAs, and all RNs, to the
administration of medications and therapeutic agents, necessary to implement a treatment … ordered by, and within the scope of practice of, a physician, dentist, podiatrist. …” The Nursing Practice Act also makes it unprofessional conduct for a CRNA or RN to administer any controlled substance or dangerous drug “except as directed by a physician, dentist or podiatrist.” The California Board of Registered Nursing (BRN) has long denied that the words “ordered or directed” are synonymous with “supervised” and, hence, have promoted a theory at odds with past court decisions and State Attorney General opinions. Several years ago, when CSA sued the BRN for disseminating these views as “underground regulations,” the BRN removed its last statement of this sort from its website and substituted a disclaimer that “no reliance should be placed” on such guidance. This “no reliance” statement remains there today. The lawsuit was never resolved. What Governor Schwarzenegger did with the opt-out was, in effect, to adopt the position that the BRN itself could not defend in the still pending CSA v. BRN lawsuit.

Late last year CSA was given a copy of a Legislative Counsel opinion confirming that California law does indeed mandate physician supervision of nurse anesthetists. As the office responsible for reviewing bills coming before the legislature, the Legislative Counsel’s opinion has particular weight. CSA shared this document with the membership in January, and it is posted on our website to assist members dealing with their hospitals should questions arise about staffing models with unsupervised practice by nurse anesthetists.

Our lawsuit to compel the Governor to withdraw the opt-out was filed jointly with the CMA in early February. The Governor responded in late March. The Attorney General agreed that Arnold Schwarzenegger is the Governor and the suit was properly filed, and disputed all other points in our lawsuit. More recently, the California Association of Nurse Anesthetists has filed a motion to intervene as an interested party. CSA and CMA chose not to oppose that motion as long as the court allowed permissive intervention only, meaning that no new issues could be raised by CANA. The court eventually approved the motion by CANA for intervention. In the interim, AANA and CANA were attempting to win on this scope of practice issue in the court of public opinion by using the public policy arguments of access, cost, and surgeons’ desires not to supervise nurse anesthetists when no anesthesiologist is available. All of these arguments are easily refuted, but remain irrelevant to the underlying issues raised by the CSA and CMA in our lawsuit. Specifically, the legal issue of what state law says is ignored by the AANA and CANA. Our motions and arguments for summary judgment and writ of mandamus will be filed shortly. It is unlikely that there will be any final resolution for several months, whether we ultimately obtain a summary judgment or proceed to a hearing. No matter
what happens, the decision is likely to be appealed by one side or the other. This is not solely an anesthesia scope of practice issue. Both in California and nationally there is a push to enlarge the role and scope of practice of physician extenders in all specialties. This movement has gathered steam since the passage of health care reform. CMA is certainly cognizant of the larger implications for scope of practice, which is one of the reasons they are partnering with us in the lawsuit against the Governor.

One of my partners recently told me that he wrote a letter to the Governor after the opt-out, disputing the Governor's position and asking that the Governor withdraw the opt-out letter. It turns out that when Arnold Schwarzenegger was filming the movie “Twins,” my partner had occasion to see the filming in Los Angeles. At the time they were filming a stunt and Schwarzenegger's stunt double looked exactly like him. The point he made in his letter to the Governor was that one's double may resemble one superficially, but lacks the knowledge, background, and experience to be the real thing, whether that is a physician or an actor.

I urge each and every one of you to be vigilant in your communities and medical staffs regarding these scope-of-practice issues, not just in anesthesia. All patients should be able to have access to a physician for their care should they so desire. Remember that you are the real thing, with all the medical background, knowledge and training to safely guide patients through a critical time in their lives. Continue to advocate for physician care to be available to all patients in all specialties. I cannot predict how the lawsuit on the opt-out will turn out, but I can assure you that CMA, CSA and ASA will do everything in their power to affect the outcome in favor of our patients’ right to have a physician involved in all their anesthesia care.

Let’s move briefly now to another area of interest for the CSA. For several years we have been opposing the efforts of the Board of Chiropractic Examiners to have regulations approved that would allow chiropractic manipulation under anesthesia. If the Governor appeared to be in the wrong state with the opt-out, then surely this one is in Planet Hollywood.

The proposed regulations went back and forth between the Board of Chiropractic Examiners and the Office of Administrative Law (OAL), with multiple revisions along the way. CSA delivered comments opposing these proposed regulations each time a change was made. CSA does not believe that MUA is within the scope of practice of a chiropractor based on the current laws that describe the scope of the specialty. In addition we cited studies suggesting that the practice is potentially dangerous to patients.
In 2007 the CSA introduced a resolution to the ASA HOD that was ultimately adopted in the following form:

RESOLVED, that the American Society of Anesthesiologists declares that the use of general anesthesia for chiropractic spinal manipulation has no scientific basis and that there is no evidence to support a claim that its use is either safe or beneficial for patients.

This resolution was also cited in our arguments before the OAL. Despite these efforts, the OAL approved the regulations allowing MUA in March. The CSA BOD responded by adopting the ASA resolution as our own and sending a letter to various state agencies, malpractice carriers, and health insurance companies informing them of the opinion in the resolution. Unfortunately any appeal of the decision by the OAL would go to the Governor, so the chance of overturning this result is negligible. Seemingly, if the opt-out and Chiropractic MUA regulations are allowed to stand, potentially we may see something truly alarming here in California: Chiropractic MUA with independently practicing nurse anesthetists without anesthesiologists raising questions about benefit, safety, or scientific validity. CSA will continue to monitor this situation and keep its members informed. In our continuing quest to answer the question, “Where are we, and are we nowhere?”, let's move now from Hollywood to San Mateo, CSA headquarters. In my speech at the Annual Meeting of the HOD last year, I urged that we question our assumptions about “the way we do it here.” A major initiative was undertaken this year to examine our processes and update all aspects of the communications functions of the CSA. Here is some of what I said about this a year ago:

Today the electronically connected population expects up-to-date information provided in an easily accessed, brief, and interlinked manner. The ability within the CSA to cross communicate among individuals and groups, to support forums and blogs, to provide information useful and interesting to members, and to create and maintain access to our online publications, will require a change in our thinking about how we do business. First and foremost, this means that the correct technological infrastructure must be available. The Communications Committee has been charged to work with the central office, our Treasurer, and the Finance and Administration Committee to explore how the CSA can make this vision a reality. If we do not re-invest capital in ourselves through this project, we risk becoming complacent, out-of-date, and irrelevant to our members by continuing with “the way we do it here.”
I am pleased to report today that—with a lot of time and hard work devoted by members of the Communications Committee, Board, and CSA office staff—this project is now funded and well underway. You can expect to see a new and more fully functional Web 2.0 CSA Website with the capabilities described up and running in the next several months. In addition, with this the CSA will be able to bring its bulk e-mail handling in house, making it simpler to distribute messages and news to members in a timely manner. The events of this past year and the challenges of communicating with our membership have given me a deep appreciation about how useful and timely these changes will be. We are indeed somewhere in this project, even if that somewhere is in between San Mateo and cyberspace.

Today we are not where we expected to be a year ago; we certainly have taken a few interesting and unanticipated paths. We cannot allow the concept of “the way we do it here” to hold back the CSA because, as we have seen, the political and regulatory landscape does not stand still. The CSA may need to be in many places at once, but these are not “nowhere.” Rather they are a series of familiar and unfamiliar locales that we will need to both adapt to and shape in order to further the CSA’s mission and agenda on behalf of the specialty of anesthesiology, and the patients we care for here in California.

An organization is only as strong as the people it inspires to work on behalf of its goals and ideals. I thank each and every one of you for giving of your
time, knowledge, and expertise to the CSA. The Board could not do its work without all of you as part of our initiatives, whether that work involves calling Congressmen, serving on committees, contributing to ASAPAC and GASPAC, or sending in your thoughts and ideas.

As I said earlier, this has been an energetic and challenging (and I might add difficult) year. There are many people to thank here for their support, hard work and help along the way. The members of the Executive Committee deserve special notice since they have worked many hours above and beyond what is normally required. In particular, our incoming President, Dr. Narendra Trivedi, and our Past President, Dr. Michael Champeau, spent many hours working with me both on the phone and in person throughout the year. The members of the CSA Board are an energetic and creative group and have risen gracefully to the challenges we faced. Barbara Baldwin, our CEO, and her team in the central office, have done a terrific job running the day-to-day operations and business of the society, while keeping up with new, sudden and unexpected demands. Our legislative lobbyists and consultants, William Barnaby and Bill Jr., spent countless hours working on issues related to the opt-out and poring over, compiling, organizing, and analyzing thousands of pages of documents obtained in our Public Record Acts requests prior to the filing of our lawsuit. They continue to represent our interests energetically in Sacramento.

On a personal note, I have a wonderful group of partners in my practice at Anesthesia Consultants of Fresno, several of whom are here today, and who have supported me with the gifts of time and advice in my professional work at the CSA and ASA. Last but not least, for my beloved husband, David Merzel: He has always been there for me whatever I chose to do professionally. We will be married 23 years on Monday, and it seems like both a moment and an eternity. I look forward to many more wonderful years together. David and my children, Rachel and Michael, have given me the gifts of unconditional love, support, and time. I love you all dearly and am profoundly grateful for all you do. It has been a tough year for the family as well, so I know they are happy to be regaining some of my attention after this weekend.

I look forward to working with and for my friend and our incoming President Dr. Narendra Trivedi during the coming year, in whatever capacity he needs. I am certain that he is up to the challenges that face him and the CSA on your behalf.

Thank you all for your interest and support this year. It has been an honor to serve.
Ten years ago, the Division of Workers’ Compensation (DWC) announced the intent to transition the existing Official Medical Fee Schedule (OMFS) codes and unit values to Resource-Based Relative Value Scale (RBRVS). The conversion to RBRVS has been stalled for several years, due partly to opposition by those who treat workers’ compensation patients as well as to political considerations. Another influence was the call for sweeping reform in other areas of the WC system, which put other changes before the fee schedule. After releasing three iterations of an RBRVS conversion, the DWC seems committed to moving ahead with fee schedule reform.

The Lewin Group, a research think tank, was contracted in 2002 to develop a transition plan to standardize the fee schedule coding, taking into account the unique aspects of the OMFS. Overseen by Allan Dobson, one of the architects of the Medicare RBRVS, they spent several months crunching numbers and developing a model for transition. Public hearings held in mid 2003 drew criticism of many aspects of the study, from questioning the validity of the data used for modeling to using Medicare rates as a benchmark for physician payments.

Concurrently, in 2002 demands for reform and cost containment by employers and insurers were heeded, and many significant changes occurred in 2003 and 2004. The changes that were related to medical benefits included limits on the number of physical therapy, occupational therapy, and chiropractic services; expansion of the OMFS to include hospital and ASC payments; a revised pharmacy schedule; and the elimination of the patient choice to switch to his own personal physician after 30 days if the patient is in a Medical Provider Network (an HMO-like network). In 2004, physician payments were reduced by 5 percent, leaving the anesthesiology conversion factor at $32.78, slightly lower than the $34.50 conversion factor (CF) set in the mid 1980s.

In 2008 an amendment to the original Lewin report was issued, again drawing stinging criticism from stakeholders. It examined the possibility of using geographic adjustments to payments in the way Medicare applies geographic
practice cost indices. In addition, it incorporated a 10 percent increase for services provided in Health Professional Shortage Areas. It also projected a sizeable increase for evaluation and management services, with substantial decreases in payment for surgical services and modest decreases for radiology and pathology services. It proposed no change in payments for anesthesiology services. A significant complaint by physicians was that physical therapy services would receive an increase of over 10 percent.

In March 2010, the DWC released a third amendment to The Lewin Group study with a proposed fee schedule, and it invited the public and interested stakeholders to participate in an online discussion forum on the DWC Website. The report laid out, for the first time, a detailed budget-neutral option with a transition schedule to a single CF for all services except anesthesiology. Most who responded on the forum were individual practitioners who expressed outrage at the budget-neutral methodology, which shifts a portion of the funds paid for surgery to primary care services. This iteration of the proposal set the anesthesiology CF at $33.98 and all other services would transition over three years to a single CF of $45.15 in year four. Under that scenario, the surgery CF would drop from the initial rate of $53.12, and the radiology CF would decrease from an initial CF of $59.53. All other services, mostly office services, will increase from the starting point of $40.70.

Concurrently, DWC announced reductions in the facility fees paid to ambulatory surgery centers. The intended payment is set at 120 percent of Medicare. This drew fire from ASC owners, who argued that the site of service should not affect the facility rate and that access to care may be decreased. Because Medicare and other payers have separate fee schedules for hospitals and ASCs, the DWC will likely prevail in that debate.

On May 24, another amendment was released that detailed a four-year transition to RBRVS, also culminating in a single CF for all services, plus a separate anesthesiology CF. The new proposed fee schedule is significantly more appealing than its predecessor to all specialties except anesthesiology. It calculates increases in CFs to most specialties except radiology and anesthesiology. The increases will be funded by savings derived from reduced payments for spinal hardware and ambulatory surgical center fees, along with system savings gained through requiring electronic billing. Under the new proposal, the conversion factor for all services except anesthesiology will increase to $60 in 2013, with the anesthesia CF fixed at $34.
Title 8 CCR section 9789.12.4, conversion factors:

For services other than anesthesiology, the proposal includes the initial use of three conversion factors—surgery, radiology, and “all other.” The regulations include a transition period of four years during which the three conversion factors converge to a single conversion factor in year five.

Other features of the March proposal include application of the Correct Coding Initiative edits and most Medicare ground rules.

The DWC removed the draft regulations from its website on May 25, citing the possibility of an error in the content. On July 6, the regulations were reposted with an informal comment period until July 20. A 45-day notice of public hearings will occur after the comment period.

Assuming that the corrections will not affect anesthesiology services, here is the future for anesthesia that the DWC proposes:

1. The CF for anesthesiology services will be set at $34, with no increase during the four-year transition.
2. Physical status and qualifying circumstances modifiers are reimbursed.
3. Most Medicare ground rules will be incorporated.

When the corrected regulation is released, detailed examination of the effects on payment for anesthesiology services will take place under the auspices of the CSA Legislative and Practice Affairs Division. The CSA will vigorously oppose the discriminatory tactic of freezing the anesthesiology conversion factor at 1980s levels and any other proposal that disadvantages anesthesiologists.
Skyrocketing Workers’ Compensation (WC) insurance premiums blamed on abuses in the system prompted significant legislative changes in the California Workers’ Compensation Program in 2003 and 2004. One consequence of this legislation was a reduction in the amounts paid to treating physicians under the Official Medical Fee Schedule (OMFS).

Although premiums for WC insurance have been reduced and stabilized in recent years, further reductions in payment for anesthesiology services relative to other specialties have been threatened, and there is little opportunity for an anesthesiologist to avoid OMFS limits. Although there are supposed to be opportunities to negotiate alternative rates, including rates higher than the OMFS, those opportunities are extremely limited. It is possible to contract with WC insurance carriers or their medical provider networks to receive payments in excess of that provided for under the OMFS. Because the responsible payers are under no obligation to pay rates in excess of the OMFS, there seems little opportunity for any real negotiation.

In brief, as regards WC patients, a “balance billing prohibition” is in effect, which is even more comprehensive than the limitations that apply for emergency services for health care service plan patients or for Medicare patients. An action by the United States Justice Department against orthopedists in the State of Idaho allegedly colluding to refuse to accept WC fee schedule payments was recently settled. The settlement makes clear that the federal government takes the position that antitrust laws apply to boycotts of governmental programs and fee schedule amounts every bit as much as they apply to private commercial enterprises.

Although California anesthesiologists cannot collectively threaten boycotts in response to WC payment rates for anesthesiology services, there are some things they can do. The OMFS is adopted by the Director of the Division of Workers’ Compensation and is supposed to be adjusted at least every two years “after public hearings.” CSA and individual anesthesiologists have the right to
participate in this process. Indeed, the Department of Industrial Relations Website invites questions from interested persons regarding the OMFS (www.dir.ca.gov/dwc/omfs9904.htm). Anesthesiologists unhappy with the level of payment for their services under the OMFS are free to register their dissatisfaction. They are also encouraged to support CSAs efforts on their behalf, which will emphasize the access concerns relating to unreasonably low payment rates for anesthesiology services.

Additional Remarks on Workers’ Compensation

By William Barnaby, Esq. and William Barnaby III, Esq.

WC programs are in place in virtually all states. In effect, industrial accidents—“on-the-job” injuries—are exempt from the usual tort system. Employers are required by state law to maintain coverage against such employee injuries, and claims are processed on a “no fault” basis. The Division of WC (DWC) is part of the California state government executive branch. It is within the Department of Industrial Relations (DIR), the director of which, as well as the administrative director of the DWC, are gubernatorial appointees subject to Senate confirmation. A good summary of the California WC system can be found on the Department of Industrial Relations Website (www.dir.ca.gov/DWC/basics.htm). Be aware that the Governor is trying to preserve his “legacy” of reforming WC, perhaps his most praised accomplishment, at least in the eyes of the business community. The Governor and his business allies are fearful that WC reform will be undone if a new Democratic governor is elected. Labor has been increasingly vocal about allegedly low disability payments. Indeed, there is a strong suspicion that both the Governor and Labor want to fund higher WC disability payments by further reducing medical treatment payments.

And Some Supplemental Perspective

By Kenneth Y. Pauker, M.D., Associate Editor, President-Elect, and former Chair of the Legislative and Practice Affairs Division

It should be noted that WC premiums are paid by employers, then managed and administered, and ultimately paid out for claims (disability payments to injured workers, medical payments to facilities and medical practitioners) by an entity which has partial autonomy from the state government. Private WC insurance is administered by insurance companies. In the vast majority of states, workers’ compensation is provided solely by private insurance companies. Twelve states operate a state fund, and the California State Compensation Insurance Fund is the largest, with over $22 billion in assets, 7,500 employees (of which 500 are attorneys), and an average market share of 23 percent historically since it
was created by the California legislature in 1913. The fee schedule (OMFS) is determined by a branch of the government, subject to the regulatory approval process defined by the Administrative Procedure Act, and thereby conditional upon filings and testimony and public hearings, culminating ultimately in a decision by the California Office of Administrative Law. The government itself is not using tax dollars to pay claims (except for premiums paid on behalf of state employees), but it does set the fees.

2010 Primary Election Results—Positive Outcomes for CSA

By William E. Barnaby and William E. Barnaby III, CSA Legislative Counsel

Importance for CSA

“All politics is local” was the mantra of the late U.S. House Speaker Thomas P. “Tip” O’Neil. For CSA members and other California physicians, local matters provided some positive results from the June 2010 primary election. Two of the three state legislative physician candidates won their primary races and will be their party’s nominee in the November general election. Another physician won an uncontested primary and will mount a well financed challenge against a long-serving Congressional and Statewide politician. A Fresno area Congressional seat seems assured for a candidate who received ASAPAC help urged by CSA sources. A central valley Assembly seat was won by a candidate who was singled out by a politically active CSA member.

- Linda Halderman, M.D., will be representing the Fresno area where a heavy Medicare/Medi-Cal caseload forced her to close a financially unsustainable general surgery practice. She won the Republican primary in safe GOP Assembly District 29. CSA members individually (especially Past Presidents Linda Hertzberg, M.D., and Virgil Airola, M.D.) and through GASPAC were among her earliest and strongest supporters.

- Richard Pan, M.D., won the Democratic nomination in suburban Sacramento Assembly District 5 that has elected Republicans for the past 20 years. A wild card is how the race will be affected by the highly visible and leading role played by his GOP opponent, attorney Andrew
Pugno, in Proposition 8 which banned same sex marriage. GASPAC supported Dr. Pan, as it supports virtually all physician candidates.

- Don Kurth, M.D., lost the Republican nomination for Assembly District 63 (San Bernardino) after facing a negative campaign financed by Blue Cross, Blue Shield and the California Association of Health Plans. Dr. Kurth stressed his concerns over interference by managed care in patient treatment decisions. While the loss was an adverse result for CSA, it is also a lesson to be learned. When HMOs mouth concerns for practicing physicians, keep in mind where they put their money in this race. GASPAC supported Dr. Kurth.

- Ami Bera, M.D., Assembly District 3, won the uncontested Democratic nomination to challenge incumbent GOP Congressman Dan Lungren, a career politician who has sandwiched two terms as California Attorney General and a losing bid for Governor (to Gray Davis) between 18 years in Congress. Bera has raised a large war chest and is supported by ASAPAC. Because of his robust campaign, the seat no longer is considered “safe” for Lungren.

- State Senator Jeff Denham (R-Atwater) outpolled a former Congressman and a former Fresno Mayor in the GOP dominated 19th Congressional District. ASAPAC supported Denham upon favorable urging by GASPAC/ASAPAC member Paul Coleman, D.O., of Modesto and the CSA lobbying team. Denham has been accessible and supportive of CSA during his eight years in the Senate.

- Kristin Olsen, a Modesto City Councilmember, was identified by Dr. Coleman as the best candidate in a six-way race for the Republican nomination in Assembly District 25. She won the nomination and the election because no Democrat or minor party candidates filed for the seat. GASPAC translated Dr. Coleman’s recommendation into tangible help.

CSA’s Involvement

The above are indicative, though not all inclusive, of CSA’s active involvement in the electoral process. While CSA’s political action committee (GASPAC, the Greater Anesthesia Service Political Action Committee) is small by comparison with CMA’s CALPAC and the PACs of almost every friend and foe, effective partnering and timing keep GASPAC visible and appreciated. Legislative incumbents and candidates know who GASPAC represents—CSA members, in other words, anesthesiologists. And they know CSA members are not content to sit on the sidelines but are active in the political process.
Partnering with CALPAC has helped to expand the impact of medicine in key campaigns and to assure a consistent message on key issues. Similarly, participating in the CAPP (Californians Allied for Patient Protection) coalition has helped safeguard MICRA from attacks by the personal injury lawyers.

Promoting active involvement of CSA members in the political process is high among the goals of the CSA leadership. It will be a prominent CSA theme going forward.

**The Big Picture**

Voters are angry and ready “to throw the bums out,” warns the news media. In California, elected officials are churned through the political system without regard to need, necessity or even voter anger. Here, term limits force elected officials out of office much faster than do the voters. “Electeds” cycle through city, county and state offices and back again with barely time for on-the-job training. Even without the defeat of a single incumbent’s re-election bid, 39 state legislative seats will change hands this November.

Also, the gerrymandered reapportionment of 2001 has effectively prevented districts from switching political parties. 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 November ballot proposition.

Besides angry, California’s voters may also be more disgusted or fatigued. Campaign spending in the just concluded June primary election was at a record high, and voter turnout was at a record low. Negative campaigning, especially via television advertising, long has been believed to repulse voters and depress turnout. The nasty tone of recent non-stop, saturation TV spots may have helped prove the point.

**Can Money Buy Elections?**

There may be no definitive answer. Wealthy candidates continue to invest their own fortunes to win high public office even though few have been successful. Michael Huffington spent $28 million in a 1994 losing bid for U.S. Senate. Al Checchi dropped $40 million in losing the Democratic gubernatorial nomination in 1998. He ran ahead of Jane Harman who only chipped in $12 million, but both lost to the ultimate winner, Gray Davis. In 2006, Steve Westly splurged about $40 million in losing the Democratic gubernatorial nod to Phil Angelides whose $30 million effort was only partly self-funded. Of course, Angelides then lost to Arnold Schwarzenegger whose $30 million campaign was mostly financed by outside contributors.
For the June primary, former eBay CEO Meg Whitman put $81 million of her own wealth in trouncing Steve Poizner who bankrolled his campaign to the tune of (only?) $21 million. Once nominated, Whitman gave her campaign another $10 million and has vowed to dedicate upwards of $150 million to gain the Capitol’s “corner office.”

Still, voters may have sent a pertinent message. Two ballot measures, backed by big corporate dollars with no counter campaigns or advertising, were shockingly rejected. 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, the “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, Facebook General Counsel, who blew $12.5 million failing to gain the Democratic nomination for Attorney General.

Does the law of diminishing returns apply to election campaigns? An answer may be tallied on November 2, 2010.

Massive spending by wealthy individuals and corporate interests, particularly in statewide campaigns, has the effect of crowding out smaller forces that have legitimate concerns to voice. Even if GASPAC, for example, were to plunge its entire treasury into a single candidate for Governor, it would be too little to be noticed or have an impact. That’s the rationale for concentrating GASPAC funds on legislative races where they can make a difference.

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**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](http://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. Since legislative districts are determined by home address, your zip+4 is essential to provide you with this information.
ASA Director’s Summer 2010 Report

“I’m from the Government and I’m here to help.”

“The nine most terrifying words in the English language . . .”
— Ronald Reagan

By Mark Singleton, M.D., ASA Director for California

The Patient Protection and Affordable Care Act (PPACA) and its companion Health Care and Education Reconciliation Act of 2010 were passed by Congress after unprecedented national public debate, and signed into law by President Obama on March 23 and March 30, respectively. The fallout from this meteoric legislation, an undeniable historic achievement for this President and the Democrat majority Congress, will continue for the next decade and beyond as various provisions of the Act come into effect or are modified by further legislation. How the healthcare landscape in America looks after the dust settles over the next few years is the subject of many predictions, but it is certain to dramatically alter all of our practices of anesthesiology. For now there seems to be almost a numbness in Washington on the subject of healthcare reform, as if our elected leaders are simply exhausted by what went into the enactment of this monumental set of laws. The failure to dismantle and replace Medicare’s Sustainable Growth Rate Formula, which has become a ludicrous and unworkable basis for physician payments, is a prime example of this impotence. Over the coming years, unfamiliar concepts and terms like “value based purchasing,” “accountable care organizations” (ACOs), and the Independent Payment Advisory Board (IPAB) will come to be intimately known by all of us. ASA has a superb team of professionals dedicated to the analysis of the regulatory impact of all of this, and this team consists of Jason Byrd, Chip Amoe, Sharon Merrick and Loveleen Singh. I highly recommend Mr. Byrd’s article in the June 2010 ASA Newsletter: “The Regulatory Tsunami Awaits.” In addition, CSA’s own Stan Stead, Chair of the ASA Committee on Economics, presented a powerful analysis of the potential impact of the PPACA to our specialty, at both the ASA Legislative Conference in Washington in April, and again last month at the CSA Annual Meeting in Costa Mesa.

A more immediate regulatory event with which the ASA has been dealing for the past six months is the release in December 2009 of the revised Interpretive Guidelines (IGs) pertaining to the CMS Conditions of Participation (CoPs)
for hospital anesthesia services. These revised IGs establish some important
regulations and concepts which will likely be incorporated into future Joint
Commission surveys. Some highlights are:

All services along the continuum of anesthesia services … must be
organized under a single Anesthesia Service, which must be directed
by a qualified physician and consistently implemented in every
hospital department and setting that provides any type of anesthesia
services.

A distinction is made between “Anesthesia” and “Analgesia” with special
implications for obstetrical anesthesia. Anesthesia

… involves the administration of a medication to produce a blunting
or loss of: pain perception; voluntary and involuntary movement;
autonomic function; and memory and/or consciousness, depend-
ing on where along the central neuraxial (brain and spinal cord) the
medication is delivered. In contrast, analgesia involves the use of a
medication to provide relief of pain through the blocking of pain
receptors in the peripheral and/or central nervous system. The
patient does not lose consciousness, but does not perceive pain to
the extent that may otherwise prevail. During labor and delivery,
the provision of acute analgesia (i.e., relief of pain, via an epidural or
spinal route) is not considered “anesthesia,” and a CRNA administering
these forms of anesthesia services does not require supervision by the
operating practitioner or anesthesiologist.

Pre-anesthesia evaluation:
• Must occur within 48 hours of procedure
• Expanded elements of evaluation, including potential anesthesia
  problems (difficult airway, ongoing infection, limited IV access),
  additional evaluation, and anesthesia care plan (e.g., type of
  medications).
• Timing issues and re-evaluation immediately prior to anesthesia

The intraoperative anesthesia record must include:
• Name, dosage, route, and time of administration of drugs and anesthesia
  agents
• Techniques used and patients position(s), including the insertion/use of
  any intravascular or airway devices
Any complications, adverse reactions, or problems occurring during anesthesia (symptoms, vital signs, treatments, and response)

Postanesthesia Evaluation:
• Within 48 hours (of arrival in recovery area) “generally would not be performed immediately” on arrival in PACU
• Required elements: respiratory function, cardiovascular function, mental status, temperature, pain, nausea and vomiting, and postoperative hydration
• Patient participation

ASA President Alex Hannenberg, and other ASA leaders have been, and continue to be, engaged in discussions with CMS over obvious problems with these revised IGs. The clear lack of understanding of the physiology of sympathetic blockade inherent in epidural “analgesia” would seem to be an easy one, but CMS appears to be least willing to reconsider this ruling. They suggest instead that it be dealt with through a “local solution” within individual institutions. It looks like politics all over again.

Templates are now available to help anesthesiologists meet these new CMS Interpretive Guidelines for hospital Conditions of Participation in the members section of the ASA Website. For the clarification of the Interpretive Guidelines for the Anesthesia Services, go to http://www.asahq.org/Washington/UpdatedCMSIGs5-21-10.pdf.

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**Save the Date!**

2011 Winter CSA Hawaiian Seminar
January 24-28, 2011

Hyatt Regency Maui Resort & Spa
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http://www.csahq.org/up-more.php?idx=39
Changes and Challenges in Law Practice in the Past Fifty Years

By Tread Davis, J.D., LL.M.

Tread Davis, Jr., J.D., LL.M., currently is Senior Counsel at McKenna, Long and Aldridge in Atlanta. He received his J.D. degree from George Washington University, and his LL.M. degree from Harvard Law School. A member of the American Law Institute, Tread serves as an adjunct law professor and has published a book, now in its second edition, on corporate mergers. A fellow Princeton classmate of mine, Tread wrote a fascinating perspective article on the evolution of the practice and profession of law (including analogies to the medical profession) for the our 50th Reunion Yearbook. He graciously permitted me to edit it to a somewhat abbreviated version for our Bulletin, but commented that “at the worst, it could have a soporific effect for any tough anesthesia case.”

—Stephen Jackson, M.D., Editor

To consider changes and challenges in law practice over the past 50 years is to some extent to consider the changes and challenges in our world over the same period. For in many ways one reflects the other. Some are obvious: globalization, increased opportunities for women and people of color, new technologies, and a tendency towards consolidation and larger enterprises. Some are more subtle, including the increased emphasis on law practice as a business, and mobility within the United States and the world. The principles of law as a profession and of our system of justice have remained constant. At the same time, the evolution of law practice has accelerated as new demands and capabilities have been placed on the system.

The rule of law and, indeed, the practice of law, is a noble and essential part of our society and of civilization. Although lawyer jokes are standard fodder for both our conversations and nighttime comedy shows, the necessity of a rule of law is recognized throughout the civilized world for its preservation of human rights and the rights of the individual, the rights and duties of free people, and as a necessary framework for both free ideas and a healthy and free economic
system. Lawyers, like it or not, are the ones who help make the system of justice and rule of law work, day in and day out.

The Client’s Perspective

Let’s examine what has changed from the standpoint of the *client*. First, our own expectations have changed. We assume our daughters and granddaughters will be able to practice any profession or business or other employment that they wish without restriction or discrimination because of gender. We assume that competition in our business enterprises will be global and, whether we are merchants, or financiers, or in any one of many professions, that the entire world will impact what we do and our success or failure much more than it did in 1960. Generally speaking, we expect instant communication, instant answers and instant gratification. Big business now tallies its efforts and transactions in billions instead of millions. Our nation has subtly added a layer of communitarianism to its base of individualism. Good healthcare is more and more recognized as a social right. All qualified persons should have the opportunity for a college education. As clients, we expect the law to be our partner in securing and allocating the new “rights.” Alone among the nations of the world we sue at the drop of a hat and incarcerate criminals for longer sentences than any other free nation. In more homogenous nations, social mores set nationally recognized limits, and the laws, generally, deal only with the occasional maverick behavior. In a diverse nation such as ours, we increasingly have relied on the legal system to work things out—divorce, juvenile behavior, greed by corporate management, sharp practices against consumers, environmental behavior, employment rules, pension and profit-sharing plans, church disputes, access to medical care, product safety, and a host of other issues which, to the untrained eye, usually could be better resolved outside of the court system.

As clients, we have brought lawyers into this ever expanding web of legal rights and duties. Sometimes the experience relies on our Constitutional bedrock. A jury trial or impeachment or decision by the Supreme Court or passage of a law by the Congress is procedurally little changed in 50 years. The fact that all of the jurors have a TV screen showing the case documents and videos related to their case, the judge has a computer with all decisions at the judge’s fingertips and can see a transcript of all courtroom testimony instantly, or that Congressional debate is available in real time throughout the country have little changed the process or effect upon each of us when we are personally involved. On the other hand, social tectonics have formed new and vast social continents in areas that were rarely “legal” areas in 1960.

Horse racing used to be the sport of kings. Now litigation is. The bubble of expensive litigation is partly caused by new “rights.” But, the rise of an aggressive
and hungry plaintiffs’ tort bar has changed and distorted our system of justice. In the corporate area, “strike suits” are often filed as soon as a corporate stock drops in value, millions of dollars are spent pursuing and protecting the rights of shareholders, and when the smoke clears, it is often the plaintiffs’ lawyers who have walked away with millions or hundreds of millions of dollars, while the shareholder receives a discount coupon. The same is too often true in tort litigation. A few years back I served as strategic counsel to a large corporation in defending 350 lawsuits in Texas growing out of a school bus accident. They were successfully resolved from the standpoint of the corporation and its insurers, but I have often thought of the social cost of giving 40 percent of each child’s award to a plaintiffs’ lawyer who had done little. There must be a better way. The United States is notorious among the nations of the world for such a distortion of the justice system. Don’t get me wrong. I know the greed of some corporations and their tactics of simply wearing down less well financed persons. Our generation has made some reforms—from capping punitive damages, to requiring affidavits and evidence before a medical malpractice claim can be filed, to an increasing use of sanctions against the most egregious corporate abuses of the litigation system. By and large, our generation has left the litigation system in need of reform.

In 1910, the Woolworth Company entered into a lease for the Woolworth Building. The lease was contained on one single printed page. In 1964, our client asked that I help prepare a ground lease for The First National Bank Building, a 42-story building under construction in Atlanta. The lease ran 30 pages. In 2010, a lease for the same building would probably run 150 to 250 pages. As clients, we have become more aware of legal risks and have sought to encourage our legal counsel to try to reduce those risks, no matter how remote. The result has been added layers of complexity, legal costs, and, ultimately, social costs.

The Lawyer’s Perspective

Let us now turn to the view of lawyers as to the change of the law and legal practice. Obviously, the changes of tectonic plates of society and the place of law have been reflected in changes in the practice of the law. Economically, despite some recent downturns, it has been a great half century for most lawyers. There are much larger legal firms with many more specialists in them. Specialization has brought us hundreds of new specialty areas of practice such as sports law, franchise law, domain name law, cultural resources law, hospital law, government contracts law, communications law, special education law and elder law. The geographic scope of law firms and the size of law firms have changed dramatically. Today, a vigorous legal press and blogs daily tout the economic or courtroom success of one law firm and lawyer or another with a
breathless journalistic style. In 1960, a lawyer's prim and conservative ad could lead to disbarment. Today, billboards, phone book covers, TV and thousands of websites hawk the talents of particular lawyers. As business and nonprofit enterprises grew in size and geography, so did their law firms. When I started my practice in Atlanta in 1964, I joined what was then the largest law firm in the southeastern United States. I was about the 40th lawyer to join the firm. Today, our firm has about 400 lawyers who are located in many of the major cities of the United States and overseas. Our firm today would be considered one of moderate size. Oh, there are still plenty of good one-person and five-person law firms in communities small and large. But more and more lawyers, like doctors, practice in urban, large and increasingly specialized practices.

Another major change in the practice of law is speed. Time pressure—having time to think and reflect in a busy world—is measured in tenths of a billable hour. When I began practicing law, it was customary to prepare a draft of a document, mail it across town or across the country to the counsel for the other side, take a deep breath and think, and receive his comments back in a week or two. Today, I send contracts from my Blackberry or laptop wherever I am in the world and counsel for the other parties, who may immediately change those documents and return them to me. Often in a sophisticated merger, documents are “turned” several times a day. Like all improvements, this is a two-edged sword. Since lawyers and their clients have somehow fallen into the absurd trap of billing and paying by the hour, too often all of the lawyers involved in a merger or other transaction (and their clients with layers of corporate executives) delight in redrafting documents ad nauseam, rather than spending several hours early on reflecting and thinking about the key items from their side of the deal. Lawyers and clients together will wake up to the fact that the value of legal services is only partly related to time. Eventually, value-based fixed fees will be used for many legal matters, rather than billable hours spent.

A lawyer is an officer of the court. His or her duty is to vigorously represent the client, but always within the confines of legal ethics, civility and a duty to the system of justice. Law is a noble profession, but law firms have become a business and the professional emphasis has become muted. Ads for legal services blare at us in ways that would make the most hardened used car dealer blush. Clients shop for the lowest bid for particular legal work and switch lawyers often. The advent of the modern office of “General Counsel” in major corporations sometimes accelerated the rush away from professionalism and respect for a system of justice to a commoditization of many legal services. Too often the lawyer's professional watchdog role is muted either by the inside general counsel or by the outside firm anxious to curry favor and more business. Legal expenses do often reach absurd heights and clearly require some counterweight in order to maintain corporate profitability. In the 1960s, when I billed for a legal matter,
Changes and Challenges in Law Practice (cont’d)

I personally knew what each lawyer who worked on a matter had done, the value to the client, and the complexity of each component of the matter. I could adjust the bill to approximate the effort and value of the services. I still try to do that, but it is more difficult when a complex matter may represent the work of 20 separate lawyers located in three or four cities, and when their services are often in some arcane cranny of the law. Our medical brothers are struggling with similar dilemmas. Perhaps they will come up with an answer to help all professionals.

On a more positive side, the law has become much more accessible to both lawyers and clients. Minutes after a Supreme Court decision is rendered I have it on my desktop. For years, I prided myself on reading every “advance sheet” of federal and state law in the jurisdictions in which I am licensed. These paperbound volumes arrived 90 days or so after the decisions. Even the best firm law library had access to relatively few volumes. Today I can dial up an Internet site and essentially have access to all decisions and treatises anywhere in the world. Let’s take tax practice. From the 1960s to the 1990s, the inside federal tax moves underway in Congress or IRS were known in advance to a relative handful of insiders in Washington. Today, the drafts of each bill, the testimony at each hearing, the IRS officials’ speeches, the proposed regulations, and the general scuttlebutt of the tax bar is available to any lawyer or client in the country instantly and without significant cost. Tax advice is quicker, better and less time-consuming today.

Still, there is a chasm between the quality of legal help available to the poor, the indigent criminal defendant, the refugee, the old, the young, and a host of others. Most lawyers try in some way to address these needs by volunteering, or contributing or tithing some time to public service. There remains much to be done.

Where Do We Go From Here?

Where do we go from here in the law? I think that the practice of medicine, like the State of California, is 10 to 20 years ahead of most of us in many ways. I doubt that law will have the curse of significant third-party payers like medicine, but I do think that clients will take more responsibility for their own legal health. I believe that the Rule of Law will be a major export of the United States in the 21st century. The world will prize our basically predictable and fair system of justice and opt-in to it whenever possible. We will also learn from other legal systems in an increasingly flat world.

Major corporations—and many individuals—will rely more on mediation and arbitration than on the courts to resolve conflicts. These alternative dispute-
resolution mechanisms, properly used, are often quicker, cheaper, and of better quality in many situations. Judges will manage their cases better, and procedures will be streamlined using electronic communications for documents, hearings and some trials. Legal fees for the plaintiff’s bar will be capped in some way. The delivery of legal services is still just too cumbersome and too expensive. Paraprofessionals will undertake some of the more mundane tasks, on their own rather than under a lawyer’s supervision, just as nurse practitioners are doing in medicine. The Internet will allow routine services to be performed remotely over long distances and at less cost, and for clients to analyze and diagnose their own legal issues and potential resolutions. These will be positive changes. The critical and cutting edge legal questions, the bet-the-company or life-changing legal situations will still demand bespoke legal services. The trick, as in medical practice, will be to keep enough excellent generalists who know their clients well and who can direct and engage increasingly narrowly focused and efficient specialists when needed, while exercising legal judgment and common sense to often give the legal equivalent of “take two aspirin and call back in three days.” We will try to do a better job as a society of saving the courts for more important matters and adding concepts of “no fault” and alternative handling of matters which now dog our courts and require costly lawyers’ services. Most vehicle accident settlements, medical malpractice claims, and personal injury claims will be “no fault.”

The next 50 years in law and law practice will be exciting and challenging and rewarding. Lawyers, happily, will still have plenty to do. I, for one, would like to sign on for another 50 years.

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, doctors need to provide their ABA number. To obtain an ABA number, visit www.theABA.org and create a personal portal account.
Book Review

Take Charge of your Chronic Pain
by Peter Abaci, M.D., GPP Life, Guilford CT, 2010

Out of an overall population of 310 million in the United States, an estimated 50 million people live with some degree of chronic pain, and 33 million of them have suffered for more than five years. Entire industries have been built around this population, from surgical “cures” to pharmaceutical palliation. In our society, pain management has become quite lucrative, and the expectations of those who suffer have soared. In his book, Take Charge of your Chronic Pain, Peter Abaci, M.D., the medical director of the Bay Area Pain and Wellness Center, confronts many of these issues. Directed at a primarily lay audience, Dr. Abaci lays out a three-part strategy for patients trying to deal with this difficult problem. He provides a clear-cut explanation of the basics of the physiology and psychology of pain. He teaches strategies for evaluating and pursuing various aspects of pain management, and their pitfalls. Finally, he goes into some depth on topics rarely covered in traditional medical texts and discusses alternative management strategies. Overall, the text is clear and the topics important and engaging. This would be an important book to distribute to patients with chronic pain, much the way Dr. Margaret A. Caudill’s Managing Pain before It Manages You has been for previous generations.

Howard L. Rosner, M.D.
Interventional Pain Management
Medical Director, The Pain Center
Cedars-Sinai Medical Center
Associate Professor of Anesthesiology
Charles Drew University of Medicine and Science

You Could Win an iPad!

Just complete our short survey on page 36. Your name will be entered into a drawing for an iPad! This survey also is available on Survey Monkey at http://www.surveymonkey.com/s/S87XHVY
Letters to the CSA

Letter to the Editor:

I must say that I was struck by the overall negativity of “our” spring Bulletin as far as the health care reform debate/outcome was concerned. As a physician, I think that the primary concern is access to care, and any plan that insures an extra 30 million people is overall a good thing. Of course, it isn’t perfect and will need changes/additions in the future, but one must start to fix a problem before one can actually change anything. The cynical comments seemed to me to be more at home on FOX News or perhaps the Republican National Committee Website. Count me as being very disappointed in the tone projected. We all should see this as the incredible step forward that it is and help improve on it going forward. Thank you.

Robert Jarka, M.D.

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Dear Dr. Jarka:

Thank you for your comments with respect to the tone of the spring CSA Bulletin’s addressing some of the issues relating to national health care reform. I am in agreement with you that expanding health care coverage from 83 percent of Americans to 95 percent (about 32 million citizens) is, indeed, a good deed, a good first step. From my overview of the Congressional bill, it was more of a healthcare insurance reform (although it fell far short of where it could have gone) than a healthcare delivery reform. However, at least something worthwhile and sorely needed was achieved, and I hope we will keep on course to meet the ethical goal of providing quality health care for all Americans. There was, of course, no tort reform, nor was the SGR fixed, nor were there updates for certain California Medicare geographic payment localities. (This still is being debated in the Senate.) These all must be addressed in a truly comprehensive reform of our health care delivery system.

As you thankfully were interested and motivated enough to send us your letter, I am offering you to go one step further: How about writing your thoughts about health care reform for the Bulletin? I would be delighted to provide you with any needed editorial assistance in developing your opinion piece.

Thank you, again, for expressing your concerns and sharing your thoughts with us.

Stephen Jackson, Editor
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Send responses by fax to 650-345-3269 or if you prefer to do the survey online, go to http://www.surveymonkey.com/s/S87XHVY.

Circle your response.

1. How many of the last four Bulletins have you read?
0 1 2 3 4

2. In which form would you prefer to receive the Bulletin?
Printed    Electronic    Both

3. How relevant is the Bulletin’s information for your practice?
1 (minimal) 2 3 4 5 (very)

4. In comparison to the Bulletin, how valuable is the Gasline’s information?
1 2 3 4 5

5. In comparison to the Bulletin, how valuable is the ASA Newsletter’s information?
1 2 3 4 5

1 (disagree) 2 3 4 5 (agree)

7. Rate the following Bulletin articles/sections/columns.

   Editorial
   1 (poor) 2 3 4 5 (excellent)

   CSA President’s Column
   1 (poor) 2 3 4 5 (excellent)

   ASA Director’s Column
   1 (poor) 2 3 4 5 (excellent)

   District Director Reports
   1 (poor) 2 3 4 5 (excellent)
Legislative and Practice Affairs
1 (poor) 2 3 4 5 (excellent)

CEO's Report
1 (poor) 2 3 4 5 (excellent)

CME Modules
1 (poor) 2 3 4 5 (excellent)

Guedel History
1 (poor) 2 3 4 5 (excellent)

Peering Over the Ether Screen by Karen Sibert, M.D.
1 (poor) 2 3 4 5 (excellent)

California (including CMA activities) and National News
1 (poor) 2 3 4 5 (excellent)

Articles of General Interest (e.g., humor, humanities, physician well-being issues)
1 (poor) 2 3 4 5 (excellent)

Articles on topics related directly to clinical practice
1 (poor) 2 3 4 5 (excellent)

8. What topics would you add?
   ___________________________________________________________
   ___________________________________________________________

9. What sets the Bulletin apart from other anesthesiology publications?
   ___________________________________________________________
   ___________________________________________________________

10. Would you prefer that the CSA only communicate to members electronically through its website, e-mail, or other media?
    Website E-Mail Other media

11. Do you have any other comments?
    ___________________________________________________________
    ___________________________________________________________

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Faculty

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Meg Rosenblatt, M.D.  
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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 website 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>Standard/Garden View</td>
<td>$235</td>
</tr>
<tr>
<td>Ocean View</td>
<td>$290</td>
</tr>
<tr>
<td>Ocean Front</td>
<td>$475</td>
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Mauna Lani Bay Hotel and Bungalows

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❑ Resident (verification from Training Chief required) $350 $380
❑ Retired CSA Member $350 $380

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. Sorry, daily purchases are not available.

Guest Breakfast Fee: $200 per adult, $100 children ages 3-12 years
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Please provide the names of all guests for whom you are purchasing breakfast passes:

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GRAND TOTAL $ __________

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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 September 28, 2010.

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• Prior to September 28, 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, anesthesiology residents and students and other health professional in the practice of anesthesiology.
Poetic Reflections on a Propofol Induction

By Kenneth Y. Pauker, M.D., CSA President-Elect, Associate Editor

Propofol is a medication that anesthesiologists use routinely, and most would agree that because of its profile of beneficial effects, its introduction in the U.S. in 1989 was a major advance for anesthetic practice. It is also a dangerous drug, with a narrow therapeutic index in some patients, and there has been an ongoing debate between non-anesthesia practitioners who want to use it for sedation, and anesthesiologists who maintain that such use may well be inappropriate and even dangerous for patients, depending on who administers it and how. To clarify the situation and in the interest of patient safety, the ASA House of Delegates adopted in 2004 and amended in 2009 a “Statement on the Safe Use of Propofol.” The danger that had long been apparent to anesthesiologists was underscored to the general public by Michael Jackson’s death from a propofol overdose administered by a non-anesthesia trained physician in an unmonitored setting.

With all this as background, there appeared in the New Yorker magazine on June 30, 2008, an amazing poem entitled “Propofol” by Karl Kirchwey. It is a poet’s description, based upon conversations with his anesthesiologist before his routine colonoscopy, of his descent from literary repartee into the oblivion of general anesthesia. With the author’s permission, the CSA Bulletin is reprinting this poem below, with annotations by me, intended for those who might benefit from and be enriched by an understanding of some of Mr. Kirchwey’s mythological and literary references.

Propofol

By Karl Kirchwey

Moly, mandragora, milk of oblivion: I said to Doctor Day, “You bring on night.”
“But then,” he said, “I bring day back again,”
and smiled; except his smile was thin and slight.

I said to him, “Sleep and Death were brothers,
you know. They carry off great Troy’s Sarpedon in Euphronio’s famous calyx-krater”—
babbling. He said, “I am a singleton.”

Summer 2010
Poetic Reflections on a Propofol Induction (cont’d)

I said to him, “The Romans would have called you
Somnus, the Greeks Hypnos or Morpheus”
(but Doctor Day looked blank), anything to
forestall the wasp\(^1\) (Classics not his thing, I guess)
alighting on the back of my right hand.
    He said to me, “Tell me why you are here.”
I said, “To lose a page,\(^2\) I understand,
    out of the Book of Life.”\(^3\) A traveller

approached the citadel\(^4\) even while I was speaking,
    seven seconds from my brain;\(^5\) then it was snuff.\(^6\)
Pornokrates,\(^7\) naked in her black stocking,
    led one more pig on a leash to the trough.

\[\text{This poem is reprinted with permission of the author.}\
\text{© Copyright 2008. Originally published in The New Yorker.}\]

\(^1\) http://www.asahq.org/publicationsAndServices/standards/37.pdf
\(^3\) Cf. “Milk of Amnesia.” An anesthesiologist friend of the author’s family told
him that propofol is called “Milk of Amnesia,” punning on Phillips’ Milk of Magnesia, owing to its white color and its use to produce amnesia (personal communication). Beyond amnesia to oblivion is the author’s notion of where propofol would take him.
“Day” is in actual fact the name of the anesthesiologist in question on the day of his procedure, and his name was used with permission (personal communication). As happens not infrequently with creative writing, other meanings not known even to the author may spring to mind. For one, “day” is the perfect opposite of “night,” Doctor Day bringing on the night of general anesthesia. For another, an anesthesiologist (particularly one prone to tangential thinking) might divine an occult reference to “Doctors’ Day,” which commemorated the first clinical use of ether by Dr. Crawford Long on March 30, 1842.

Anesthetic “sleep” akin to darkness or night.

Emergence and awareness, “lightening” of anesthesia.

Greek gods of sleep (Hypnos was the Greek god of sleep and dreams) and death (Hypnos brother was Thanatos, god of death) were twin brothers, and anesthesia might be considered a third brother. Nyx, their mother, was goddess of night. Morpheus, the god of dreams, was the son of Hypnos, god of sleep. Somnus was the Roman equivalent of Hypnos.

Internet “Classic Encyclopedia, based upon the 11th edition of the Encyclopaedia Britannica (pub. 1911),” http://www.1911encyclopedia.org/Sarpedon “SARPEDON, in Greek legend, son of Zeus and Laodameia, Lycian prince and hero of the Trojan war. He fought on the side of the Trojans, and after greatly distinguishing himself by his bravery, was slain by Patroclus. A terrible struggle took place for the possession of his body, until Apollo rescued it from the Greeks, and by the command of Zeus washed and cleansed it, anointed it with ambrosia, and handed it over to Sleep and Death, by whom it was conveyed for burial to Lycia, where a sanctuary (Sarpedoneum) was erected in honour of the fallen hero. Virgil (Aen. i. 100) knows nothing of the removal of the body to Lycia. In later tradition, Sarpedon was the son of Zeus and Europa and the brother of Minos. Having been expelled from Crete by the latter, he and his comrades sailed for Asia, where he finally became king of Lycia. Euripides (Rhesus, 29) confuses the two Sarpedons.

See Homer, Iliad, V. 479, xii. 292, xvi. 419-683; Appian, Bell. civ. iv. 78; Herodotus i. 173., with Rawlinson’s notes.”

http://en.wikipedia.org/wiki/Euphronios “Euphronios (circa 535-after 470 B.C.) was an ancient Greek vase painter and potter, active in Athens in the late 6th and early 5th centuries B.C. As part of the so-called ‘Pioneer Group,’ Euphronios was one of the most important artists of the red-figure technique. His works place him at the transition from Late Archaic to Early Classical art … The Sarpedon krater or Euphronios krater, created around 515 B.C., is normally considered to be the apex of Euphronios’ work. As on the well-known vase from his early phase, Euphronios sets Sarpedon at the centre of the composition. Following an order by Zeus, Thanatos and Hypnos carry Sarpedon’s dead body from the battlefield. In the centre background is Hermes, here depicted in his role of accompanying the dead on their last voyage. The ensemble is flanked by two Trojan warriors staring straight ahead, apparently oblivious of the action that takes place.
between them. The figures are not only labelled with their names, but also with explanatory texts. The use of thin slip allowed Euphronius to deliberately use different shades of colour, rendering the scene especially lively. But the krater marks the peak of the artist’s abilities not only in pictorial terms; the vase also represents a new achievement in the development of the red-figure style. The shape of the chalice krater had already been developed during the black-figure phase by the potter and painter Exekias, but Euxitheos’ vase displays further innovations created specifically for the red-figure technique. By painting the handles, foot and lower body of the vase black, the space available for red-figure depictions is strictly limited. As is usual for Euphronios, the pictorial scene is framed by twisting curlicues. The painting itself is a classic example of the painter’s work: strong, dynamic, detailed, anatomically accurate and with a strong hint of pathos. Both artists appear to have been aware of the quality of their work, as both painter and potter signed it. The krater is the only work by Euphronios to have survived in its entirety. On display at the Metropolitan Museum, New York since 1972, it was officially returned to Italian ownership in February 2006, but remained on display as a loan to the Metropolitan Museum until its repatriation to Italy in January 2008.

The back of the Sarpedon krater shows a simple arming scene, executed more hastily as the massive krater’s clay dried and rendered it less workable. This explicitly contemporary scene, depicting a group of anonymous youths arming themselves for war, is emblematic of the new realism in content as well as form which Euphronios brought to the red-figure technique. These scenes from everyday life, and the artistic conceit of pairing them with a mythological scene on the same piece, distinguish many of the pieces painted by Euphronios and those who followed him.”

10 The author begins to babble and “free associate” from the effects of propofol.
11 The doctor is no twin, not like sleep or death, unique in himself, just like CSA’s own Dr. Singleton, as he rightly pointed out when he read this poem.
12 Propofol burns on injection, like a wasp.
13 “To lose a page” is wonderful symbolism for what propofol does epistemologically.
14 http://en.wikipedia.org/wiki/Book_of_Life The Book of Life (Hebrew: transliterated Sefer HaChaim) is the allegorical book in which God records the names and lives of the righteous. According to the Talmud it is open[ed] on Rosh Hashanah; its analog for the wicked, the Book of the Dead, is open[ed] on this date as well. For this reason extra mention is made for the Book of Life during Amidah recitations during the Days of Awe, the ten days between Rosh Hashanah, the Jewish new year, and Yom Kippur, the day of atonement (the two High Holidays). During the Days of Awe, Jews have an opportunity to repent for their sins and ask forgiveness of God for sins against Him, and to ask forgiveness from individual people whom they have wronged. On Yom Kippur, the books are sealed, and what will happen to a person for good or bad during the coming year is then a matter which further repentance cannot alter.
Meaning an external force, propofol, broached my fortified castle of my awake being. The author reflects that “when travellers approach citadels (think of Oedipus coming to Thebes!) in ancient Greek mythology, it's often with disastrous consequences (personal communication).”

Seven seconds from IV propofol injection to reach the brain is a reasonable estimate.

Snuffed out the light, the consciousness, the life even.

http://www.artandpopularculture.com/Pornokrates “Pornokrates,” also known as Pornocratie, is an 1879 painting by Félicien Rops. It depicts a blindfolded woman being led by a pig on a leash. For some the pig with the golden tail represents the image of luxury and lucre steering the woman, whose only excuse is her blindness; for others, it is the image of man, bestial and stupid, kept in check by the woman. This image of the pig, as well as those of the puppet and the pierrot are shared by many of Rops’ contemporaries.

Pornokrates heralds the advent to the art world of the contemporary woman which Rops glorified. She is characterised by her arrogance, her composure and her ruthlessness.

In a letter to his friend Henri Liesse, he described the painting: “My Pornocratie is complete. This drawing delights me. I would like to show you this beautiful naked girl, clad only in black shoes and gloves in silk, leather and velvet, her hair styled. Wearing a blindfold she walks on a marble stage, guided by a pig with a ‘golden tail’ across a blue sky. Three loves—ancient loves—vanish in tears (...) I did this in four days in a room of blue satin, in an overheated apartment, full of different smells, where the opopanax [a.k.a. sweet myrrh] and cyclamen gave me a slight fever conducive towards production or even towards reproduction.”—Letter from Rops to Henri Liesse, 1879.

Kirchwey writes, “I had seen the Felicien Rops painting at a show in Lausanne earlier in the spring of the year when I had the colonoscopy (personal communication).” He intended a different take on Pornokrates: “I think of Circe, turning Odysseus’ men into pigs. To put it plainly, as the maiden-no-more said: Men Are Beasts. ‘Pornokrates’ would translate from the Greek as ‘Government by Harlots,’ I believe. So the naked lady is actually walking a pig on a leash, I think, rather than being led by same (personal communication).”

The pig as the image of luxury and wealth leading the blindfolded woman versus the woman walking the pig, the image of man, bestial and stupid — you decide. It’s a chicken and egg thing, and—babbling now—the Easter Egg here is that propofol spelled backwards is lofo-porp (last on, first off, belly button lint). OK, I’ll keep my day job …
A Urologist Dissects Apostate*

By Aaron Spitz, M.D.

Dr. Spitz is a urologist in part-time academic and private practice in Orange County. He is very active in the American Urological Association (AUA), and is a specialty delegate to the AMA House of Delegates.

The recently enacted federal HCR bill, H.R. 3590, was opposed by the ASA, which joined with a coalition representing 240,000 surgical specialists in articulating opposition by sending a strong letter to Speaker Pelosi. (This letter appears at the end of the article.) The AUA was one of the specialty societies that joined with the ASA in this effort.

Dr. Spitz conveys his perspective on what happened and why, and what will happen to our profession if physicians do not get to work immediately to change the politics that produced this legislation. He offers some novel suggestions for how we can act to turn things around.

—Kenneth Y. Pauker, M.D., Associate Editor

This past March, I attended the AUA’s Joint Advocacy Conference in Washington, D.C. I was there the very weekend that the healthcare reform bill passed. It was a historic weekend. It was like being in the eye of a hurricane. The public face of the legislation was that it was an effort to fix a broken system. America was notified that the AMA supported it, and that after much careful deliberation, this legislation was the best compromise deliverable to our nation. I had the opportunity to hear directly from legislators, aids, and pundits. It was clear that after several congressmen who are physicians spoke with us that the process of the current healthcare reform legislation neither sought meaningful input from physicians, nor did it make any meaningful concessions to physicians. Incredibly we learned that the legislation was actually a “housing bill” with a 2,700 page “amendment,” sent back from the Senate to the House for its approval. Even Democrat members of the House had trouble with some of the provisions in this “amendment.”

The real crisis facing our healthcare system is its unsustainable costs. In 2008, the latest year for which data is available, healthcare expenditures were 16.2 percent of the Gross Domestic Product (GDP). In 70 years, at current trends, this figure will grow to 100 percent. Of course the breaking point would happen well before that, perhaps at 25 percent or 35 percent, but there is no mistaking that it is coming soon. The two main drivers of these almost unimaginable expenditures are (1) an ever-increasing utilization of expensive technology by an ever sicker and older population, and (2) an ever more

* “One who has abandoned one’s religious faith, a political party, one’s principles, or a cause.” http://dictionary.reference.com/browse/apostate
virulent malpractice environment that every day silently stimulates utilization in the service of keeping lawyers at bay. Physician fees account for 12 percent to 15 percent of all healthcare expenditures. Even if physicians worked for free, the projected cost curve would bend only slightly. The new legislation does absolutely nothing material to bend the cost curve, except potentially to make physicians work for less, and many argue that it indeed bends the curve in the wrong direction. Insurance premiums are uncapped, the pharmaceutical conglomerate (PhRMA, the Pharmaceutical Researchers and Manufacturers of America, so called “Pharma”) has secured stunning safeguards, lawyers are protected, and 30 million more lives are added onto the governmental health plan responsibilities.

At this point, the only recourse available to us is to repeal and replace the federal legislation. Physicians, for the most part, sat virtually mute on the sidelines as the AMA, which, for better or for worse, is perceived to represent physicians, failed America’s physicians by supporting healthcare reform legislation from conception to adoption. No meaningful concessions were won. The Sustainable Growth Rate fix never came.

Moreover, even if the SGR fix does come, going forward, the Independent Payment Advisory Board (IPAB) has been empowered to undercut it, eventually and with impunity. IPAB cuts to physicians will begin in 2015, but initial modest reductions will give way to potential major slashing by 2019. CMS is already attacking urology payments, independent of any SGR cuts, by simply redesignating the RVU values of many of our bread and butter office procedures. In fact, starting in 2012, urologists will see a 30 percent to 35 percent reduction in payment for common office procedures, the lifeblood of a urology practice.

The IPAB is charged with finding $500 billion in cuts from Medicare. Given that under the new law, brand name biotech drugs have 12 years of protection from generic competitors; there is a 50 percent discount mandated for Medicare patients in the donut hole but there are federal subsidies, more patients, and pharma sets prices to be discounted from; there can be no importing of cheaper drugs; and Medicare price negotiations will not occur, it seems clear that the “savings” are not coming from pharma. That leaves physicians, hospitals, and surgery centers squarely in IPAB’s crosshairs.

The provisions in the legislation pertaining to tort reform are a real non-starter. Fifty-three million dollars has been earmarked for tort reform demonstration projects. Fifty-three million out of a 1 trillion dollar bill? As my teenage son would say, “Really? Wow, really?!” Trial lawyers spent 220 million dollars compared to medicine’s 96 million dollars in lobbying efforts. Do the math.
The AUA, along with all major surgical specialty societies, representing 240,000 surgical specialist physicians (certainly a huge chunk of the 750,000 practicing physicians in the U.S.), signed onto a formal letter of opposition to the legislation. I never heard that mentioned in any significant media outlet. Hardly anyone appreciates that the AUA or the ASA opposed the legislation. All anyone knows is that the AMA, (against the will of its own House of Delegates Resolution #203), supported the legislation at every step. Perhaps the prospect of more focus on primary care has been alluring to some physicians out there. Granted, there is a shortage of primary care doctors, but already we are witnessing a shortage of surgical specialists as well, especially in Urology. The plight of primary care doctors has been used repeatedly and extensively as a rallying cry to press for the reform of a broken system, while specialists have been vilified by finding the worst apples in the basket and focusing in on their worm holes.

So, now it is high time for the specialists of America to get into the game. We can start a trend that can spread across specialties and ultimately bring repeal. Legislators were clubbed into submission by Speaker Pelosi and President Obama, but they still fear the electorate. We physicians are in a unique position to influence the electorate because ultimately we are the “experts” on healthcare in the eyes of our patients. They repeatedly ask us, “What do you think about the healthcare reform legislation?” and most of us don’t really know what to say. However, whatever we do say, they take as the most authoritative thing that they’ve heard—“straight from the horse’s mouth,” if you will. We physicians, more than any pundit, more than any politician, can sway the opinion of our own patients regarding this new law. I have publicly proposed to the AUA legislative leadership that we immediately craft carefully vetted talking points that are easy for both urologists and their patients to understand, and which make a clear and succinct case for the disastrous nature of this legislation. Furthermore, I requested that they craft a letter, again one that is easy to understand, that could be distributed to patients to sign and to forward to their legislators, calling for repeal of this legislation. Whether a physician or a patient is a Democrat or a Republican, the flaws in the legislation are equally grave. Calling for repeal of the legislation does not in itself mean that we are calling for a legislative turnover from Democrats to Republicans. Because the AUA opposed this legislation, such a proactive move is not in any way radical or “out there,” but instead is consummately professional and consistent with our own professional medical organization’s publicly expressed sentiment. This is true for all the surgical specialty societies that signed on to our formal letter of opposition.
The time for action is now. The majority of patients, and sadly the vast majority of urologists, has absolutely no idea what this legislation really does. We must rapidly educate and mobilize urologists, and then do the same for their patients. This approach will catch on in other specialties. If there are almost 750,000 doctors and only half agree with this sentiment, then there are 375,000 doctors influencing on average 300 new patients or more a year each. If only half of these patients agree, that’s still 42 million voters! That’s a tremendous potential for a grassroots tidal wave—so much greater than the Tea Party or any other force out there now. I urge all specialty society legislative staffers to put together talking points and letters as soon as possible. Let’s get this flawed legislation repealed, and then let’s move forward with a plan that is thoughtful and rational and not an amendment to a housing bill!

I saw a poignant presentation by a general surgery resident at UAB: http://www.vimeo.com/11378278. Contained within it is a quote from the 1957 novel by Ayn Rand, Atlas Shrugged. The quote is from a character named Dr. Hendricks, who retired from Neurosurgery when the healthcare system became nationalized:

"I quit when medicine was placed under State control, some years ago," said Dr. Hendricks. "Do you know what it takes to perform a brain operation? Do you know the kind of skill it demands, and the years of passionate, merciless, excruciating devotion that go to acquire that skill? That was what I would not place at the disposal of men whose sole qualification to rule me was their capacity to spout the fraudulent generalities that got them elected to the privilege of enforcing their wishes at the point of a gun. I would not let them dictate the purpose for which my years of study had been spent, or the conditions of my work, or my choice of patients, or the amount of my reward. I observed that in all the discussions that preceded the enslavement of medicine, men discussed everything—except the desires of the doctors. Men considered only the ‘welfare’ of the patients, with no thought for those who were to provide it. That a doctor should have any right, desire or choice in the matter was regarded as irrelevant selfishness; his is not to choose, they said, only ‘to serve.’ That a man who’s willing to work under compulsion is too dangerous a brute to entrust with a job in the stockyards—never occurred to those who proposed to help the sick by making life impossible for the healthy. I have often wondered at the smugness with which people assert their right to enslave me, to control my work, to force my will, to violate my conscience, to stifle my mind—yet what is it that they expect to depend on, when they lie on an operating table under my hands? Their moral code has taught them to believe that it is safe to rely on the virtue of their victims. Well, that is the virtue I have withdrawn. Let them discover the kind of doctors that their system will now produce."
Let them discover, in their operating rooms and hospital wards, that it is not safe to place their lives in the hands of a man whose life they have throttled. It is not safe, if he is the sort of a man who resents it—and still less safe, if he is the sort who doesn’t.

Let’s hope this remains a work of fiction and not a prophecy.

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Letter from ASA to The Honorable Nancy Pelosi

March 19, 2010
The Honorable Nancy Pelosi
Speaker, U.S. House of Representatives
H-232 The Capitol Building
Washington, DC 20515

Dear Madam Speaker:

On behalf of the more than 240,000 surgeons and anesthesiologists we represent and the millions of surgical patients we treat each year, the undersigned organizations are committed to meaningful health reform that will make affordable, quality health care more accessible to all Americans. Our organizations have consistently stated that the health care reform package must be built on a solid foundation and in the best interest of our patients. Unfortunately, the Senate-passed Patient Protection and Affordable Care Act of 2009 (PPACA, H.R. 3590) fails to build such a foundation, and it falls short when considering the needs of our patients. As a result, we are opposed to H.R. 3590.

Over the past year and a half, we have regularly communicated with Congress regarding our concerns such as the creation of the unelected, unaccountable Independent Payment Advisory Board (IPAB), the failure to repeal the sustainable growth rate (SGR) and implement a new Medicare payment system, and other provisions in H.R. 3590. Following the release of the Patient Protection and Affordable Care Act of 2009 last November, our organizations were left with no choice but to oppose H.R. 3590, and we clearly conveyed our disappointment to Senate Majority Leader Harry Reid in December. Our opposition was also shared with House leadership and the House Committees of jurisdiction. Likewise, our organizations sent a February 19 letter to the President expressing our continued concerns with H.R. 3590. Finally, this letter to the President was also followed by a March 12 letter to you outlining our concerns and the reasons for our opposition to H.R. 3590. In spite of our considerable effort to share our concerns, our fundamental concerns remain unaddressed.
The surgical coalition remains committed to the passage of meaningful and comprehensive health reform that preserves and improve Americans’ ability to access high quality surgical care and health care services. It is this commitment that requires the surgical coalition to oppose a bill that would undermine quality and threaten patient access to surgical care.

Sincerely,

American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Ophthalmology
American Academy of Otolaryngology-Head and Neck Surgery
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Congress of Obstetricians and Gynecologists
American College of Osteopathic Surgeons
American College of Surgeons
American Osteopathic Academy of Orthopedics
American Pediatric Surgical Association
American Urological Association
American Society of Breast Surgeons
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Colon and Rectal Surgeons
American Society for Metabolic & Bariatric Surgery
American Society of Plastic Surgeons
Congress of Neurological Surgeons
Eastern Association for the Surgery of Trauma
Society for Vascular Surgery
Society of American Gastrointestinal and Endoscopic Surgeons
Society of Gynecologic Oncologists
Society of Surgical Oncology

(http://www.asahq.org/Washington/SS_HR3590FINAL.pdf.)

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Have You Changed your E-mail Address Lately?

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Pediatric Anesthesia CME Program

Module 1

Module 1 of CSA’s Pediatric Anesthesia CME Program appears in this issue of the Bulletin; this is the first module of this program which will consist of four modules. One module will appear in each issue of the CSA Bulletin consecutively. To receive CME credit, submit your registration page, answers to the questions, and evaluation to the CSA office. Your CME certificate will be mailed to you. Alternatively, the full text of each module will be accessible through the CSA Website, www.csahq.org, in the Online CME Program section. Instructions to complete Module 1 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.

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The following Important Information about Critical Care Module 1 must be read and acknowledged before proceeding to the rest of the module. Check the acknowledgement box on the registration page.

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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 activity. In addition, speakers must disclose when a product is not labeled for the use under discussion or when a product is still investigational.

Tae W. Kim, M.D., FAAP (author of Module 1)
Clinical Associate
The Johns Hopkins Medical Institutions
The Johns Hopkins Hospital

Dr. Kim 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, California, 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.
Registration/Instructions

Method of Participation: The physician will read and study the materials and complete a quiz and an evaluation of the module. Some modules may have slides available online. To register for and complete this module: Complete the registration page, complete the test questions and the evaluation that can be found after the article, and submit your quiz to the CSA office by mail or fax (650-345-3269). Your CME certificate will be mailed to you.

Estimated Time to Complete the Module: One hour

Please check the box on the registration page to acknowledge that you have read everything in these introductory pages.

Availability

Module 1: Sickle Cell Disease

Release Date: June 30, 2010
Expiration Date: June 30, 2013

CME Sponsor/Accreditation

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 critical care program for a maximum of 4 AMA PRA Category 1 Credit(s)™. The program consists of four modules with one credit per module. Physicians should claim credits commensurate with the extent of their participation in the activity.

Fees, Target Audience, Evaluation

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Objectives

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

- Discuss sickle cell disease and its medical management
- Cite relevant studies regarding sickle cell patients and anesthesia
- Develop an anesthetic plan for the perioperative management of a sickle cell patient
- Recognize limitations in anesthetic management

* * * * *

Sickle Cell Disease

By Tae W. Kim, M.D., FAAP
Clinical Associate, The Johns Hopkins Medical Institutions

Prior to his current position, Dr. Kim was in practice for 14 years, the last 11 years of which were at Texas Children’s Hospital, reaching the rank of Associate Professor at Baylor College of Medicine. His academic interests have been divided between the study of sickle cell disease and anesthesia and malignant hyperthermia. He has presented an ASA Refresher Course on sickle cell disease. He serves as a Hotline Consultant for the Malignant Hyperthermia Association of the U.S. Dr. Kim is a member of the ASA Committees on Pediatric Anesthesia and Standards and Practice Parameters and a member of the Society for Pediatric Anesthesia Sickle Cell Interest Group.

Introduction

Sickle cell disease is a medical condition that is commonly recognized, but its anesthetic implications are not generally familiar to most anesthesiologists. The population at risk extends beyond African Americans and includes people from the Mediterranean countries, Africa, the Middle East and the Asian Subcontinent.1 In addition, the mobile nature of today’s world and the increasing number of cross-cultural marriages enables this autosomal recessive disease to easily spread to other parts of the world and increases the probability of caring for someone afflicted with this disease among descendants of families from these regions.1 In the United States, one in 500 African Americans has sickle cell disease, while one in 12 is a carrier for the disease and one in 36,000 Hispanic Americans has the disease according to the Centers for Disease Control.*

The basic biochemical defect lies in the substitution of thymine for adenine on chromosome 11, resulting in a substitution of valine for glutamic acid on the

sixth position of the β-globin gene. This alteration leads to an unstable β-globin chain. Hemoglobin is comprised of two α-globin chains and two β-globin chains. Under stressful conditions, the hemoglobin chain may polymerize and form tactoids leading to distortion of the red blood cell into a sickle shape. The pathophysiology of sickle cell disease centers around the abnormal red blood cell or sickle cell, resulting from a gene mutation, and the vasculopathy associated with the constant sickling and hemolysis. The term sickle cell disease encompasses many of the genotypes of the disease, such as SS, SC, SE, Sβthalassemia and Sβ+thalassemia. However, sickle cell disease classically is defined as the homozygous state of having two sickle cell genes or SS. This designation signifies SS hemoglobin concentration ranging from more than 80 percent up to 95 percent.

The conformational changes induced by exposure to low oxygen and pH states as the cell traverses the circulatory system result in increased fragility of the cell membrane. The sickle cell has a finite capacity to undergo reversible sickling, until the cell membrane loses its elasticity. The cell may rupture releasing iron, hemoglobin and arginase. Iron is irritating to the vessel endothelium and may cause a local inflammatory response. In addition, hemoglobin and arginase are known scavengers of nitric oxide, which plays a role in maintaining normal vascular tone and patency. The result is increased predisposition to thrombus formation, further sickling, ischemia and pain.

Early detection of hemoglobinopathies is achieved through neonatal screening programs routinely performed in all states, as well as prenatal screening using DNA analysis of samples from chorionic villi, amniocentesis and fetal blood sampling. Screening is performed by hemoglobin electrophoresis, and more sensitive tests are conducted using isoelectric focusing and high performance liquid chromatography. Identification of newborns allows for early treatment to minimize the morbidity and mortality associated with sickle cell disease. A preoperative screening program to identify at-risk patients with unknown sickle cell disease status, however, has not proven as beneficial. A study conducted by Crawford et al. preoperatively screened 1,906 children of African ancestry at the Hospital for Sick Children, Toronto, regardless of their health, family history, or the planned procedure. Of those screened, only one asymptomatic child with undiagnosed sickle cell disease and a negative family history was identified. The conclusion of their study was to recommend selective screening of individual patients.

Sickle cell disease patients periodically experience what is referred to as a sickle crisis. There are four types of sickle crises: vaso-occlusive, sequestration, aplastic, and hemolytic. The severity of the disease is based on the age of onset and the frequency and duration of sickle cell crises. The most chronic
and debilitating symptom of the disease is pain, resulting from the ischemia induced by thrombus formation and vasospasm. A major complication is acute chest syndrome, which is defined by the constellation of pain, fever, respiratory distress and new chest radiographic findings, and which accounts for 25 percent of sickle cell deaths. 2, 7, 8

Medical management of sickle cell disease is targeted at reducing the occurrence of sickle cell crises by addressing key inciting events such as infections and inflammatory conditions. Sickle cell patients represent a subset of patients considered immunocompromised by the loss of their spleen, either from a splenectomy or autoinfarction, prior to seven years of age. 9, 10 This immunocompromised state makes them vulnerable to infections from encapsulated bacterium, such as pneumococcus. 1 Preventative medical care begins with early identification and prophylaxis against infection. Children at risk for sickle cell disease begin a regimen of daily antibiotics, typically penicillin, beginning at the age of two months until five years of age. In addition, a strict schedule of vaccinations is emphasized for the life of the individual.

The treatment for sickle cell disease patients ranges from conservative measures to more radical therapy. Many sickle cell patients benefit from supplemental oxygen, intravenous fluid hydration and pain management. Antibiotic therapy is instituted when indicated based on the findings of cultures. Blood transfusions are for more specific indications, such as an aplastic crisis or hemolytic crisis. Many patients on a chronic transfusion regimen have suffered from alloimmunization (making crossmatching difficult) and hemochromatosis. 11 Patients requiring frequent blood transfusions are therefore placed on an iron chelating medication such as deferoxamine or deferasirox. Bone marrow or stem cell transplantation has been attempted in patients, who are matched to suitable donors, and gene therapy holds promise to address the sickle cell defect in the future.

Preoperative evaluation of sickle cell patients should focus on their history of sickle crisis, past treatment, current therapy and comorbidities. The most common age group to suffer painful sickle crises is between 20 to 40 years of age with the most severe forms being acute chest syndrome, cerebrovascular accidents and priapism. 10 Those individuals suffering three or more episodes a year have an increased risk of death. 10

The history of blood transfusions is especially important in determining whether the patient is in optimal condition. The life span of normal red blood cells is 120 days. In contrast to normal red blood cells, sickle cells have a life span of approximately 15 days. The knowledge of a blood transfusion within the past month may indicate that the percentage of sickle cells may be significantly
lower, and therefore the probability of a sickle crisis reduced under the stress of surgery and anesthesia. The importance of reducing the percentage of sickle hemoglobin through a blood transfusion was validated by a study looking at sickle cell patients undergoing cholecystectomies. Haberkern et al. enrolled 364 sickle cell patients into four groups based on whether the patient was randomized, received a blood transfusion or no blood transfusion. The group with the highest incidence of sickle cell events (32 percent) was the non-transfused group. An alternative approach to blood transfusions has been to stimulate the production of fetal hemoglobin. The increased production of fetal hemoglobin has shown a significant amelioration of sickle cell complications with the reduction of sickle hemoglobin to less than 85%. This is the premise of hydroxyurea therapy, which stimulates the production of fetal hemoglobin with a target of 15 percent to 20 percent.

The role of blood transfusions in the perioperative management of sickle cell patients is highly dependent on the indications for a blood transfusion. The traditional approach to a preoperative blood transfusion was an aggressive transfusion to reduce the proportion of sickle cells to ≤30 percent and raise the hemoglobin to 10 gm/dL. However, a study by Vichinsky et al. demonstrated a simple blood transfusion to raise the hemoglobin to 10 gm/dL was as effective as an aggressive transfusion in preventing perioperative complications. This conservative approach was found to have less transfusion related complications. Also, studies comparing the complexity and location of surgery and the indications for blood transfusion found transfusions in minor operations, such as placement of ear tubes, to be unnecessary, while operations posing a greater risk—intrathoracic, neurologic, orthopedic or laparoscopic surgery—necessitated a reduced sickle hemoglobin concentration to avoid perioperative complications.

Sickle cell patients must be evaluated for co-morbid conditions. Beyond the chronic anemia ranging from 6-9 gm/dL, the cardiopulmonary system is affected by repeated episodes of sickling in the microvasculature or development of hemochromatosis, and therefore, the patient may manifest decreased cardiac function, elevated pulmonary pressures and poor gas exchange. In addition, the hepatorenal system may be affected by the development of cirrhosis—whether from hemochromatosis, blood borne infection or intravascular sickling—and renal dysfunction resulting from intramedullary sickling and papillary necrosis. Central nervous system involvement may present as transient ischemic attacks or a more severe cerebrovascular accident and its consequent neurologic deficits.

Laboratory studies should be based on a thorough examination of the patient and the anticipated operation. A minimalist approach for a simple, routine
operation, such as exam under anesthesia, myringotomies and tube insertion, would be to order a complete blood count. More complex procedures, such as a laparoscopic cholecystectomy, may additionally require a recent hemoglobin electrophoresis or documentation of a blood transfusion. A type and cross for blood should be ordered in advance of the operation to allow for identification of compatible blood as the sickle cell patient may have developed multiple antibodies.

Preoperative NPO orders must be timed to minimize the risk of significant dehydration. The treatment protocol of the Preoperative Transfusion in Sickle Cell Disease Study Group required at least eight hours of preoperative fluid hydration. Although there are no formal guidelines, many studies have referred to preoperative hydration, preoperative intravenous fluid hydration at 1.5 times the fluid maintenance rate or encouraged oral fluid intake up to two to four hours prior to surgery. The emphasis placed on preoperative hydration is to minimize the proportional increase in sickle hemoglobin and the propensity for sickling as a result of cellular dehydration, as well as to counterbalance the effect on blood pressure from vasodilatation. The intraoperative management of sickle cell patients centers on providing a stress free anesthetic technique. In one study looking at 4,000 patients undergoing more than 1,000 surgical procedures, it was found that more complications occurred in the sickle cell patients undergoing a regional anesthetic technique compared to a general anesthetic technique. The goal is to avoid hypoxemia, hypovolemia, hypothermia and hydrogen ion accumulation (4 “H’s”). Oxygen consumption increases 400 percent when shivering; therefore, it is important to maintain a neutral thermal environment to minimize the body’s metabolic response in order to promote thermogenesis. Warming of intravenous fluids may also help to achieve and/or maintain normothermia. Hyperosmolar solutions, such as intravenous contrast may pose a risk of cellular dehydration of sickle cells. Blood pressure cuffs are capable of producing a tourniquet effect and must be carefully applied to minimize the risk of this side effect. The reduction or interruption of blood flow may be enough to trigger localized sickling, which could initiate a cascade effect throughout the body with the release of the tourniquet. The time interval of inflation of the blood pressure cuff should be adjusted based on the needs of the operation. Positioning and padding is important to minimize the development of venous stasis and resultant ischemia. Sickle cell patients are more at risk for peripheral neuropathies secondary to ischemia associated with sickling.

The use of tourniquets in the sickle cell population has not been validated as a safe technique. The routine use of a tourniquet for placing an intravenous catheter has not been controversial. However, the use of tourniquets to aid in a peripheral nerve block or especially for use in the operative technique has

Sickle Cell Disease (cont’d)
been a topic of debate. There are no prospective randomized trials to confirm the safety of this practice. There are case reports and case series of the successful use of tourniquets in sickle cell disease patients without any perioperative complications, such as acute chest syndrome or pain.25, 26, 27, 28 Many of these patients were from the Middle East, where those affected by sickle cell disease often have a higher percentage of fetal hemoglobin into their adulthood. In addition, many were preoperatively transfused to reduce the level of sickle hemoglobin and were closely monitored.

Vigilance in the care of the sickle cell patient should be carried into the postoperative period. Postoperative pain management may be challenging, especially when caring for individuals with chronic pain. Early intervention is needed to avoid the increased oxygen demands associated with pain-related increased sympathetic activation and release of endogenous catecholamines. Pain out of proportion to the patient’s operative experience may signal the onset of a vaso-occlusive crisis. This requires immediate therapy with supplemental oxygen, continued intravenous hydration and pain medication. The decision for transfusion of blood should be based on consultation with the patient’s hematologist. Acute chest syndrome has an incidence of 10 percent to 15 percent in association with intra-abdominal and joint replacement surgery.3, 4, 7, 8 This requires immediate attention, because the mortality rate is between 2 percent to 12 percent and accounts for 25 percent of deaths in sickle cell patients.3, 7, 8

The best practice for anesthetic management of sickle cell patients having obstetric, cardiac and neurosurgical procedures is not well defined because of a lack of prospective randomized clinical trials. The obstetric sickle cell patient represents a high risk for complications related to pregnancy, including hypertension, preterm labor, and small-for-gestational-age baby.29 In the most recent retrospective study of 55 pregnant women, general anesthesia was identified as a risk factor for postnatal sickling complications, which include acute chest syndrome, vaso-occlusive crisis and stroke.30 The findings of this study run counter to the previously cited study for all-comers with surgical procedures that found regional anesthesia to be associated with a higher incidence of complications.17 In both studies, however, the authors emphasize that the key to a well managed anesthetic is to avoid the inciting events of hypothermia, hypoxemia, hypovolemia, acidosis and hypotension.

The management of cardiac and neurosurgical patients is based mainly on case reports and case series. It traditionally has been taught to reduce the level of sickle hemoglobin to ≤ 5%.2 The timing of such hemoglobin reduction in patients undergoing cardiac surgery is anecdotally reported, based on clinical experience with some patients receiving preoperative transfusions, while others
have been allowed to go on bypass with the expectation that the pump prime will help dilute the sickle hemoglobin concentration and preferentially filter out the sickled cells. In a more recent case series, three patients aged three weeks, three months and 18 months old underwent surgery for congenital heart disease using cardiopulmonary bypass without preoperative blood transfusion and with sickle hemoglobin concentrations ranging from 10.9 percent to 38.8 percent. The children did well and the post bypass hemoglobin S concentration ranged from 4 percent to 14 percent. There also have been case reports where sickle cell patients have undergone successful cardiac surgery without a blood transfusion. However, the lack of level one evidence for a safe limit of sickle hemoglobin makes it difficult to provide level A recommendations for managing the care of these critically ill patients.

The care of sickle cell patients at high risk for a catastrophic neurologic event has continued to evolve with clinical research. Early recognition of this risk resulted in the Stroke Prevention in Sickle Cell Anemia (STOP) Trial, which recommended screening programs to detect abnormal flow velocity using transcranial Doppler ultrasonography. A time-averaged mean blood-flow velocity $\geq 200$ cm/sec in the internal carotid or middle cerebral artery qualified the child to be enrolled in a study regimen involving blood transfusions to reduce the hemoglobin S concentration below 30 percent. A follow-up study (STOP II) to determine how long blood transfusions are required for primary stroke prevention revealed that cessation of blood transfusions after 30 months was associated with debilitating neurologic complications. Another clinical trial to determine how to wean pediatric sickle cell patients off a chronic transfusion regimen is The Stroke with Transfusions Changing to Hydroxyurea (SWiTCH) trial. The increase in fetal hemoglobin to $\geq 15$ percent is thought to reduce the incidence of complications related to the homozygous disease state.

The acceptable hemoglobin S concentration for neurosurgery has not been established. In one review article there was a report of a sickle cell patient undergoing neurosurgery without a blood transfusion. However, based on the literature on cerebrovascular disease in sickle cell patients, a blood transfusion to reduce the hemoglobin S concentration $\leq 30$ percent with a hemoglobin around 10 gm/dL appears to be commonly accepted as safe practice. The choice of anesthetic technique is less important than the avoidance of those events that precipitate a sickle cell crisis. There have been conflicting retrospective studies examining anesthesia techniques for patients undergoing surgery for moyamoya disease. Therefore, the focus of anesthetic management should be placed on the avoidance of inciting events for sickle cell related complications.
Sickle Cell Disease (cont’d)

In summary, the anesthetic management of sickle cell patients presenting for surgery requires careful planning prior to the day of surgery. Early consultation with the patient’s hematologist can provide a clear understanding of the patient’s sickle cell status, comorbidities, medical therapy and especially the history of blood transfusions. The avoidance of inciting factors: hypoxemia, hypovolemia, hypotension, hydrogen ion accumulation and hypothermia is key to reducing the risk of perioperative complications. Preoperative hydration, whether orally or intravenously, is important to minimize the risk of sickling. The administration of a blood transfusion should be based on the patient’s medical condition, surgical procedure and anesthetic plan. Retrospective studies on anesthetic technique are inconclusive; however, the common element in the studies has been to avoid inciting factors for sickling. Perioperative complications can occur in the post anesthesia care unit and therefore require vigilance on the part of the nursing team and anesthesiologists to recognize and identify complications associated with sickle cell disease, and to aggressively treat any early signs or symptoms related to a sickle cell crisis.

References


Sickle Cell Disease (cont’d)


Pediatric Anesthesia Module 1 — Sickle Cell Disease
The first module in the Pediatric Anesthesia Bulletin and Online CME Program is now available in this issue. You may do the module by taking the assessment and faxing a copy to the CSA office at 650-345-3691, or you may go online and take the module in the Online CME section of the CSA Website (http://www.csahq.org).
Sickle Cell Disease (cont’d)

Questions

1. Sickle cell disease (SS) affects:
   a. Only African Americans
   b. Only males from the Mediterranean region
   c. 50 percent of offspring when both parents are genotypically AS
   d. Individuals possessing a point mutation on chromosome 11

2. The sickle shape of red blood cells results from:
   a. Conformational change due to polymerization of sickle hemoglobin
   b. Substitution of glutamic acid for valine on the globin chain
   c. Release of arginase
   d. Decrease serum osmolality

3. The earliest time to test for sickle cell disease in the baby is:
   a. Immediately after delivery using umbilical cord blood
   b. After the transition from fetal hemoglobin to adult hemoglobin
   c. In utero by chorionic villus sampling
   d. After a blood transfusion

4. Individuals with sickle cell disease require a daily regimen of penicillin because:
   a. They are at risk for infection from encapsulated bacterium
   b. They are at an increased risk for bacterial endocarditis
   c. They are at increased risk for viral infections
   d. Penicillin reduces the incidence of renal dysfunction

5. The most severe sequelae from a sickle crisis is:
   a. Acute chest syndrome, osteomyelitis, cholecystitis
   b. Cerebrovascular accident, nephrocalcinosis, osteomyelitis
   c. Acute chest syndrome, cerebrovascular accident, priapism
   d. Acute chest syndrome, cerebrovascular accident, cholelithiasis

6. Acute chest syndrome:
   a. Is a major cause of death in sickle cell patients
   b. Affects only those sickle cell patients with asthma
   c. Is associated with sinus surgery
   d. Occurs after a blood transfusion

7. The STOP II trial:
   a. Demonstrated the efficacy of a conservative transfusion therapy on a routine basis
   b. Demonstrated the continued need for blood transfusion therapy to reduce the recurrence of neurologic events
   c. Demonstrated the benefits of a simple transfusion
   d. Demonstrated sickle cell patients with a transcranial Doppler flow of greater than 200 cm/sec could be safely withdrawn from receiving blood
8. Pre-operative fluid hydration:
   a. Requires pre-admission for intravenous fluid therapy overnight
   b. Allows liberal oral fluid intake until the time of surgery
   c. Increases serum osmolality
   d. Minimizes cellular dehydration and the propensity for red blood cells to sickle

9. Retrospective studies on pre-operative blood transfusions showed:
   a. A simple blood transfusion to 10 gm/dL was superior compared to an aggressive
      transfusion protocol with reduction of sickle hemoglobin to below 30 percent and 10 gm/dL.
   b. The perioperative sickle cell complications were similar in both transfusion groups
   c. Transfused red blood cells have a short half-life of 30 days
   d. No harmful effects beyond 10 gm/dL

10. Retrospective studies have shown:
    a. No conclusive benefit of general over regional anesthesia and vice-versa
    b. Regional anesthesia was an independent risk factor for postnatal complications
    c. Patients for cardiac surgery and bypass require hemoglobin S values below
        5 percent to ensure a safe anesthetic
    d. Obstetrical sickle cell mothers have the same risks as a non-sickle cell mother

11. The use of surgical tourniquets:
    a. Has been validated with prospective, randomized control trials
    b. Is limited to use in Middle Eastern people only
    c. Isolates the extremity and therefore eliminates the need for a blood transfusion
    d. Has yet to be validated as a safe anesthetic technique in sickle cell patients

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**Evaluation of Module 8**

As part of the CSA Educational Programs Division's ongoing efforts to offer
continuing medical education, the following evaluation of this program is
requested. This is a useful tool for the EPD in preparing future CME programs.

1. How well were the learning objectives of this program met?
   - Very Well 5
   - Above Average 4
   - Average 3
   - Below Average 2
   - Not Well at All 1

2. How relevant was the information in this program to your clinical practice?
   - Very Relevant 5
   - Above Average 4
   - Average 3
   - Below Average 2
   - Not Relevant 1

3. How would you rate this program overall?
   - Excellent 5
   - Above Average 4
   - Average 3
   - Below Average 2
   - Poor 1

4. Did you detect any commercial bias in this module? Yes No
Registration

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

Pediatric Anesthesia CME Course, Module 1
Available June 30, 2010, to June 30, 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 that I have read the Important Information about Module 1.
On May 26, 1928, Ralph Waters wrote a letter to Arthur Guedel with the comment that Guedel should not write a book about something that he could not define. In Waters’ own words:

You can’t write a book about something you don’t know what is. You don’t know what is anesthesia. Therefore I’m sending you a definition: “Anesthesia is the reduction of reflex irritability to such a point as to make a required piece of surgery possible without pain or annoyance to the patient. Although Novocain may completely relieve pain, unless it is accompanied by sufficient mental sedation for that patient is not anesthesia. If the surgery can be done by mental suggestion or hypnotism, these measures for that case and patient are anesthesia.”

Guedel answered Waters’ letter within one week. As Guedel’s correspondence often did, the letter contained abundant speculation about a number of subjects. He did not expand upon the subject of “what is anesthesia.” Guedel was a practical man and seemed to be mostly concerned about actually giving anesthetics rather than thinking about what the word meant. In the early days of anesthesia it was not easy to find paid work. In his diaries he notes that he often provided anesthetics without pay (Figure 1), simply because he enjoyed the work and apparently was gratified by his results.

![Figure 1](image.png)

Figure 1. Excerpt from one of Guedel’s written diaries, undated. It is apparent that he was not puzzled by the questions that Waters had raised, but was concerned about developing a remunerative practice. The note confirms that Guedel brought not only his anesthetic apparatus (see Figure 2) but also the anesthetic agents. Courtesy of the Guedel Anesthesia History Museum.
The word “anesthesia” has a long history. It was used by several early Latin, Greek, and Islamic authors including Plato, Aristotle, Epicurus, Demosthenes, Galen, Hippocrates, and Avicenna. The common meaning was to signify insensitivity of any body part to touch. The Roman physician Dioscorides Pedanius was the first to use the word “anesthesia” in the context of drug-induced loss of sensation. His book entitled *de Materia Medica*, written in the first century of the Common Era, was translated into Arabic where it survived the dark ages, and then reappeared in the western medical literature in the 14th century.

Oliver Wendell Holmes chose the word “anesthesia” to describe the phenomenon that occurred on October 16, 1846, when William Thomas Green Morton delivered ether vapor to Gilbert Abbott while the surgeon John Collins Warren excised a vascular tumor of Abbott’s neck. By 1928 anesthesia providers had discovered new methods for allowing surgery to proceed without discomfort, which included spinal anesthesia and peripheral nerve blocks. Waters’ new description of anesthesia thus included regional anesthetics and hypnosis. He proposed that a regional anesthetic without adequate anxyolysis for that particular patient should not be labeled anesthesia.

Although Waters could not have predicted the variety of agents that are currently available, his definition is broad enough to include low dose ketamine, dexmedetomidine, neuroleptic agents, lidocaine infusions, monitored anesthesia care, and other methods where the patients are not always asleep but the surgery can proceed without annoying them. It would also include anesthetic techniques such as low concentration epidural anesthesia for labor and delivery, during which sensation is not usually totally lost but the labor proceeds without annoying the laboring mother.

In 1928, Waters and Guedel were giving anesthetics without intravenous access and this limited the interventions they could make. Muscle relaxants were 12 years into the future and surgical stress was not treated with opioids or adrenergic antagonists for another 40 years. The concept of anesthesia as a triad of components consisting of hypnosis, analgesia, and muscular relaxation was introduced in the 1950s. Our ability to maintain hemodynamic stability and provide muscular relaxation does allow the surgeon to “make a required piece of surgery possible” so Waters’ definition still applies with these added features.

A trend is underway that will eventually make Waters’ definition inadequate to explain what we do when we administer an anesthetic. Read the following conversation that would be consistent with Waters’ definition and consider whether you agree with it. Here we have the 1960 postoperative interview:
“Good morning, I’m Doctor X and I provided your anesthetic. How are you doing?”

“Good morning Doctor, yes, I’m okay. Your anesthetic was fine.”

“Excellent. Did you have any sickness, fatigue, or pain?”

“Yes, the pain has been nearly intolerable and I have been nauseated and I vomited twice.”

“Sorry to hear about that, but I am happy to hear that you were satisfied with the anesthetic.”

“Yes, doctor, your part did not annoy me at all. I expected to have pain, weakness, and sickness; after all, I had a major operation.”

One might ask why we would ever desire to move away from this paradigm. It was simple and uncomplicated, and everyone understood what the anesthetic was. For these reasons, it is likely that a large percentage of anesthesia practitioners even today conduct their practice in this manner. Nevertheless, within the past 50 years, there has been a trend toward expanding the concept of anesthesia into the postoperative period. The reason for taking on this added responsibility is that we have learned that patients want it. The problem today is not so much whether we should take on this responsibility, but rather how we are supposed to be paid for doing it. In many ways our predicament is similar to that expressed by Guedel 100 years ago: It is rewarding work but a fiscal disaster.

This concept of anesthesia has had a slow evolution and it is still underway. During the era of Waters and Guedel, the surgeons would manage every aspect of the postoperative period, including the analgesics. Guedel was traveling between hospitals each day to provide anesthetics for specific surgeries. He was usually on his way to another appointment once the patient had awakened. Accordingly, he was not concerned about postoperative problems and so the surgeon dealt with them.

Recovery rooms were introduced in the 1950s and the issues that occurred there became part of the anesthetic, insofar as the nurses would look to the anesthesia practitioners to manage problems of hypotension, respiratory failure, and pain. In the 1980s acute pain services were introduced and were usually directed by the Anesthesia Departments. This further lengthened the time of involvement of anesthesia practitioners into the first two or three days after the surgical date. The longer-term involvement of the anesthesiologist has slowly progressed during each decade since the mid-twentieth century. As a sign of
One of the methods to improve long-term outcome is to incorporate nerve blocks into the anesthetic and often these are placed before the induction of the “anesthetic.” With this new definition of anesthesia, the patient has to be informed as to the reasons why “block” needles should be part of the anesthetic. Why should they be placed prior to the induction of anesthesia? Why is that part of the anesthetic? Do I have to undergo this extra procedure to have the anesthetic? Clearly, to the anesthesiologist who wants to make available perioperative pain relief and to minimize nausea and vomiting from opioid therapy, the definition of anesthesia needs to be expanded to include the continuation of nerve blocks during the anesthetic and into the first 24 to 48 hours after the operation is finished.

Consequently, what we do no longer fits in with Waters’ definition and does not always fit with what patients think that we can do. Televised documentaries show the simple blow dart anesthetics given to wild animals and some patients think we perform a similar technique on them:

Patient: “Just knock me out, doctor.”

Anesthesiologist: “I think we can do better than that for your case.”

Holmes suggested other words to define the specialty in his letter to Morton: anti-neuric, aneuric, neuro-leptic, neuro-lepsis, and neuro-stasis, but none
of these words fit in with what we are progressing towards. George W. Crile suggested the word “anoci-association,” but that is cumbersome. “Perioperative physician” seems a bit presumptuous because it appears to encroach upon what the surgical team should be doing, like pulling drains and advancing diets, but then again there is more to the peri-operative experience than just the technical aspects of the surgery. We could be called “anocicists” or “anociologists” (root word is nocere, meaning “to do harm”): “I will be your anociologist for the next few days.”

Between the time when Holmes coined the word “anesthesia” and the Waters letter is a span of 82 years. This year (2010) is another 82 years since the quoted Waters letter was sent to Guedel. In the interim it has become apparent that what we mean by an anesthetic has undergone a change during these 82 years. What will our idea of anesthesia be another 82 years from now, in 2092?

Now, with a nimble use of word derivations from languages we no longer speak or read and certainly do not understand, we can move from here to a creative and curiously different perspective on anesthesia. For the moment, just consider this:

“Anesthesia” is a physical condition or state related to “esthesia,” which is defined as the capacity for “feeling” or “sensation,” and the “an” negates it into a “lack of feeling.” “Anesthetic” is a drug used to produce “anesthesia,” and it has as its root “esthetic,” defined (dictionary.com) as “pertaining to a sense of the beautiful,” and thus anesthetics would be drugs employed to produce a loss of a physical sensation or perhaps a loss of the perception of beauty (a non-physical sensation).

Now, in popular culture we label those who perform facials and advise customers on makeup as “estheticians.”

In contemplating this modern usage of the root word esthetics, could we begin to rethink our role into some kind of negation of beauty, e.g., an- (without) -esthesia? Maybe we might someday drop the “an,” or at least produce “esthetic anesthetics,” for then we would also be estheticians of sorts—of the mind, not the face.

Could we develop the anesthetic experience into a beautiful event? We have at our disposal the most potent mind-altering drugs that have ever been devised by the pharmaceutical industry. Anyone who has given anesthetics for several years has had the occasional patient say that the experience was so exhilarating that they would like to return for a repeat session (without the surgery) sometime in the future. This outcome usually comes about through pure luck.
because it is impossible to repeat consistently, given our rudimentary science. Why not strive to provide this service to our surgical patients on a daily basis?

We encounter patients who are at a low point in their life. A cancer or a gallstone requires removal. A hernia or a major joint needs fixing. The surgical experience gives them pain, stress, fatigue, and stomach upset. Could we someday consistently provide these (usually) unhappy patients with an uplifting beautiful anesthetic, free of pain, vomiting, and fatigue? This is one idea for the definition of anesthesia (perhaps renamed perioperative esthesia) in the year 2092.

Plan Now to Attend!

2010
Fall CSA Hawaiian Seminar
November 1-5, 2010

Mauna Lani Bay
Hotel & Bungalows
Kona, Hawaii

http://www.csahq.org/
up-more.php?idx=38
California and National News

**Surgery Centers Fail Infection Control Inspection:**
Little is known about the quality of care at ambulatory surgical centers. Most elements intended to monitor regulatory compliance have been primarily the responsibility of individual states (often by inspectors not trained in infection control), and direct observation has not been federally mandated. “Reporting mechanisms are disjointed and extant quality-related data are sparse, particularly in the realm of postoperative infection.” (Barrie editorial) Furthermore, the incidence of surgical site infection does not appear to be as low as might be predicted, given the relatively “clean” site surgeries performed at ASCs. The published results for ASC infections are “mixed,” but the incidence is likely underreported, especially in light of the poor compliance with voluntary reporting by surgeons of infections, events that usually are diagnosed far beyond the reach of the postoperative time in which ASCs remain in contact with patients. Prompted by the largest reported outbreak of healthcare-associated infections caused by hepatitis C in U.S. history in two now-closed Las Vegas ASCs (as many as 63,000 patients may have been exposed to blood borne pathogens), a recent investigation by the Centers for Disease Control and Prevention’s trained surveyors found exceedingly high rates of breaches of infection control in ASCs in North Carolina, Oklahoma and Maryland. These lapses in infection control included hand washing, wearing surgical gloves, unclean surfaces in patient care areas, unclean handling of glucose meters, reuses of devices intended for single patient use only, and use of single dose vials of medications for multiple patients. Sixty-seven percent of centers had at least one lapse in infection control, and 57 percent were cited for deficiencies. These shockingly unacceptable high figures occurred despite the fact that the healthcare workers in the centers knew that they were being observed by the inspectors! There currently exist 5,200 outpatient centers that perform more than six million procedures and collect $3+ billion per year just from Medicare. Sixty-one percent of ASCs are physician owned and 96 percent are for profit. Moreover, there are many more surgeries performed in physician offices, about which there is even less data than about ASCs. (Summarized from both Shaefer M, Jhung M, Dahl M, et al, *JAMA* 303:2273-2279, 2010, and Barrie P, (editorial) *JAMA* 303:2295-2297, 2010.)

**U.S. Department Of Justice (USDJ) Declares War On Physicians:**
In a strikingly aggressive action against a group of Idaho orthopedists, the USDJ has declared that refusal to accept government price controls for workers compensation (WC) patients is a form of illegal price fixing. The USJD, along with the Idaho Attorney General, also has forced those physicians to accept certain HMO contracts as well as WC fees as part of a settlement. It was alleged that the orthopedists had, through a series of meetings and other communications, agreed to avoid treating most WC patients, and this “boycott” forced the Idaho
Industrial Commission to increase their WC reimbursement rates. In a parallel action, the same “conspiring” group threatened to terminate their contracts with Blue Cross of Idaho if their reimbursement rates did not increase. The Idaho Orthopedic Society and those orthopedists now will not be permitted to agree on fees and contract terms, nor will they collectively be able to deny care to patients, refuse to deal with any payer, or threaten to terminate their contracts with those payers! The key in this case, and what should be frightening to physicians, is that the USDJ has civil and criminal jurisdiction, whereas the Federal Trade Commission, which until now has prosecuted such cases, only has civil and administrative jurisdiction. As the Sherman Antitrust Act does not distinguish between civil and criminal “price fixing,” it becomes the choice of the USDJ as to whether to charge violators with a civil or criminal offense. Assuredly, in this case, the USDJ clearly stated its position that refusal to accept governmental prices controls was tantamount to “price fixing.” Of even more concern to physicians is that the USDJ has linked the governmental WC decrees with a refusal to accept a non-governmental insurance company’s contract offer! It is important to appreciate that this settlement was done under the threat of criminal prosecution by the USDJ, and is not a court ruling with general precedent beyond the facts of this case. See further the articles by Barbara Baldwin, CEO, (p. 15) and Phillip Goldberg, Esq. (p. 18). (Summarized from article by Harez Ghanbari, Christian Science Monitor, May 31, 2010.)

Open Primary Initiative—Proposition 14: California voters approved Proposition 14, which allows voters to choose any candidate in a primary election, regardless of party affiliation, the two top vote-getters facing each other in the general election. This gave Governor Schwarzenegger a rare victory in his stormy seven years in office. Prop. 14 was over the opposition of powerful political opposition from both the Democratic and Republican parties, Congressional Speaker Pelosi, the California Teachers Association and public employee labor groups! The end result hopefully would force contenders to seek votes from all parties, resulting in the election of candidates with broader appeal, and then, a less hyper-partisan legislature. In theory, moderate politicians would gain an advantage because all candidates would have to appeal to voters across a wide spectrum, and therein be more representative of the district as a whole, in contrast to many current races where legislators are elected with less than 10 percent of the voters, a reflection of the breakdown of the two party system. Abel Maldonado, current Lieutenant Governor was most influential in getting Prop 14 onto the ballot. (Summarized from an article in Capitol Weekly, June 8, 2010.)

Big Pharma (Pharmaceutical Research and Manufacturers of America) Is One of Biggest Winners with Health Care Reform Bill: Pharma’s lobby was perhaps the biggest winner in the Congressional health care reform battle: The drug industry managed to fend off price controls and other restrictions, while now licking its chops over the newly added 30+ million previously
uninsured Americans to gain health insurance. Although the law also levied taxes and other costs on these companies valued at tens of billions of dollars, they still anticipate a trajectory of major profits in the future. Importantly, they must provide 50 percent discounts to Medicare beneficiaries who have entered the “doughnut hole” gap in drug coverage, but those discounts plus gradually increasing federal subsidies will equate to more of the elderly purchasing more drugs. Amazingly, Pharma lobbyists defeated proposals to mandate that Medicare negotiate drug prices with them, to permit importation of low-cost drugs, to bar brand-name manufacturers from paying generic companies to delay marketing of competitor drugs, and to mandate rebates from industry for Medicare and Medicaid beneficiaries! Do note, however, that “discounts” are a potential farce as the drug companies still kept the power to set drug prices themselves! Costly brand-name biotechnology drugs, about 15% of pharmaceutical sales, will now have 12 years of protection against generic competitors. Pharma also avoided the expansion of drug discounts to hospitals serving mainly low-income patients. Of note, Pharma paid tens of millions of dollars for advertisements favoring health care reform, donated $1.2 million to the Obama presidential campaign, and increasingly has favored Democrat over Republican candidates in recent campaign contributions. (Summarized from article by Alan Fram, HuffPost Politics, March 29, 2010.)

Two California Physicians Win Primaries for State Assembly: Two of the three physicians running in State Assembly primaries won and could become the only physicians in the State Legislature should they win the general elections. Richard Pan, M.D., a pediatrician, won his primary in the 5th Assembly District (Sacramento). He is well known to CMA and CSA because of his chairing the CMA’s Council on Scientific Affairs. Linda Halderman, M.D., a surgeon, won her race in the 29th AD (Fresno). She, too, is well known to CSA as she has reported on her experiences in American Samoa as a volunteer physician in our Bulletin, and has published many other opinion pieces in other media venues. Unfortunately, Don Kurth, M.D., lost his primary race in the 30th AD (Inland Empire). (From CMA Alert, June 14, 2010.)

Georgia Supreme Court Strikes Down Cap on Medical Malpractice Awards: In a stunning decision, the Georgia Supreme Court unanimously struck down the limits on jury awards in medical malpractice cases, ruling that the $350,000 cap on noneconomic damages violates the right to a jury trial guaranteed by the Georgia’s State Constitution. The Chief Justice stated that the cap “clearly nullifies the jury’s findings of fact regarding damages and thereby undermines the jury’s basic function.” Any such ruling signals the importance of continued support for CMA’s vigilant efforts to protect MICRA. (From the Newsletter of the American College of Physician Executives, March 2010.)
New CSA Members

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

**Active Members**

Angela E. Azar
Minh X. Bui
Catherine B. Chung
Ana M. Crawford
Jason G. DaCosta
Renato V. Etrata
Max Gouron
Matthew J. Haight
Betty A. Helton
Ada T. Hernandez
Jung Hong
Rouzbeh Jahansouz
Ji-Guang Jin
James D. Kim
Kerstin Kolodzie
Artemio J. Largoza
Phillip K. Lau
Tan K. Le
Jason C. Lee
Henry Liang
John L. Lin
Ali D. Morrell-Balanon
John T. Munro
Pedro Orozco
Li Qin
Robert E. Raffel
Barugur S. Ravi
Nicholas A. Riegels
Swapneel K. Shah
Alok Sharma
Daniel Shin
Amy Thomas
Cynthia P. Wang
Dennis Yun

**Resident to Active Members**

Quoc-Chuong Bui
Jessica E. McDermott
John H. Nguyen
Arun Prakash
Susan S. Yoo
Karl Zheng

Maxime Cannesson

**Affiliate Members**

Johnny C. Chen
Amgad H. Hanna
Erica Klaus
Jonathan Li

Bahar A. Mjos
Elena K. Paik
Neil S. Shah
Christopher L. Stalker
Troy Tada
Ryan Young

**Retired Members**

Balveer S. Bhati
Juliet Fliegel
James E. Foster
Leo W. Kwan
Thien Y. Ng
Wayne K. Thorpe
Jordan Waldman
David C. Yang
Mark Your Calendar

2010

Sep 24-25  California Society of Anesthesiologists Board of Directors Meeting
            Marriott, San Mateo, California

Oct 2-4    CMA’s House of Delegates Annual Meeting, Sacramento
            Convention Center, Hyatt and Sheraton Hotels

Oct 16-20  ASA Annual Meeting, San Diego, California

Nov 1-5    2010 CSA Fall Hawaiian Seminar, Mauna Lani Bay
            Hotel and Bungalows, Kona, Hawaii
            http://www.csahq.org/up-more.php?idx=38

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 24-28  2010 CSA Fall Hawaiian Seminar, Grand Hyatt Kauai
            Resort & Spa, Poipu Beach, Kauai
            http://www.csahq.org/up-more.php?idx=41

CSA Web Site  www.csahq.org
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>
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<tr>
<td>2. Edgar D. Canada, M.D. (11)</td>
<td>Jonathan F. Barrow, M.D. (11)</td>
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<td>5. Christine A. Doyle, M.D. (12)</td>
<td>Uday Jain, M.D. (11)</td>
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<td>22. Earl Strum, M.D. (13)</td>
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<td>23. Peter E. Sybert, M.D. (11)</td>
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<td>24. Narendra Trivedi, M.D. (12)</td>
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<td>25. Samuel H. Wald, M.D. (13)</td>
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<td>26. Paul B. Yost, M.D. (12)</td>
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<td>27. Mark I. Zakowski, M.D. (11)</td>
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IN MEMORIAM

Richard L. Applegate, M.D.           Upland, CA
Donald L. Cox, M.D.                  Chino Hills, CA
Nolan W. Cramer, M.D.                Long Beach, CA
Ruben DeLira, M.D.                   San Diego, CA
Edmund G. Duvall, M.D.               Rancho Cucamonga, CA
Walter L. Howell, Jr., M.D.           Northridge, CA
Leonard B. Kaufman, M.D.             Glendale, CA
Chaur K. Lee, M.D.                    Riverside, CA
Marianne C. Link, M.D.               Wilmington, CA
Arthur J. Martinson, M.D.             Alhambra, CA
Frank S. Maruyama, M.D.              Nuevo, CA
Seymour A. Spungin, M.D.             Fallbrook, CA
Robert L. Worthington, M.D.          Danville, CA

Upon notice that a CSA member is deceased, a donation is sent to the Arthur E. Guedel Memorial Anesthesia Center in their memory.
## CSA District Directors and Delegates

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<th>District Director</th>
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CSA Future Meetings

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
CSA Bulletin and CSA Web Site (www.csahq.org)

November 1-5, 2010
CSA Fall Hawaiian Seminar
Mauna Lani Bay Hotel & Bungalows
Kona, Hawaii

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