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Educating Anesthesiologists: Process, Opportunity and Evolution

By Stephen Jackson, M.D., Editor

The CSA Bulletin has always focused on education, intending to communicate an eclectic spectrum of new and relevant information that can enhance both the professional and the personal lives of our readers. We aim to assist CSA members in their quest to fulfill our ethical obligation for lifelong learning, particularly regarding issues of quality of care, patient safety and practice management.

In November, together with fellow Californians Mark Singleton, Stan Stead and Randolph Steadman, I had the opportunity to attend the ASA’s “Educational Summit” (the brainchild of Dr. Arnold Berry, ASA Vice-President for Scientific Affairs), part of the ASA’s first-ever, long-range education planning. I was startled to learn that even though we all recognize the ASA to be a highly credible and effective provider of educational information, there is evidence that it can take as long as 17 years to effect widespread adoption of new practice guidelines! The natural follow-up question to this disquieting “shot across the bow” is: How can the ASA and CSA better deploy their considerable educational resources to inculcate best practices, while concurrently reducing this disturbingly prolonged adoption time?

The AMA lists seven recognized learning formats that are eligible for the AMA’s Physician’s Recognition Award (PRA) credits. They include live activity, enduring materials, journal-based CME, test item writing, manuscript review, performance improvement CME, and Internet point of care.

Live educational activity occurs at a specific time, one in which participation may be in person or remote, and may be offered through a variety of delivery mechanisms, including conferences, workshops, seminars, regularly scheduled conferences, journal clubs, simulation workshops, structured learning activities presented during a committee meeting, and webinars. However, it is important to appreciate that a live activity’s presentation of information, concepts, or principles in a general lecture or traditional classroom format is highly inefficient and ineffective. The principal advantage of general lectures is that they are useful for disseminating knowledge and skills to large groups in a single time frame, but their downside is that most information is lost, the average retention rate for this passive reception format being only 5 percent!
This meager percentage can be improved somewhat by including discussion, demonstration and clinical application, but not enough to label this method an effective learning modality.

**Enduring educational material** is a learning format that persists over a specified time, including print, audio and video (CDs and DVDs), and Web-based formats (such as online versions of journals, monographs, and other print materials; podcasts; and archived webinars). Printed information has served as a staple of learning since our childhoods. Its advantage is that it allows us to participate in activities at different times, advancing at our own pace and in our preferred environment. However, once again, the average retention rate is low: only 10 percent, although the addition of audiovisual components increases that paltry figure to 20 percent. An encouraging note is that when practice exercises with immediate feedback to learners are added, there can be dramatic enhancement of retention to as much as 75 percent! The use of case studies also can be effective for achieving higher-level cognitive objectives.

Next, we have the time-honored **journal-based CME activity**, in which an article appearing within a peer-reviewed, professional journal is certified for AMA PRA Category 1 credit prior to its publication. The CSA Bulletin’s educational modules (free of charge for members) presented for CME during most of this past decade dwell in this category. Nonetheless, it is disappointing to learn that despite the obvious advantages of being self-directed, self-paced, and engaging the reader to become informed about emerging science or best practices, the average retention rate for journal-based CME is still only 10 percent, just like enduring materials!

So, where does the CSA (and for that matter, the ASA) go from here? The answers are not easy to come by, but I am hopeful that Dr. Berry will provide us with some direction. In the interim, with the guidance and assistance of our Educational Programs Division, we plan to continue with our program of Bulletin-based CME. In this issue, we present a particularly challenging module written by Dr. Samuel Wald, one that addresses pregnancy testing of adolescents and its associated thorny nexus of science, politics, our multiple legal and regulatory systems, and—most important to my way of thinking—ethics. In fact, your editors expect to receive energetic and even vociferous correspondence regarding this module.

This Bulletin also contains two important articles on clinical practice. Dr. Kenneth Pauker considers the revised ASA Standards for Basic Anesthesia Monitoring with respect to the newly mandated monitoring for exhaled carbon dioxide during moderate and deep sedation (pages 40–46), while Drs. Linda Hertzberg and Beverly Philip elucidate the complicated historical evolution
of the ASA document on deep sedation provided by non-anesthesiologist practitioners (pages 72–75).

In addition, we have a current exposition of the Maintenance of Certification in Anesthesiology (MOCA) process that affects all diplomates of the American Board of Anesthesiology (ABA) who were certified beginning with the year 2000. Moreover, all grandfathered ABA diplomates who are not part of the MOCA process (as well anesthesiologists who are non-boarded) might be interested in becoming familiar with MOCA, because the Federation of State Medical Boards (FSMB) has approved a report (www.fsmb.org) that paves the way for strengthening the medical license renewal process by implementing new standards for lifelong learning by physicians. Under the FSMB’s proposed system, known as Maintenance of Licensure (MOL), current requirements will be expanded by mandating that physicians participate in a more robust program of continuous professional development relevant to their specialties, and one that is measured against objective data sources with the goal of enhancing performance over time. When fully implemented, MOL will require physician lifelong learning and create a system to confirm practice improvements. This will align with and incorporate the ASA and CSA educational activities that promote enhanced quality and patient safety through promotion of education.

What is more, this issue also contains an extraordinary article, hopefully the first in a series of such, on Stanford’s Department of Anesthesia. Dr. Ronald Pearl, the department’s chair, briefly reviews the department’s history, and then enlightens us in greater detail about current research activities; innovative educational programs not only in the residency and fellowship arenas, but also at the undergraduate and medical school level; simulation and immersive learning activities; pain management services; critical care activities; and pediatric, cardiac and other clinical services.
Every day another political pundit rants about health care in the United States. Fox News believes that health care reform will end all civil liberties, while MSNBC believes that reform will not protect the American citizen enough. After one listens to the hundreds of opinions, one begins to question one's own cognitive abilities. At the end, physicians need to evaluate our nation's state of health care and determine where they want to it to be a decade from now.

Regardless of one's political disposition, most believe health care delivery must be reformed. With health insurance rates rising by 35 percent every year, we need a change. The real question is: How involved will physicians be in the process of driving this change? When President Obama’s health care reform was passed, the only vocal physician group was the American Medical Association, which represents less than a quarter of U.S. physicians. As the country moves forward with implementing health care reform, many questions will arise: How do we control health care costs? How do we increase access to medical providers? How will physicians be reimbursed? What role will physician-extenders play? Physicians will need to decide if they want to play an active role in modifying health care delivery or if they want to fight to hold the status quo.

Physicians have a lot going for them, as they are the most respected members of health care delivery in the country. If physicians play their cards right, they can drive public opinion to preserve the quality of care Americans have grown accustomed to receiving. However, physicians cannot sit around idly and expect politicians to come to them for advice. We need to proactively increase our interaction with politicians and build relationships with state and national legislators.

The CSA has already started to reach out to our country’s leaders. In collaboration with the ASA, we have spoken with many congresspeople, reached out to the California Democratic Committee, attended the Republican National Governors’ Convention, and increased our voice in Sacramento. CSA leadership continuously submits opinion pieces to major influential newspapers. We actively are battling to preserve patient safety by repealing the CRNA “opt-out” provision signed by former Gov. Arnold Schwarzenegger. I have launched
the “Committee on the Future of Anesthesiology” to help the CSA identify innovative ways to advance the practice of anesthesiology by bringing new advances to anesthesiologists while reducing the cost of anesthesia and maintaining the quality and safety of patient care.

However, the CSA cannot do this alone. We need all anesthesiologists to take an active role and contact their elected officials, meeting with them and educating them so that they understand our cause. We need to write op-ed pieces promoting the safety, quality and other benefits of having a highly trained and educated anesthesiologist provide anesthesia services. CSA will continue to advocate for you and your patients, but if all physicians were to contact their elected officials, speak to the local newspaper, and stand up for what is right for their patients, then we will be able to guide health care reform, truly improving quality of care while reducing the costs associated with that care.

Join the CSA leadership and me in improving health care in the United States.

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**CSA Bulletin Cover for Volume 60, Number 1 “Snow Geese and Snow-capped Mountains”**

The cover photograph of this Bulletin issue was taken in November 2010 at the Gray Lodge Wildlife Area in Northern California. The snow geese flying in this massive liftoff numbered in the many thousands that day. The snow-capped mountains in the distance are the Northern California Coastal Ranges. This image was captured with a DSLR in RAW and processed in Photoshop and Silver Efex.

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From the CEO
The CSA as a CME Provider

By Barbara Baldwin, MPH, CAE

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

The mission statement above states that one of the CSA’s primary purposes is to foster “excellence through continuing medical education [CME].” For over 30 years, the CSA has been a provider of CME, and for the past 12 years we have been accredited by the Accreditation Council for Continuing Medical Education (ACCME). This designation insures learners will receive CME that meets the standards set by the national accrediting body, and that the credit they earn by participating in learning activities meets the requirements set by state medical boards and other entities. In California, physicians licensed by the California Medical Board must acquire at least 50 credits every two years to maintain licensure. Physicians licensed by the Osteopathic Medical Board of California must complete 150 credits in every three-year licensure period.

In recent years, other entities like hospitals and national boards have come to require CME as an indicator that a physician is engaging in the process of lifelong learning that is necessary to keep knowledge, competence and performance current. The American Board of Anesthesiology requires anesthesiologists who were board-certified after 1999 to recertify every 10 years, and within the 10-year certification period, to complete at least 250 Category 1 CME credits.

The face of CME has changed considerably over the past decade. A new challenge for CME providers is that accreditation is moving from being process-based to being outcomes-based. That is, while previously it was sufficient to document that quality CME was provided, now providers must take steps to ascertain if the activity met the objective of improved knowledge, competence or performance. This can be measured by means such as pre- and post-tests, self-reporting, and faculty assessment. Large, well-funded providers can utilize sophisticated methods to measure outcomes, but many providers use self-reporting as the primary method.
Commercial Support and Conflict of Interest

Another important change came with new rules governing in-kind and financial support for CME programs from commercial entities. The ACCME began applying strict Standards of Commercial Support to activities presented by CME providers in 2001 and modified them in 2004. The six standards are to insure:

1. independence in all aspects of activity planning, including selection of educational objectives, content, faculty, educational methods and evaluation,
2. resolution of personal conflicts of interest,
3. appropriate use of commercial support,
4. appropriate management of associated commercial promotion,
5. content and format without commercial bias,
6. disclosures relevant to potential commercial bias.

Adherence to these standards requires providers to have systems and documentation that confirm compliance.

Almost concurrently, the pharmaceutical industry responded to criticisms and allegations of unethical practices by assigning the Pharmaceutical Research and Manufacturers of America (PhRMA) to become a watchdog over its practices. The stated objective was to eliminate behaviors such as paying physicians for “educational” vacations, which were considered inducements to prescribe their drugs. In 2002 PhRMA issued a voluntary code of conduct for interactions with health care professionals, and in 2009 an updated code became effective. These rules set parameters for how pharmaceutical companies may interact with physicians and CME providers with respect to promotion and support of CME activities. In addition, these restrictions add complexity to arranging and receiving commercial support.

The most obvious of these restrictions is the prohibition against giving physicians items that may be construed as inducements to use their products:

Providing items for healthcare professionals’ use that do not advance disease or treatment education—even if they are practice-related items of minimal value (such as pens, note pads, mugs and similar “reminder” items with company or product logos)—may foster misperceptions that company interactions with healthcare professionals are not based on informing them about medical and scientific issues. Such non-educational items should not be offered to healthcare professionals or members of their staff, even if they are accompanied by patient or physician educational materials.
How the CSA Assures Quality and Ethical CME

The CSA has a formal system for planning educational activities and insuring compliance with all ACCME requirements. Members of the Educational Programs Division (EPD) serve as program chairs for CSA educational activities. In addition, they provide guidance in the development of new delivery methods like enduring materials (*Bulletin*) and Internet self-study. Moreover, in the past few years, hands-on workshops in regional anesthesia have given anesthesiologists the ability to develop skills that enhance the quality of their practice.

Evaluation of each CME activity helps us learn whether participants’ learning needs were met, and also if the CSA met its overall program objectives in presenting that activity. This enables the CSA to give constructive feedback to faculty on their content, materials and presentations. Evaluation results are kept for several years. When program chairs begin to plan an educational activity, they are given evaluation summaries so that they can work with prospective faculty to insure that presentations are current and of the quality for which our CME is known.

In 2006 the ACCME modified its criteria for accreditation in several ways. It now requires that CME providers consider the best ways of presenting CME based on the content and learning objectives. Reading printed content or attending a lecture, then taking a quiz, is not necessarily the most effective or efficient way to learn new skills. While some well-funded CME providers have the ability to offer state-of-the-art educational videos with 3-D enhancement, the CSA is a nonprofit provider and must limit its offerings to methods more suitable to available resources. However, we continuously evaluate how to provide the best learning environment for our members, with attention to advances in technology and reductions in the cost of learning enhancements that are, at present, prohibitively expensive.

Every four years the CSA is required by the ACCME to do a self-study that reviews all aspects of the overall CME program and educational activities. This process takes months and calls for the EPD to examine many areas. Currently we are gathering information and drafting a report due at the end of March. With this report we will submit 15 activity files selected by the ACCME that show “performance in practice,” with documentation that the planning, development, presentation and evaluation of CME activities meet the ACCME requirements.

The CSA has a long history of providing high-quality, meaningful CME. If you haven’t attended a live educational activity, try the CSA Annual Meeting or one
of the Hawaiian seminars. There are also online modules on the CSA Web site, free to members. Take advantage of CSA’s great member benefit, and meet your lifelong-learning needs at the same time!

Pediatric Anesthesia Module 2
Pediatric Resuscitation
ERRATUM

The information in Module 2 that appeared in the Fall 2010 issue of the Bulletin should be modified as follows:

On page 67, under “Pediatric Advanced Life Support,” the fifth sentence describing a cycle of cardiopulmonary resuscitation should read: “A cycle of cardiopulmonary resuscitation (CPR) is 30 compressions: 2 ventilations for a lone rescuer and 15 compressions: 2 ventilations for 2 two or more rescuers.” We apologize for any inconvenience or confusion this error may have caused.
“California, the Great Exception” is a mid-20th century classic, written by historian and journalist Carey McWilliams, on the phenomenal resources and explosive growth that have made California a unique economic, social and political force. The phrase proved to be an apt description once again in the recent election when the national conservative tidal wave stopped at California’s eastern border. Despite a deeply troubled economy and dysfunctional governance, the state’s voters declined to participate in the dramatic turn to the political right that occurred almost everywhere else in the country.

General Election Summary

Democrats swept all eight statewide offices, taking the posts of governor, lieutenant governor and insurance commissioner from Republicans. None of California’s 53 incumbents in the U.S. House of Representatives lost. In the State Legislature, Democrats defied the odds and picked up an additional assembly seat. For medicine, the “pickup” was an extraordinary success: Richard Pan, M.D., is the first Democratic physician/legislator in modern California history.

- **Governor:** Former governor Jerry Brown crushed billionaire former eBay CEO Meg Whitman by 12 percent. She joins a list of wealthy self-funded candidates whose bids for high office in California failed to win the prize.

- **Lieutenant Governor:** San Francisco Mayor Gavin Newsom outpolled appointed Lt. Gov. Abel Maldonado by 11 percent.

- **Attorney General:** San Francisco District Attorney (DA) Kamala Harris pulled off a major upset in defeating Los Angeles DA Steve Cooley. She was vigorously opposed by the law enforcement community because
of her refusal to seek the death penalty against an accused cop killer early in her tenure as SF DA. The Cooley campaign was well financed, led in pre-election polls, and was endorsed by every major California newspaper. Yet after 9 million votes were counted, Harris won—although by less than 1 percent, and only after three weeks of counting all the absentee ballots.

- Other “down ticket” Democratic incumbent victors were Treasurer Bill Lockyer, Controller John Chiang and Secretary of State Debra Bowen. Dave Jones, a soon-to-be-terminated assemblyman, won the state insurance commissioner race.

U.S. Congress: Several incumbents faced serious challenges but none lost.

- U.S. Sen. Barbara Boxer, a 28-year Democratic incumbent, turned back former Hewlett-Packard CEO Carly Fiorina by 9 percent.
- Four seats in the House of Representatives were strongly contested, but the incumbents prevailed. They are Democrats Jim Costa (Fresno), Jerry McNerny (Pleasanton) and Loretta Sanchez (Garden Grove) and Republican Dan Lungren (Gold River).

State Assembly

Instead of losing at least two districts as earlier predicted, Democrats held all their seats, broke a long GOP grip on a suburban district, and increased their majority to a 52-to-28 margin, the largest since 1974.

- In northern suburban Sacramento Assembly District (AD) 5, UC Davis pediatrician Richard Pan defeated Republican Andrew Pugno, a leading advocate of Proposition 8 (in 2008) and opponent of same-sex marriage. The district had been in the GOP column since the 1980s.
- Another physician, Republican Linda Halderman, M.D., a surgeon, was elected to the assembly from AD 29 in the Fresno area. Her victory was pretty much sealed when she won the June primary in this safe GOP district. Of note, she has written articles for the CSA Bulletin.

State Senate

No changes in party composition occurred as Republicans held Senate District (SD) 12 in the central San Joaquin Valley. Ceres Mayor Anthony Cannella overcame Assemblywoman Anna Caballero of Salinas, a moderate Democrat, despite a significantly higher number of registered Democrats in the district.
Over the next few months, special elections will fill three senate vacancies owing to the deaths of Sens. Dave Cox (R-Fair Oaks) and Jenny Oropeza (D-Long Beach) and the move of George Runner (R-Antelope Valley) to his newly elected post on the State Board of Equalization.

When the 2011–12 legislature convened on December 6, the senate lineup was 24 Democrats and 13 Republicans. Once the special elections are concluded, it is expected to revert to the 25-to-15 margin that has existed for the past several years.

Election Implications for the CSA

For the first time, there will be a physician member of each party caucus in the Assembly. Both have familiarity with the legislative process. Dr. Pan was chair of the Council on Legislation (COL) of the California Medical Association (CMA), and Dr. Halderman served as top health advisor to State Sen. Sam Aanestad. The importance of their insider access to closed-door partisan policy discussions cannot be overestimated at a time when many health issues could be on the front burner.

A variety of proposals relating to scope expansion for ancillary health practitioners is expected in the 2011 legislative session. Nurses, physical therapists and optometrists are among those likely to be seeking broader practice authority. The influx of newly covered populations resulting from enactment of federal health reform has been cited as necessitating greater roles for physician “extenders.” For each of these “extender” categories, scope expansion is the single biggest issue; they will devote all the resources at their command to it and plead for “just this one vote.” Physician advocates, however, must deal with a myriad of issues including each and every “extender” scope expansion attempt.

A MICRA cap increase may be on the table. During the recent campaign, Governor-elect Jerry Brown, who signed MICRA into law in 1975, reportedly saw “no need” to revisit the landmark medical malpractice law. More recently, the Consumer Attorneys of California (CAOC) have claimed Brown is now open to increasing the $250,000 cap on noneconomic damages. Whatever the former and new governor’s stance is, he can only act on legislation that reaches him. We have made a continuing effort to work with new and returning lawmakers on maintaining the cap with its affordable premium levels that work to stabilize patient access. If a bill to increase the cap is introduced, then the campaign positions of many candidates will be tested. CAOC and its allies are not to be underestimated. Their resources and ability to communicate a message, even if misleading, are impressive. Moreover, the mere passage of time since
1975 leaves relatively few Californians who are aware of MICRA’s existence, let alone its contribution to patient access or why it was enacted.

A Final Word on the 2009–2010 Legislature

The 2009-10 session of the California Legislature did not display the legislative process or California state government at its best. Voter approval ratings for lawmakers and the state’s chief executive sank to all-time lows. Partisan bickering was at an all-time high. Chronic state budget deficits persisted despite smoke, mirrors and bookkeeping legerdemain. To put a final exclamation point on worst-ever categories, the legislature ran out the clock on the last night of the regular session. Several controversial bills died because of incomplete roll calls at the midnight deadline, while other bills in line to be considered were not even taken up as time expired. Basic time management was nonexistent, and the state budget was two months overdue. When the Budget Act of 2010–11 was finally signed on October 8, 2010, more than 100 days late, it was desperately described as “tenuously balanced.”

A month later, the nonpartisan Legislative Analyst Office found that the deficit over the next 18 months had swollen to $25.4 billion, including a $6 billion shortfall in the month-old 2010–11 spending plan. In response, Governor Schwarzenegger called a special session commencing December 6, 2010, swearing-in day for the 2011 Legislature, to deal with the latest fiscal emergency. It was an unprecedented greeting for the new lawmakers from the departing chief executive. Welcome to the Capitol!

2010 Legislation of Interest to the CSA

Election years usually result in limited legislative productivity, but many hard-fought controversies, and 2010 was no exception. In the end, the results were a mixture of wins, losses and stalemates for medicine and the CSA.

A detailed listing of major 2010 bills of interest to the CSA along with their final disposition may be found on the CSA Web site. A brief recap follows:

- Efforts to undercut the bar against the corporate practice of medicine were blocked.
- Reform of managed care was unsuccessful again except for stringent limits against the arbitrary cancellation (rescission) of health coverage due to pre-existing conditions.
- Enhanced disclosure of health practitioner license credentials and education was enacted.
- Peer review improvements were vetoed.
Discounted fees for emergency services rendered to indigents were limited.

Implementation of federal health reform was begun.

The Schwarzenegger Legacy

Governor Schwarzenegger, who arrived amid great fanfare and public support in 2003, leaves the state in no better shape than when he arrived. Promises of no new taxes, “tearing up the state’s credit card,” and cleaning up “waste, fraud and abuse” proved impossible to keep. Initially the best fundraiser for the Republican Party in years, he lost the trust of many GOP legislators as his term progressed. He occasionally tried to fashion bipartisan efforts with Democratic lawmakers, but he never really reached out to them as previous Republican governors Pete Wilson and George Deukmejian had. He chose not to be part of the Sacramento Capitol scene, but he made clear his preference for the Hollywood celebrity arena.

Physicians’ relationship with Schwarzenegger soured after the defeat of his health care reform plan of 2007-08. When medicine remained on the sidelines, opponents of the plan were emboldened and ultimately prevailed. The worsening economic conditions fed into uncertainty over the plan’s many shaky assumptions. However, the unwillingness of medicine to play a strong publicly supportive role left an irritation that seemed to infect many subsequent actions.

When it was possible to expand the lawful scopes of practice of nonphysicians by administrative rule or action, this administration did. The nurse anesthetist opt-out and chiropractic manipulation under anesthesia are two cases in point. Schwarzenegger constantly sided with health insurers and managed care plans against treating physicians. Vetoes of bills sponsored or supported by the California Medical Association and medical specialties were numerous and often stated in vague and gratuitously negative terms. The governor’s staff from top to bottom denied any “payback” or an anti-medicine bias, but the results speak for themselves.

Granted, California politics and state government were growing increasingly dysfunctional before Arnold Schwarzenegger ousted Gray Davis as governor in the 2003 recall. Yet the situation has worsened since then. Tough economic times have limited public policy options and made effective governance more difficult.

The New Year has brought a new governor, a new administration and many new members to the legislature. Of the 120 state legislative districts, 40 are changing faces even though no incumbent was denied re-election, and only
one district (AD 5) changed to a different party. Whether all these new individuals will engender a new willingness to work across party lines to resolve an array of challenging issues remains to be seen.

Report from the Legislative and Practice Affairs Division (LPAD)

By Paul Yost, M.D., LPAD Chair

First, I would like to thank the outgoing LPAD chair, Dr. Ken Pauker. His leadership, knowledge of the political landscape, dedication to the CSA, and ability to gently encourage his fellow committee members to contribute to LPAD are all greatly appreciated. During his tenure, Ken turned LPAD into a committee that people enjoy attending by changing the meeting format to a more interesting and productive one, including bringing in outside speakers and elected officials. He has done a great job as the President-elect of the CSA, and I expect that he will be a valuable mentor and contributor to LPAD for many years to come.

On the legislative front: With the 2010 midterm elections over, we have finally finished with the endless television commercials. Amid a landslide of epic proportions for the Republican Party almost everywhere except California, there were a few bright spots for physicians and anesthesiologists.

One piece of great news was the first anesthesiologist elected to Congress! Dr. Andy Harris, a Republican from Maryland, is now a member of the United States House of Representatives. Many thanks to everyone who supported Andy! In addition, two physicians, Democrat Richard Pan, M.D., and Republican Linda Halderman, M.D., were elected to the California State Legislature (see the Barnabys’ report).

At the federal level, the incumbent Democrats lost 63 seats in the House of Representatives, and therefore, control of the chamber. In the Senate, the Democratic Party lost six seats to the Republicans, but maintained majority control. What does this mean for medicine in general and the specialty of anesthesiology in particular? The situation is still very unclear, with minefields on all sides for both political parties.
Many Americans are not happy with the Patient Protection and Affordable Care Act (PPACA) and still prefer the current system to an unknown one made very ominous in campaign-oriented media sound bites. However, the public does favor some of its provisions (hindering insurance companies from denying coverage for pre-existing conditions and doing away with lifetime coverage limits, to name a couple). Additionally, a growing number of citizens do understand that the costs of our current health care system are rising at an unsustainable rate, and there have been challenges to the constitutionality of certain aspects of the bill. Having gained control of the House, the Republicans can simply refuse to fund the many appropriations necessary to enact the legislation. With a Democratic president and a Senate majority, this is likely to create gridlock, which would not be good for our nation. It will be an interesting year and one in which there may be opportunities for us to impact the process. As contributions are one of the fuels that make the political process run, please continue to support ASAPAC!

California’s passage of Proposition 25—which allows a state budget to be adopted with a simple majority instead of the previously required two-thirds majority—and the election of a Democratic governor mean that the Democrats will have more power to pass items of importance to their party.

LPAD’s legislative goals for the coming year are as follows:

1. Increasing the participation, visibility and effectiveness of our advocacy efforts. To this end, we will be updating the “Advocacy” part of the CSA Web site, including a Grass Roots Advocacy section.
2. Carefully honing our message and concentrating our efforts.
3. Working closely with the CMA, other specialty associations, and the public to leverage our position and improve our chances of success on issues of concern to us.

We would like to continue with electoral successes, but to do so we need YOU to become more involved in the political process. All politics are local and personal. We need you to get to know your state assembly person and senator personally, and take part in the ramped-up “grass roots” political arm of the CSA. Please go often to “Advocacy” on the new CSA Web site and continue to support GASPAC.

On the practice affairs front we have been quite busy as well. Some current projects are:
Legislative & Practice Affairs (cont’d)

• Creating an area of the new Web site that contains sample policies and procedures on topics such as obstructive sleep apnea, massive hemorrhage, anti-coagulation, regional anesthesia and others.
• Creating a more useful set of links to ASA practice affairs resources.
• Creating a section on the CSA Web site devoted to recent regulatory inspections (the Joint Commission, California Department of Public Health, etc.) to help our members prepare for the ever-changing inspection process.
• Continuing to expand and refine the use of our Group President’s Forum.
• Posting leadership development resources on the Web site, for example, “How to be effective on a hospital committee.”

Through LPAD, we develop and express the CSA’s political message and direct efforts to influence legislation and regulation to improve the lives of our members. If you would like us to look into a particular area, please let us know, including some following helpful information:

• The section of current code or legislation that is problematic
• A concise, clear statement of how it adversely affects your practice (including any financial impacts)
• Suggestions for alternate legislation or regulation that would help
• An anecdote that illustrates the problem

We at LPAD look forward to working with you to make the practice of anesthesiology safer for our patients and easier and more productive for our physicians.

Update on “Opt-out” Litigation

By Linda B. Hertzberg, M.D., Immediate Past President

The CSA and CMA are pursuing an appeal seeking reversal of a court decision upholding Governor Schwarzenegger’s “opt-out” of the Center for Medicare and Medicaid Services (CMS) requirement that a physician supervise nurse anesthetists. In October 2010, the San Francisco Superior Court refused to block the governor’s decision, ruling that he acted consistent with California law. The appeal argues that California law allows nurse anesthetists to administer anesthesia, but only under physician supervision. CSA and CMA
believe that the Superior Court erred in its interpretation of state regulations regarding the requirement for physician supervision of nurse anesthetists. Attorneys for the CSA and CMA filed the appeal in the State of California Court of Appeal on February 1, 2011.

In June 2009, then Governor Schwarzenegger submitted a letter to CMS requesting that California be allowed to “opt out” of the regulation that physicians directly supervise or administer all anesthesia for Medicare patients. Medicare allows hospitals to “opt out” of physician supervision regulation if the governor's request to CMS is preceded by the following steps: 1) the governor consults with the state boards of medicine and nursing on issues relating to access to and quality of anesthesia services; 2) the governor concludes that the change is in the best interests of the state; and 3) the governor declares that the action conforms with state law.

Two of the arguments cited in the appeal petition are:

• It is the default rule that nursing practice is subject to the supervision of the patient’s physician. Removing the supervision requirement violates the default rule that nurses report to, are answerable to, and subject to the direction of the patient’s physician … Nursing practice is derivative of the physician's practice. Indeed, the purpose of nursing practice is to further the interest of the patient in accomplishing the purpose for which the physician is consulted.

• The California Legislature has not said that California nurse anesthetists are “licensed independent practitioners” … They do not supplant physicians as the providers of medical care in California. They do not engage in the independent, unsupervised practice of medicine. Governor Schwarzenegger was wrong. The California Association of Nurse Anesthetists was wrong. They stated what they thought the law should be. None of them is qualified to determine what the law is.

“For the governor and Superior Court to decide for the people of California that it is perfectly safe to remove the medical and physician component from anesthesia care is absolutely irresponsible,” said Dr. Narendra Trivedi, President of the CSA. “The governor's plan goes against the belief of most practicing physicians that nurses should be supervised by the physician ordering the treatment, in this case anesthesia, and potentially jeopardizes the quality of care that citizens of California will receive. The CSA and CMA are appealing the Superior Court ruling in an effort to right this assault on the rights of patients to have a physician involved in their anesthesia care.”

The CSA and CMA will be working closely with the ASA and AMA on this issue. The CSA anticipates that it may take several months for arguments in the appeal to be filed and for a three-judge panel to hear the case.
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The new CSA Web site was launched in early November 2010. It features many upgraded elements, including more user-friendly and intuitive navigation, improved graphics, and a member photo gallery. The most notable and perhaps most highly anticipated new element is the Member Groups area, which was designed, in part, to replace the outdated and expensive e-mail-based listserv system, used for over a decade to provide a discussion format mainly for CSA officers and committee members. The new “groups” area provides a secure platform for members to communicate within specified groups via either blog posting or e-mail-based discussions. A tutorial on the home page of the Web site provides instructions on joining and participating in groups.

With the new site, the CSA can utilize the latest in technology and communications to deliver, in a timely way, relevant and important information. For example, on the CSA home page, one may view summary versions of “Hot Topics,” “CSA News” and “Anesthesia in the News” with links to more detailed content. Moreover, there is an expanded and improved social media outreach via Facebook, Twitter and LinkedIn. Members are invited to utilize these resources to connect with people and events related to your profession and practice.

The Practice Resources section of the site is being reorganized and updated with the goal of making available the latest relevant information and resources regarding issues that affect your practice.

An exciting development is the launch of the mobile site version of the Web site, which will greatly improve the experience of users who access csahq.org via smart phones, PDAs, iPads or other mobile devices.

In addition, the CSA is in the process of digitally preserving its print photograph collection. Once digitized, the photos will be uploaded into the CSA Picasa photo and video storage site and members will be invited to view, add captions, rate or annotate these historical photos.

Several projects and further improvements to the Web site are being considered, including upgrading our online CME delivery platform and installing an optional online “reader” for the Bulletin.

Members are invited to contact the CSA at csa@csahq.org with suggestions and comments regarding our ongoing communication efforts.
The third week of October in San Diego can usually be expected to display the magnificence of sunny southern California weather that causes envy elsewhere in the nation, where temperatures begin to chill and storm fronts threaten. This year, instead of balmy Santa Ana winds, the shroud covering Mission Bay and Coronado Island looked more appropriate for Seattle, and even brought out the umbrellas at times. However, during a week in which those attending the American Society of Anesthesiologists Annual Meeting experienced much that was unexpected and different, the weather was perhaps the only disappointment.

This was the first year in its history that the meeting required a registration fee from ASA members. By all accounts, this did not dampen attendance, which was tallied at 7,519 ASA members. It did mean separate tickets were not required for refresher course lectures and panels, providing attendees great flexibility to “shop” the wide array of educational offerings.

A pair of opening-day innovations was also designed to set this meeting apart and add something special. First, an Official Opening by ASA President Alex Hannenberg, highlighting the new multifaceted dynamism of ASA, was followed by a spellbinding talk by Jeff Skiles, co-pilot of US Airways flight 1549, “the Miracle on the Hudson.” This plane’s encounter on January 15, 2009, with a flock of geese and subsequent emergency landing on the near-frozen river consumed only five minutes, yet melded together, inexorably, the lifetime experience of each person aboard. His candid story of “just another day” was an amazing testament to the essence of professionalism, and the importance of thoroughly refined training to ensure public safety in a hazardous world. The obvious parallels to the practice of anesthesiology were given a spectacular staging. Days later, this same theme would be replayed from another perspective in the Rovenstine Lecture by Dr. Kevin Tremper.

The second special event of opening day was an open house at Petco Park, home of the San Diego Padres baseball team, where we enjoyed a free cookout and walkabout. It was a unique, close-up look from outfield to infield and even the dugouts and locker room!
The House of Delegates (HOD) met as usual, in sessions on Sunday and Wednesday mornings, and acted on a number of items of importance, in addition to electing officers for the coming year. No contested elections took place, incumbents were retained and the expected ascendancies occurred. The HOD approved an additional refinement of the ASA Standards for Basic Anesthesia Monitoring, that monitoring for the presence of exhaled carbon dioxide is required for moderate or deep sedation “unless precluded or invalidated by the nature of the patient, procedure or equipment.” This standard will take effect July 1, 2011, in order to allow clinical practices to prepare for it. (See pages 40–46 for more information on this newly added standard.)

A Practice Guideline for Preoperative Fasting and the Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration (healthy patients/elective surgery), and Practice Advisories for Perioperative Management of Patients with Cardiac Implantable Electronic Devices and Prevention of Perioperative Peripheral Neuropathies were passed. A proposed Practice Guideline for Central Venous Access received significant debate, mainly surrounding a mandate for the use of ultrasound, and was eventually rejected; however, it is expected that refinements will allow for passage by the next HOD.

A significant suggested change to the existing Physician Quality Reporting System anesthesia quality measure for maintenance of normothermia will make this purely an outcome measure and remove the performance component that allows credit for efforts made to warm patients intraoperatively. Exclusions for patients with trauma and other emergency conditions, pre-existing hypothermia, cardiopulmonary bypass, and deliberate hypothermia will be submitted to the AMA Physician Consortium for Performance Improvement (PCPI) and National Quality Forum (NQF) for endorsement. In addition, a new Anesthesia Quality Measure concerning multimodal therapy for the prevention of PONV in patients at high risk will be submitted to PCPI and NQF and probably added to our ever-growing reporting requirements, so look for this on an anesthesia record in your neighborhood soon!

Another potentially big change to our clinical practices may come from the HOD approval to adopt as ASA policy the recently promoted recommendations from the Centers for Disease Control and Joint Commission that syringes and needles, in any setting (including anesthesia administration), be disposed of after every single use and that re-accessing of a medication container, even for the same patient, be prohibited.

The HOD finally approved the Statement on Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners, which has had a long and twisted history
with significant nurturing and promotion by leaders from the CSA. The CSA has in turn moved to retire our own Guideline on the subject in favor of this ASA document. (See pages 72–75 for more information on this important Statement.)

In non-clinical matters, a proposal to develop an ASA Health Policy Research Institute, for the purpose of studying and making recommendations relating to the “anesthesia profession” and workforce issues, was referred to a committee of the president’s choice. The idea behind this proposed institute is for the ASA to develop meaningful analysis, valid research, and robust practical strategies to influence public policy, advance our profession, and counter “junk science” propaganda.

Furthermore, a major multiyear effort to deal with the inadequate physical plant of our growing organization and meet its future needs is underway, starting with the purchase several years ago of property adjacent to the ASA Park Ridge, Illinois, headquarters. The ad hoc committee assigned to this issue presented many options to the HOD for debate, including various potential uses of the existing property and structure, as well as possible relocation sites for the ASA headquarters. In all probability, a new location will emerge over the next year or two, and the existing property will find its best use as a disposable asset.

The October 2011 annual meeting of the ASA, to be held in Chicago, promises to carry on the tradition of “best-ever” meeting. The prizewinning author, journalist and surgeon Atul Gawande is scheduled to be the keynote speaker. His observations and insights on state of medicine in America will surely be compelling. I hope you are fortunate enough to be in the audience.

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Two anesthesiologists, Natalie (Nat) Strand, M.D., and Kathy (Kat) Chang, M.D. (left to right above), teamed up to win the seventeenth season of “The Amazing Race” (“TAR”), a “reality show” competition on CBS television. Millions of viewers watched on December 12, 2010, as the three finalist teams (of the 11 teams that began the competition) completed physically and intellectually challenging tasks in their race to the finish line. Nat and Kat, as they were referred to in the show, were the first all-woman team—as well as the first anesthesiologists—to win this event in which teams compete in locations around the world. I would like to think that most of the TV audience cheered for Nat and Kat, as they are among the nicest and warmest people whom I personally have known.

Nat and Kat both finished their anesthesiology residencies at the University of California, Los Angeles, a year and a half ago. I had the pleasure of working with and teaching them when they rotated through obstetric anesthesia at Cedars-Sinai Medical Center. Nat also served on the 2008–2009 CSA Board of Directors as the director of the residency district (#15). She went on to complete a pain fellowship at the Mayo Clinic in Arizona. I thank Nat and Kat for granting me individual interviews, and Mallory Mason of CBS for her assistance. Following are excerpts from those interviews, conducted on December 22, 2010, and January 10, 2011.
The Amazing Race (cont’d)

MZ: What are you doing now that the race is completed?

Nat: I’m working in the private practice of pain management in Newport Beach [Orange County]. About half of my time is spent seeing patients in the office, while the other half is occupied in performing interventional pain procedures. Currently, I rarely administer anesthesia. I also still am involved with research in that I am writing papers to be published on work that I did in my pain management fellowship. At this point in time I am adjusting to the pace of the private practice.

Kat: I’m working full time in the operating rooms at Kaiser Woodland Hills.

MZ: Did your medical education and training help you compete in “TAR”?

Nat: Without question, our medical background helped us. We joked a lot about how often people asked us, “How did you keep your cool under such stressful circumstances?” In fact, we were called “unflappable.” Well, as anesthesiologists, we all know that we frequently are presented with critical, life-and-death situations, so how can putting a rickshaw together [one of the challenges, in Bangladesh] compare in “scariness” with having to anesthetize an emergency heart transplant, or crash cesarean delivery, or intubating a small child with epiglottis? When we were physically and emotionally exhausted, we still were able to keep that important perspective, although the TV viewers might not have understood that. We were used to working together as a team under duress and also were able to communicate efficiently. So we certainly had an advantage because we avoided those communication breakdowns while other teams “lost it” and began to scream as they flailed with managing their stresses. Being accustomed to dealing with difficult and distressing challenges, and having familiarity with the potentially adverse effects of sleep deprivation and physical exhaustion, each of which one experiences in anesthesiology, were extremely useful during the competition. I have received messages from viewers who said something to the effect of, “You gals are acting like typical anesthesiologists, staying cool, calm and efficient under pressure.”

Kat: Oh, definitely. The other teams all were saying, “Oh, this is the most stressful thing I have done in my entire life.” As “TAR” progressed, the other teams became more tired and sleepy and stressed-out. Nat and I looked at each other, and we both thought that our day-to-day lives are more stressful. On “TAR” the worst thing that can happen is that we are eliminated from the race. At work, the day-to-day “worst” thing that can happen is orders-of-magnitude worse. It helped us to keep perspective and took away a little bit of the stress. We were used to being sleep-deprived as residents, and it helped us to be able to go a day and a half without sleeping. We were pretty functional without adequate sleep.
MZ (with a twinkle in my eye): I agree that the ability to assess quickly, prioritize, and make critical decisions at a rapid pace would be quite helpful in “TAR.” Would you recommend that all future participants in the show go through medical school and an anesthesiology residency?

Nat: Well, if you are competing for the prize money, that kind of “preparation” would cost you a bit more in years and cash than what you could get from winning the race! But, if you happen to have a passion for becoming a physician, then that kind of background assuredly would be helpful.

MZ: Do you feel as though you had personal growth by participating in “TAR”?

Kat: Absolutely, yes. The race helped me to realize more clearly that in order to grow personally, you have to enjoy life, and you can do that by introducing into your daily routine something crazy and uncomfortable—just to try to live in the moment a lot more. So much during medical training is delayed gratification and always looking to the future. Even if you only have an afternoon off, try to do something small that makes you feel alive. It benefits you for a much longer period of time. These kinds of little things make a big difference.

Nat: I definitely do. The fact that it occurred and while having a great amount of fun was, upon reflection, somewhat surprising to me. It is rare in life that you are stripped from all or most of your defining factors. You don’t have your circle of friends, or access to family, or even your own wallet or cell phone, so you are not able to draw upon the support systems that you have in your daily life. All of a sudden, your only resource is yourself and your teammate. It is a unique position in which to be, and I really enjoyed that aspect of the experience. Successfully meeting challenges in multiple countries around the world—all totally foreign to me in just about every aspect—required internal preparation, self-confidence and fortitude.

MZ: I really felt compassion for you, Nat [who has a fear of heights], in the season finale in which you had to deal with that frightening experience of the giant bungee jump.

Nat: No question that the bungee jump was the most frightening thing that I ever had done, not just in the race, but in my entire life!

MZ: Were you “athletic” before the show?

Nat: I am “athletic” in that I ski, run half marathons and ride bikes; being active always has been an important part of my life.

Kat: I played sports in college and ever since then. I run races—half marathons—and take spinning classes with Nat. Being physically fit really helped us on “TAR.”
The Amazing Race (cont’d)

MZ: How long did it take to actually film the show?
Kat: We were actually traveling for 23 days. Every other day we travelled to another country.

MZ: I would think that would contribute to fatigue as a big factor.
Kat: Absolutely. I was one of those people who used to watch “TAR” at home and wonder, what happened to the racers? Not infrequently, they are making a simple mistake—for instance, a clue says “walk to the next clue” and they take a taxi. But in the moment you are exhausted and fatigued, just like when you are sleep deprived, and you are more likely to make a simple mistake than you would normally. That is what makes “TAR” so much harder than you would think from the vantage point of your living room.

MZ: Nat, how was it being on the show as an insulin-dependent diabetic? Was it particularly difficult for you, or was that just another one of the rigors encountered?
Nat: One of the reasons that I wanted to be on the show was to serve as a role model for how well an active diabetic can function even under the most arduous of conditions. Yes, it is a big deal having an insulin pump, but it does not necessarily constitute a limitation on what you can accomplish. Since the show went on the air, I have had people come up to me in the hospital, as well as having received numerous letters and emails, saying something to the effect of “My child was just diagnosed as having diabetes. Your being on “TAR” and going through medical school and residency were an inspiration for him or her.” Some of those comments were personally very touching. In other words, I in some way helped put others at greater ease that their children’s lives weren’t necessarily going to be significantly limited. In fact, I must say that, for me, was the most meaningful accomplishment of my being on TV. Personally, I know that it has been extremely helpful having had role models who are actively pursuing leading very full lives. It takes away excuses and unnecessary feelings or fears of limitations.

MZ: Kat, what was your greatest fear during the race?
Kat: Other than Nat’s fear of heights, it probably was the same as with Nat—health concerns. Being in a distant place, you are somewhere far distant from your comfort zone. Even with the best planning for medical staff or being airlifted, you realize that a good hospital is not a mile away.

MZ: With respect to the teamwork, were you and Kat friends before the show? You seemed so naturally empathetic toward each other.
The Amazing Race (cont’d)

Nat: Yes, we were, and lots of people commented on the fact that we had been so mutually supportive and genuinely kind to each other. But isn’t that how physicians are supposed to behave? When someone is in distress, then it is natural for physicians to offer that person some empathy and understanding, some kindness and assistance, whether it is a patient, colleague, family member, friend or acquaintance. I was really pleased that so many people recognized those qualities in us. Kat was amazing, wonderful, great—I don’t have enough adjectives to describe how I felt about her—as my teammate. We had so much mutual respect, trust and caring that we never reached the point where we had a breakdown that resulted in blaming the other. It is interesting that some people blogged that we were “boring.” However, most commented that we seemed to be genuinely supportive and caring and polite, and that it was refreshing to observe in a competition, especially with the winners.

MZ: The two of you worked great as a team. How do you feel you best complemented each other?
Kat: In large part it was our personalities, similarities, friendship, and being supportive of each other that helped us as a team. Having trained as anesthesiologists, we are used to being autonomous and working on our own, but also being there to help out our colleagues if needed. I don’t think Nat and I needed to have someone constantly motivating us. We are used to being self-motivated.

MZ: I might add to that comment that I was at the gym during the final stage of the race, and nearby were a sixtyish woman and a trainer, both of whom were rooting enthusiastically for you because, they exclaimed, they thought you both were so nice. Moving on, could you tell me the most important lessons that you learned from participating in “TAR”?
Nat: The first lesson that comes to mind is that teammates have to function as a team—that is, you cannot turn on a partner and blame the other person for their failures or weaknesses. Rather, you function best when you are mutually and cohesively supportive. Second: never give up! “TAR” is a good allegory for life: sometimes things bounce your way, and other times they don’t. Sometimes your hard work pays off, and other times it doesn’t. You never know for certain where you are in relation to other competitors until you arrive at the finish line. There are occasions when you think that there is no way that you can prevail, but never give up, and indeed, you may well be pleasantly surprised with the outcome. And third, those of your readers who viewed all of the episodes will understand that you should not participate in a Norwegian Christmas tradition without knowing more about it! [For those who didn’t see the episode, a challenge in Norway involved a difficult eating experience—MZ]
Kat: First, I learned about myself. By testing yourself, you prove to yourself your inner strength. Second, how important good friendships are. Nat and I were good friends to start with. If you can manage being with someone 24/7 for a month straight, never more than 15 feet away, especially in stressful situations, then you work out your issues without fighting, and you have a good strong mature friendship. Third, the importance of enjoying life and living in the moment, even in everyday life.

MZ: Did you have any role models for the show?
Kat: Nat and I were not necessarily trying to follow other people. We really just wanted to be ourselves and not change during the race—not be so competitive or cutthroat that we end up being different people. We discussed this before starting “TAR”—that we wanted to do the race as ourselves and not as caricatures or different people. We have role models in our everyday lives, which helped make us who we are. For the race, we just wanted to enjoy ourselves the entire time. We also knew that a part of winning is luck.

MZ: Did anything in your childhood or adolescence prepare you for the show?
Kat: I loved the show because of the travel. I love to travel and was lucky to have had opportunities to travel as a child. Even though super busy at school or at work, I would always try to find time to travel. I would save up for it because travel is one of my passions, although admittedly, “TAR” is a different way to travel.

MZ: What did your parents think about your being on “TAR”?
Kat: At first they were cautious about my taking time from the job that I just started a year ago. Then, seeing me on the show and what a great experience it was for me, they were happy and proud.

MZ: I would be proud of you even if you didn’t win. Were the people in your practice supportive of your taking the time off?
Kat: Oh yes, they were great, really supportive. They let me take the time off, and the philosophy here [Kaiser] is much more about having balance in your life. Taking time off to do something special is valued where I work. I really appreciated it, especially as this was a once-in-a-lifetime opportunity.

MZ: For the people now coming out of residency, balancing their lives is important to them. This is in contrast with the prior generation of physicians, where we “lived” medicine. How important is quality of life to you—your personal interests outside of medicine—and what would you tell your colleagues?
Kat: I think it is really important to have a balanced life outside of medicine. It ultimately makes you happier and lets you take better care of your patients as well as relate better to others. You'll be happier in your job, you'll be less likely to burn out, and when you are at work, you are excited to be there. You will have a happier family life as well. I am a child of the generation that lived to work, instead of working to live. I didn’t see my father as much as I would have liked because he was working a lot. That definitely influenced my views on how I want to live my personal life and how to balance my professional work with outside interests.

MZ: How meaningful was it for you and Kat to be winners of “TAR” as the first all-female team?

Nat: It was not a mission of ours to be the first female team to win. We wanted to represent females in a strong, positive and friendly manner. Being professional females does not mean not being able to have fun, or preclude sweetness or “femininity.” I am glad that we could make it happen, as it was meaningful for other females to see us win. There were fantastic teams in the past on “TAR”; we were pleased to be the team to make it through “the glass ceiling.”

MZ: Are there any further thoughts that you would like to leave with our readers?

Nat: Medicine can be such a passion, a noble calling that is time- and energy-consuming, and for me, it was helpful to be able to do something else. As Kat said, one should take advantage of opportunities that can provide a better balance between your personal and professional lives. Taking the risk of putting myself in a new element like “TAR”—and it does not have to be something so “sensational” or “public”—gives you a fresh perspective and appreciation of what it is to practice medicine. It helps to have other sides to yourself so you can evolve and grow personally and come back to medicine refreshed and reinvigorated, an antidote to burnout, a health and well-being issue that finally has become “front page” even in our journals.

Final comment by MZ: The triumphant victory of Nat and Kat over the diverse challenges of “TAR” truly encapsulates the values of our specialty of anesthesiology—vigilance, competence, empathy, leadership and teamwork. This team of genuinely nice human beings also served as role models to diabetics and others with illnesses or disabilities across our nation. Congratulations to Nat Strand, M.D., and Kat Chang, M.D., winners of the seventeenth season of “The Amazing Race.”
Peering Over the Ether Screen:
The Elephant in the Room

By Karen S. Sibert, M.D., Associate Editor

One of my partners recently sent out a call for an extra pair of hands to help out in the operating room—and with good cause. The patient on the OR table was a woman in her 60s whose massive stroke had left her hemiplegic, aphasic and unable to swallow. She weighed well over 400 pounds. Attempts to place a percutaneous endoscopic feeding tube had failed due to her size, and she was now scheduled for open gastrostomy tube placement under general anesthesia.

Even with two experienced anesthesiologists working on the patient, getting vascular access and an endotracheal tube in place wasn't easy. She was anemic for reasons that weren't fully worked up, and her blood pressure was alarmingly labile. At the end of the procedure, the patient could not be extubated, so she went to the ICU. As it turned out, she never left. The family could not agree on any reduction in the level of life support, and after a stormy five-week stay, she finally expired. The cost must have reached hundreds of thousands of dollars—resources drained away to sustain a patient who had no hope whatsoever of meaningful recovery.

This is really the elephant in the room in all the endless talk about health care costs in America, and it's a subject that few policy makers will discuss in public: the amount of money that we spend fruitlessly on nonbeneficial end-of-life care. I am not talking about comfort measures, hospice care, palliative medicine, or any of the other valuable support functions that ease the process of dying. I'm talking about using the full technical and pharmacologic armamentarium available in our hospitals, and depleting the finite economic resources available for health care, in order to treat people who cannot be restored to any reasonable level of health, function, or quality of life.

In anesthesia, we see this problem every day. As consultants, we aren't involved in the decision-making process, but we are the ones responsible for getting desperately ill patients through a variety of diagnostic and therapeutic procedures. There are days when not a single patient I look after is likely to survive six months, or in some cases, ever to leave the hospital.

Some procedures are palliative and are justified on humanitarian grounds alone—for example, talc pleurodesis for recurrent malignant pleural effusion, or pinning a painful hip fracture. Others are more questionable. How many lung biopsies on ventilated ICU patients ever lead to a diagnosis that changes the treatment plan and improves the outcome?
I bet that most anesthesiologists at some point have asked themselves the question, when faced with a terminally ill patient, “Why are we doing this?” Sometimes the answer is that the family is pushing to have “everything” done—out of loyalty, guilt, or an inability to face the inevitable. Sometimes it seems that the primary doctor is casting about to find something else to offer as a treatment, whether or not there is much likely benefit. Sometimes a deadening inertia takes over, and it involves more effort to stop doing things than it does to continue. (No one enjoys conferring with the hospital's ethics committee.) Once everyone has agreed to schedule a procedure, the anesthesiologist hesitates to put any roadblocks in the way. Raising any objection will only upset the family. And, let’s be honest: in a fee-for-service system, cancelling the case will deprive both the surgeon and the anesthesiologist of income.

Lately there has been more public discussion about the millions of dollars we are spending on patients in the last months of life. Dr. Atul Gawande published a thoughtful article titled “Letting Go” in the August 2, 2010, issue of The New Yorker magazine. It focuses most on the experiences of relatively young cancer patients, and the difficulty of balancing quality of life and heroic treatment. Anesthesiologists have a different perspective. Many of our aging patients suffer from chronic problems that compound to the point where meaningful recovery is improbable. At what point does it become unreasonable to pursue further aggressive, costly treatment? Should intensive care units continue to evolve into premortem holding wards?

One of the saddest facts about the health care reform bill is that an important provision was deleted in the final negotiations: one that would have allowed Medicare to compensate doctors for time spent with patients and families to plan for end-of-life care. In the public hysteria over “death panels,” this provision was dropped. Certainly in managed care or “accountable care” systems, we must guard against an unethical incentive to reduce services or cancel cases just to save money. However, time-consuming counseling is critical so that patients and families can truly understand their options. This should occur with the patient and/or family well before the patient comes to the operating room. The fallback position inevitably is to “do everything,” wasting millions if not billions of dollars in the process.

A few months ago, I was scheduled to give anesthesia to a 99-year-old man for a cardioversion. He had come into the hospital with an exacerbation of congestive heart failure and now was feeling much better since his medications had been optimized. In fact, he was ready to go home. Although he already had a pacemaker, the cardioversion had been proposed because his underlying rhythm was atrial fibrillation, and it might slightly improve his cardiac output.
The patient was alert and delightful, but he weighed only 110 pounds and looked as fragile as a bird. He might do fine with a cardioversion, but the slightest complication (let alone CPR) almost certainly would be the end of him. For the first time in my more than twenty years in anesthesia, I pulled the brakes. I took the patient's daughter into the hallway and said that if he were my father, I would put him in the car and take him home to enjoy the high holidays with his family. The daughter looked startled but relieved. The cardiologist had no objection, and said that cardioversion probably wouldn't help much anyway. The patient and his daughter left. I was actually quite shaken up after the fact, hoping that I had done the right thing.

If anesthesiologists never speak up, are we doing our job as physicians? Or are we ignoring the elephant in the room, and furthering the uncontrolled consumption of medical care in the last weeks of life? There is only so much money available to pay for health care services. Our nation needs for physicians to make sure that we use our resources wisely and ethically, for care that brings true benefit.

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Guide to Maintenance of Certification in Anesthesiology (MOCA)

By David L. Brown, M.D., Secretary, The American Board of Anesthesiology, Inc.

What Is MOCA?

Maintenance of Certification (MOC) is an active process of assessment and continuous professional development that allows participants to demonstrate ongoing competency with advances in the field of medicine throughout their entire careers. The MOC concept originated with the American Board of Medical Specialties (ABMS) in 1999. As a member board of the ABMS, the American Board of Anesthesiology (ABA) has been charged with implementing MOC activities that will assure the public that its diplomates:

- Are up-to-date with knowledge of their specialties
- Hold unrestricted medical licenses
- Are respected in their practices by peers and patients
- Demonstrate professionalism as physicians
- Continually evaluate and improve their practices

The ABA recognized the importance of such an initiative and developed the Maintenance of Certification in Anesthesiology (MOCA) program to help physicians demonstrate their commitment to quality clinical outcomes and patient safety. MOCA offers ABA-board-certified anesthesiologists the opportunity to participate in a four-part process for continuous learning, while advancing the standard of specialty medical care.

Each MOCA cycle is a 10-year period that includes ongoing Lifelong Learning and Self-Assessment; continual assessment of Professional Standing (medical licensure); periodic assessments of Practice Performance; and a decennial assessment of Cognitive Expertise. MOCA is an opportunity for physicians to improve their skills in six general competencies—Medical Knowledge; Patient Care; Practice-Based Learning and Improvement; Professionalism; Interpersonal and Communication Skills; and Systems-Based Practice.

ABA diplomates certified in 2000 or after hold a time-limited certificate and are automatically enrolled in MOCA after initial board certification. This allows them the full 10-year period to meet all requirements. To avoid expiration of certification, all MOCA requirements must be completed within the 10-year period.
period. Participation in MOCA by non-time-limited diplomates, those certified before 2000, is voluntary and encouraged.

Who Benefits From Participation in MOCA?

The Public. MOCA should benefit the public to the extent that participation requires assessment of clinical practices and pursuit of changes to improve them, and hence, patient quality. Medical specialists who participate in MOCA are using evidence-based practice guidelines, practice parameters, and standards in their specialty and are recognized as leaders in the national movement for health care quality.

Our Physicians. From a professional perspective, MOCA is an indication to the public that an anesthesiologist has met—and is maintaining—a high standard of knowledge in the specialty. Through MOCA, physicians demonstrate that they can assess the quality of care they provide compared to peers and national benchmarks, and then apply the best evidence or consensus recommendations to improve that care. MOCA also may help meet payer, regulatory and consumer demands for quality.

Health Systems and Medical Centers. If MOCA participation is a driver of improved patient outcomes, then these may translate to increased efficiencies, reduced complications, and cost-effective care. As case-based payment plans proliferate, health systems and medical centers benefit greatly when their patients have fewer complications and undergo care more efficiently.

What Are the MOCA Requirements?

The MOCA requirements have changed over the past 10 years in order to meet ABMS standards. Diplomates certified in years prior to 2010 (2000–2009) will have differing requirements based on the year they were certified. A full list of requirements by cohort is available on the ABA Web site at www.theABA.org.

The following requirements are valid for diplomates certified in 2010 or after.

Part 1: Professional Standing

ABA diplomates must hold an active, unrestricted license to practice medicine in at least one jurisdiction of the United States or Canada. Furthermore, all U.S. and Canadian medical licenses that a diplomate holds must be unrestricted. To fulfill this requirement, diplomates should annually review and update their medical license information via their portal account at the ABA Web site at www.theABA.org.
Part 2: Lifelong Learning and Self-Assessment

ABA diplomates should continually seek to improve the quality of their clinical practice and patient care through self-directed professional development. This should be done through an assessment of current knowledge and participation in continuing medical education (CME) activities and other learning opportunities.

To fulfill this requirement, diplomates certified in 2010 and after must complete 350 CME credits during the 10-year cycle. Of that total, at least 250 credits must be Category 1 credits—that is, ACCME (Accreditation Council for Continuing Medical Education)/AMA (American Medical Association) PRA (Physician’s Recognition Award)-approved. A maximum of 70 credits per calendar year will be applied toward the requirement.

Ninety of the 250 Category 1 credits must be evaluative CME. Accordingly, diplomates must complete 90 CME credits through the ASA’s Anesthesiology Continuing Education Program (ACE) and/or the ASA’s Self-Education and Evaluation Program (SEE). Finally, 20 CME credits of patient safety education must be included in the diplomate’s CME portfolio. Both the ASA and the ABMS offer Patient Safety Modules that meet this requirement.

Diplomates should submit CME activities to the ABA via their portal accounts at www.theABA.org. Self-reported CME activities are subject to audit and verification by the ABA within three years of submission. CME activities reported to the ABA by qualified CME providers, such as the ASA, are not subject to audit.

Part 3: Cognitive Examination

Diplomates must demonstrate their cognitive expertise once every 10 years by passing an ABA examination. The examination may be completed only in years 7 through 10 of the MOCA cycle.

Diplomates certified in 2010 and after must have satisfactory Professional Standing, one satisfactory Practice Performance Assessment and Improvement Activity (see page 39), and at least 200 CME credits to be eligible for the examination.

Diplomates are allowed to take the examination up to twice a year. If the examination is not passed before the end of the 10-year MOCA cycle, then the diplomate’s certification will expire.
Part 4: Practice Performance Assessment and Improvement

Diplomates certified in 2010 and after must complete two activities over their 10-year MOCA cycle to demonstrate that they are participating in evaluations of their clinical practice and are engaging in practice improvement activities.

They must complete one four-step case evaluation process to assess their practice and implement changes that improve patient outcomes. They must also complete one simulation course at an ASA-endorsed simulation center.

One of these activities must be completed during the first five years of the MOCA cycle and the other activity must be completed during the last five years. Please note that diplomates will only receive credit for 1 simulation course per 10-year MOCA cycle.

Examples of case evaluations and a link to ASA-endorsed simulation centers can be found in the MOCA section of the ABA Web site at www.theABA.org.

The above MOCA requirements are valid for diplomates certified in 2010 or after. A full list of requirements by cohort is available on the ABA Web site at www.theABA.org. You may also contact the ABA Customer Service Center with any questions at 866-999-7501.

ABA Numbers for Reporting CME credits!

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

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

Just this past October, the ASA House of Delegates (HOD) amended the ASA Standards for Basic Anesthetic Monitoring to include monitoring for the presence of exhaled carbon dioxide (CO₂) during moderate or deep sedation. At first blush, this change seems simple enough, but it will have some very far-reaching effects on many levels, for a range of practitioners, in diverse settings. To appreciate its implications, a little peek into the realm of ASA Practice Parameters—the what, the who, and the how, as regards our common fundamentals of anesthetic practice—seems like a good place to start.

Standards and Other Practice Parameters

Parameters are factors or characteristics, often used to define limits, boundaries, or an acceptable range of values, or guidelines, as in “the parameters of our foreign policy.” Practice Parameters, as used by the ASA, intend to provide guidance for a range of behavior by practitioners “to improve decision-making and promote beneficial outcomes for the practice of anesthesiology.” These Practice Parameters may be either evidence-based (standards, guidelines, or advisories) or consensus-based (policies concerning professional conduct or statements concerning clinical care). Of the evidence-based parameters, standards are essentially rules or minimum requirements that may be modified only in rare situations such as dire emergencies or when equipment is unavailable. Standards are supported scientifically with multiple clinical trials and meta-analyses (Category A, Level I evidence). Guidelines and advisories are also supported scientifically, but with lesser levels of evidence; they may be modified or rejected for clinical reasons, and local institutional policies can overrule them. Statements reflect the opinions and expertise of the ASA HOD, Board of Directors (BOD), or senior leadership.

Practice parameters are written, updated, and revised by the ASA Committee on Standards and Practice Parameters (CSPP), then brought to the ASA BOD, and eventually to the ASA HOD for ratification or rejection. There they must be either voted up or down, or referred for revision; no modification is permitted. There is a rigorous standardized process that includes both scientific and
consensus-based evidence: analysis of the literature, expert opinion, surveys of ASA members, feasibility data, and open forum commentary.

It was just 20 years ago, in 1991, that the ASA embarked upon the development of evidence-based practice parameters, and this was after the only three existent and enduring ASA standards (Basic Standards for Preanesthetic Care, Standards for Basic Anesthetic Monitoring, and Standards for Postanesthesia Care) had already been written. Going forward, all new standards will require the highest levels of evidence, but as those now in effect are considered for modification (every five years, as stipulated by ASA policy), the process may well be more akin to that of creating consensus documents, i.e., based upon science but lacking the availability of Class A, Level I evidence. This accounts for the fact that there are still only three ASA standards. All other practice parameters to date are not supported by a sufficient level of science to qualify as standards. If and when more scientific studies become available—that is, when there is more rigorously derived scientific evidence—then the standards will likely be rewritten to reflect that level of evidence. For this reason, we are left with the counterintuitive curiosity (essentially an artifact of history and organizational evolution) that at present the ASA parameters that are most prescriptive, our specialty’s only three standards, essentially rules of conduct, were not developed with as rigorous attention to evidence as are our present guidelines or advisories.

**General Anesthesia, Endotracheal Intubation, and Exhaled CO₂**

Now, back to the future with exhaled CO₂ monitoring. A previous revision to the Standards for Basic Anesthetic Monitoring, in order to ensure the adequacy of ventilation during general anesthesia, mandated that “continual monitoring for the presence of expired carbon dioxide shall be performed unless invalidated by the nature of the patient, procedure or equipment.” Moreover, it required that exhaled CO₂ must be detected upon insertion of an endotracheal tube or laryngeal mask airway, quantitative analysis for exhaled CO₂ shall be performed, and end-tidal CO₂ alarms shall be activated and audible. These requirements were readily accepted by anesthesiologists, and in fact others who insert endotracheal tubes also have accepted the necessity of confirming correct positioning by detecting exhaled CO₂.

**Monitoring Exhaled CO₂ with Moderate and Deep Sedation**

Meanwhile, in a parallel universe, there were several years of impassioned discussion about moderate and deep sedation at the ASA and in various...
component societies. ASA leaders developed a growing appreciation that the CSA’s approach to privileging non-anesthesiologists was perhaps more realistic or useful than the initial ASA statement, which declared that deep sedation and general anesthesia are essentially equivalent and thus should only be administered to patients by anesthesia-trained practitioners. This discussion now also began to include extending the use of exhaled CO₂ monitoring to settings beyond general anesthesia. With a focus on enhancing patient safety, CSPP concluded that monitoring exhaled CO₂—both as a kind of “apnea monitor” and as a trending device to help identify progressive hypoventilation⁸—would help anesthesiologists better care for patients having both deep and moderate sedation. Although deeply sedated patients are more likely to have issues of airway obstruction and hypoventilation than moderately sedated patients, the stages of sedation (defined by four parameters—responsiveness, airway adequacy, spontaneous ventilation, and cardiovascular function)⁹ are a continuum, blending into one another. Surely patients intended to be moderately sedated may become more deeply sedated and thereby have potential issues of inadequacy of ventilation. In fact, experienced clinicians have long known that supplemental oxygen therapy may disguise the presence of marked hypercapnia—and even suppress ventilatory drive—in patients manifesting normal oximetry readings.

Consequently, the Standards for Basic Anesthetic Monitoring were revised with a consensus in the committee, acceptance at the BOD, and little discussion or fanfare at the HOD. Beginning in July 2011 (allowing time to appreciate the change and secure the required monitoring equipment),

*During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.*

Hence, regional anesthesia with moderate or deep sedation is subsumed within this mandate. Moreover, the preamble to the Standards clearly states that they apply to all anesthetic care, including general anesthesia, regional anesthesia, and monitored anesthesia care (i.e., moderate or deep sedation), with limited exceptions (e.g., obstetric care).
Revised CMS Interpretive Guidelines

In the meantime, while the ASA is focused on patient safety and updates Standards intended to improve care by anesthesiologists, the Centers for Medicare and Medicaid Services (CMS) is busy completely rewriting its Interpretative Guidelines (IGs) relating to Hospital Conditions of Participation (CoP) governing anesthesia services, aiming to standardize care for all patients within hospitals that have contracts with Medicare. CMS promulgated regulations in December 2009 and May 2010 that decreed that all anesthesia-related services along the continuum of anesthesia care available in a hospital 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. Moreover, CMS-defined “anesthesia” (general anesthesia—deep sedation is treated like general anesthesia by CMS—regional anesthesia, and monitored anesthesia care) now can only be given by anesthesiologists, non-physician anesthesia practitioners, other physicians, dentists, oral surgeons and podiatrists who are qualified to administer anesthesia under state law. CMS specifies that other anesthesia services that are not “anesthesia” (topical and local anesthesia, minimal sedation, moderate sedation/analgnesia, also known as “conscious sedation,” and obstetrical “analgesia” short of surgery) are not subject to these restrictions as regards who may administer them. To respond to this major change by CMS, the ASA has written a Statement on Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners.¹⁰

Putting together the revised ASA Standards and the revised CMS IGs, what was written by CSPP for anesthesiologists now appears to apply more broadly. There appears to be a de novo requirement by CMS that all anesthetic care must be rendered to the same standard within one hospital, no matter in what location or by what practitioner. This should mean that monitoring for exhaled CO₂ must be done for all moderate and deep sedation not only by anesthesiologists wherever they render services (Cath Lab, ER, PACU, ICU, GI Lab, etc.), but also by all other non-anesthesiologist sedation practitioners. However, this is complicated and confused by CMS’s looking at this with the perspective of its own unique parsing of what is and what is not “anesthesia.” As far as CMS is concerned, moderate sedation is not “anesthesia,” but to the ASA, during moderate sedation, exhaled carbon dioxide must be monitored. There is no indication that CMS expects anyone to follow the ASA Standards, but if anesthesiologists are to be held to this standard, should not those with less expertise in administering sedation do the same? At a minimum, anesthesiologists must work with their facilities to have available in all anesthetizing locations the equipment for adhering to these newly modified ASA Standards,
and this includes sedating locations (moderate or deep sedation, so-called by others “conscious” or “procedural” sedation) where they may be called upon to render any level of anesthetic care. The effective date of July 2011 is intended to allow reasonable and adequate time for this to be effected and to avoid any accreditation inspection issues.

**Non-Anesthesia Practitioners and Exhaled CO$_2$ Monitoring**

This whole issue potentially becomes more problematic for non-anesthesia practitioners, who may object and claim that these are not their standards and that moderate sedation is not “anesthesia,” according to CMS. Fortunately, some specialty societies already appear to be moving to embrace and to adopt these new standards. Indeed, consider this scenario: if some anesthesiologist is the physician director of anesthesia services for a particular hospital and mandates these standards of monitoring, then it becomes a privileging matter for the hospital medical staff. Many anesthesiologists as individual practitioners might personally believe that policies for moderate and deep sedation could be different, but that is not what the ASA Standards say, at least as far as monitoring for exhaled CO$_2$ is concerned. If, perhaps for local political reasons, or perhaps because they do not accept the ASA logic, an individual medical staff via its Medical Executive Committee (MEC) decides not to institute the mandate, then that MEC will have set its own minimum standard, which could be exceeded by anesthesiologists. Dr. Jeff Apfelbaum predicts, based upon his knowledge and experience,\textsuperscript{11} that if such a hospital were to be surveyed by CMS, then it is very likely that compliance with their own medical staff policies would likely be sufficient because CMS’s focus is on compliance with CMS regulations. If, however, the MEC does not set a minimum standard, considering what an anesthesiologist director of anesthesia services might mandate and what the revised IGs require, then this might not pass muster with CMS surveyors.\textsuperscript{12}

Each of the deemed accrediting organizations survey at a minimum for compliance with CMS regulations, but they may also have standards beyond this “minimum.” The Joint Commission, by far the most common surveyor for CMS, declares this mission:

*To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.*

How a hospital with two different levels of care for moderate sedation would fare with any of the deemed surveyors is not predictable at this time.
It is likely that monitoring for exhaled CO₂ will become the standard in all health care institutions. Whether the “driver” for this change will be departments of anesthesiology or rather managers of patient safety and risk management remains to be seen. However it plays out, it is important that CSA members digest the implications of the revised ASA Standards, and thereby be poised to serve as a resource in their own institutions for improving patient care and ensuring compliance with regulatory mandates.

The author wishes to thank Dr. Jeffrey Apfelbaum, Chair of the ASA Committee on Standards and Practice Parameters, Professor and Chairman of the Department of Anesthesia and Critical Care at the University of Chicago Hospitals and Pritzker School of Medicine, Past President of the ASA, and currently President of the Society of Academic Anesthesiology Associations and the Association of Academic Anesthesiology Chairs, for sharing his considerable knowledge and expertise, and for serving as a resource and a mentor for me as I wrote this article.

1 “Standards for Basic Anesthetic Monitoring” http://www.asahq.org/For-Healthcare-Professionals/~/media/For%20Members/documents/Standards%20Guidelines%20Stmts/Basic%20Anesthetic%20Monitoring%202011.ashx


3 “Policy Statement on Practice Parameters” http://www.asahq.org/For-Healthcare-Professionals/~/media/For%20Members/documents/Standards%20Guidelines%20Stmts/Practice%20Parameters.ashx

4 The Preamble to the Standards document clearly delineates the circumstances in which the Standards do and do not apply, as does the “Policy Statement on Practice Parameters” (cited just above) for other practice parameters.

5 A description of the Classes and Levels of evidence is found in all recent ASA Practice parameters, e.g., in the newly revised “Practice Advisory for the Prevention of Peripheral Neuropathies” http://www.asahq.org/For-Members/Clinical-Information/~/media/For%20Members/Practice%20Management/PracticeParameters/PerioperativePeripheralNeuropathies.ashx

6 Roster of the Committee on Standards and Practice Parameters http://www.asahq.org/sitecore/content/Home/For-Members/About-ASA/ASA-Committees.aspx#stan

7 “A task force of 8-10 anesthesiologists leads each practice parameter project. Its members are chosen carefully to provide a balance between private practice and academia as well as representation from each major geographic area of the United States. Each task force, in turn, identified approximately 75-100 consultants who serve as an additional source of opinion, practical knowledge, and expertise. The consultant group’s diversity helps to ensure a broad perspective and good ‘reality testing.’” Ahrens, JF, Chair. Interim Report of the Committee on Practice Parameters, March 2003.

8 Dr. Jeffrey Apfelbaum, Committee Chair, personal communication.
Monitoring Exhaled Carbon Dioxide (cont’d)

9 Continuum of Depth of Sedation https://www.asahq.org/For-Members/Clinical-Information/~media/For%20Members/documents/Standards%20Guidelines%20Stmts/Continuum%20of%20Depth%20of%20Sedation.ashx


11 Dr. Jeffrey Apfelbaum, Committee Chair, personal communication.

12 For hospitals, there are now three CMS-approved accreditation organizations—The Joint Commission (TJC), the American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP), and DNV (Det Norske Veritas) Healthcare (DNV). As of July 2010, TJC’s “deemed” status is no longer written into the law, and it must apply to CMS for deeming authority, just like any other organization.


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Workshop registration fees are in addition to conference registration. If you aren’t attending the conference, and wish to only attend the workshop, please contact CSA at 650-345-3020 to be put on a wait list. Workshop only fee is $300. Conference attendees and CSA members receive priority for the workshop. This workshop is for physicians only.

Total $ _______

No refunds for cancellations after April 21, 2011

Register for this meeting online: www.csahq.org

Disabled persons with special requirements should contact the CSA office 14 days prior to the meeting.
Stanford’s Department of Anesthesia Celebrates 50 Years

By Patricia I. Rohrs, Medical Editor and Writer, Department of Anesthesia, Stanford University, and Ronald G. Pearl, M.D., Ph.D., Chairman, Department of Anesthesia, Stanford University

In 1959, the Stanford Medical School moved from San Francisco to Palo Alto in order to take advantage of Stanford University’s strengths in basic science. The next year, 1960, the Department of Anesthesia was founded by Dr. John Bunker, who noted, “My job at the outset was to attract a research-oriented faculty.” And he did. However, over the next 50 years the department also has expanded its clinical care, education and leadership in our ever-more complex and challenging environment. The following is a small snapshot of some of today’s exciting areas, acknowledging our debt to the many who have built the department that we have become.

Research

Because anesthesiologists “own” all organ systems, the department’s research questions have explored interlocking themes: mechanisms, safety and toxicity, physiology, clinical pharmacology, monitoring technology, simulation training, and, more recently, the merger of neuroscience, pain, immunology, molecular biology, and genetics. Neuroscience and pain studies in the 1980s included neuronal ischemia, introduction of neuraxial opioids into obstetric anesthesia practice, characterization of nociceptors, and “pressure reversal of anesthesia,” which served as a precursor to studying anesthetic effects on synaptic circuits. In the 1990s, themes included models of cerebral ischemia that defined injury mechanisms and identified the responses of brain cells to stroke. In addition, the first human experimental pain laboratory was established. And then during

Real-time fMRI scan demonstrating the training effect in rostral anterior cingulate cortex

Winter 2011
the 2000s, pain research exploded. Human studies included (1) systems neuroscience techniques—neuroimaging, psychophysics, and neurocognitive assessments—to characterize pain systems and to teach patients to control brain networks to reduce pain; (2) objective biomarkers of pain; (3) the interrelationship of persistent pain and opioid use after surgery; (4) pain mechanisms during pregnancy or after cesarean surgery; (5) clinical trials of glial cell modulators to treat chronic pain; (6) anesthetic effects on brain cells and neuronal circuits during deep brain stimulation; (7) opioid-induced hyperalgesia in chronic pain patients; and (8) the genetic heritability of opioid responses. In animals, studies included the role of heme oxygenase and other mediators in nociceptive mechanisms, pain mechanisms, and treatment of chronic pain with cell transplantation and gene therapy. Over the next decade, our biomedical research will use new data-intensive tools—computational genetic mapping, haplotype mapping, and pharmacogenetics—to study how genetic variation affects disease susceptibility and drug response.

Education

Following the early days of anesthesia apprenticeship training, Stanford anesthesia's educational environment has grown more technology-intensive, innovative, and personal. We generate interest in medicine and anesthesiology by teaching undergraduate seminars and directing medical students' scholarly concentrations (neuroscience, biomedical ethics and medical humanities). Through START, a 10-month online course, we engage and prepare interns from all over the country before they actually begin their residency training. Once at Stanford, first-year residents dive into a resident-designed and -led one-month mentorship program. During residency, they do cases in pediatric, cardiac, orthopedic, and ambulatory anesthesia, chronic pain, and perioperative medicine, including multidisciplinary and subspecialty-focused critical care. They learn the principles and practices underlying the management of crisis situations. Through the vehicle of laser capture technology, residents can download recorded, searchable lectures (such as Grand Rounds) to their iPods in order to learn and review at their convenience.
Residents benefit from exceptional faculty who develop in-depth learning experiences through our nationally recognized Teaching Scholars Program. Several departmental websites (ether.stanford.edu and med.stanford.edu/anesthesia/) and the MedHub system provide extensive resident resources. Research-oriented residents can jump-start their research careers by becoming Stanford FARM (Fellowship in Anesthesia Research and Medicine) scholars and joining the Stanford Society of Physician Scholars. Many of our residents and fellows participate in medical missions related to global health throughout the world. Residency graduates have the opportunity to pursue fellowship training, reflecting the increasing subspecialization within the field of anesthesia. Stanford is one of only two California departments (Loma Linda is the other) to offer all four ACGME-approved fellowships (pediatrics, cardiac, pain, and critical care), and additional fellowships are offered in areas such as OB, regional anesthesia, patient safety and crisis management, perioperative management, difficult airway/ENT, and basic or clinical research. In all stages of education, simulation and immersive learning are integral to training (see below). Finally, not to be missed is residency director Alex Macario’s blog, Ask Alex, in which he addresses any and all questions!

Simulation and Immersive Learning

According to Dr. David Gaba, Professor of Anesthesia, Associate Dean for Immersive and Simulation-Based Learning, and the developer of realistic medical simulation in anesthesia, “The goal is to have experiential learning completely embedded, starting at the beginning of students’ education and maintained through their careers”\(^2\) to help the trainee “go from being under supervision to being it.”\(^3\) In the 1980s, noting the parallels between skills development, dynamic decision-making, and teamwork on an aircraft’s flight deck and the same factors in an operating room, Dr. Gaba and colleagues built the first mannequin-based, realistic anesthesia patient simulator. The simulator incorporated monitoring, lifelike physiological responses, clinical pharmacology, and anesthesia effects. Standardized skills training resulted and expanded to include anesthesia crisis resource management, which focuses on communicating with—and leading—the medical team in an emergency. Now, in the medical school’s brand-new, 28,000-square-foot Center for Simulation and Immersive Learning, trainees can work within a simulated OR, ICU, or ER as well as large-disaster environments.

Trainees also participate in pediatric and OB simulation at the Lucille Packard Children’s Hospital (LPCH). These environments contain computerized mannequins simulating standard patients, a mock clinic in which patient-actors interact with trainees, rooms for learning hands-on medical and surgical
procedures, and virtual-reality worlds in which trainees’ avatars solve patient crises. Dr. Gaba and colleagues plan to add more simulations to the working environment throughout the School of Medicine. For instance, residents may answer an emergency call only to find an in situ, simulated crisis with which to deal. The objective for learners within these high-fidelity simulation situations is to hone skills, get fully debriefed, incorporate expert feedback, continuously improve performance, and build confidence.

Pain Management

As the field of anesthesiology has evolved into perioperative medicine, we have begun to study why chronic pain develops after injury or surgery and how to prevent or reverse it. The department’s Pain Management and Pediatric Anesthesia divisions have pursued multidisciplinary approaches to researching, treating, and managing chronic pain in adults and children. “The subspecialty of pain medicine has developed its own identity over the last decade or two,” says Dr. Sean Mackey, chief of the adult, 24-physician Pain Division. Dr. Elliot Krane, head of the pediatric pain management clinic, concurs. A single-physician approach has evolved into a collaborative team that includes physicians, psychologists, physical therapists, nurses, and, in pediatric pain, even a golden retriever, who together seek to “predict, prevent, and alleviate pain.” One overarching goal is to teach patients self-management techniques, such as cognitive behavioral change, distraction, relaxation, breathing, meditation, massage, exercise, and functional MRI neurofeedback, which trains the mind to change its response to pain, thereby modulating the pain itself.

The new Stanford Medicine Outpatient Center (shown on the facing page) is a perfect venue for Pain Division doctors to team up with neurologists (headaches), gastroenterologists (abdominal pain), ENT physicians (orofacial pain) and other specialists who practice in the center. The Pain Division offers two residency rotations—acute pain and chronic pain—and seven multidisciplinary fellowship positions. The division receives significant support from the National Institutes of Health (NIH) and other research sponsors and publishes widely
cited papers. In 2008, the American Pain Society recognized the Pain Division's clinical and research excellence with one of the first Clinical Center of Excellence Awards.

**Pediatric Anesthesiology** \(^4,5\)

In 1970, long before pediatric anesthesiology was a formal subspecialty, Dr. Alvin Hackel invented an infant transport incubator/monitor to transfer critically ill neonates to centers equipped to treat them. Today, Division Chief Dr. Anita Honkanen states, “The physiology of every organ system differs, depending on a child’s development, including a child’s emotional needs, which change dramatically with age.” Pediatric patient complexity, combined with the fact that LPCH has the highest acuity index of any U.S. children’s hospital, has resulted in pediatric anesthesia’s explosive growth. The 30 fellowship-trained pediatric anesthesiologists practice in a variety of locations, including LPCH’s new OR suite, several out-of-OR facilities (Procedure, Preop, PICU suites), a post-anesthesia care unit suite for pediatric oncology patients and their families, an outpatient chronic pain clinic, and an in-patient palliative care service.

Fellowships have grown, too, including the popular pediatric pain and cardiac anesthesia super-fellowships. The pediatric in situ simulator (SimBaby) can be wheeled to any pediatric location, where trainees learn to manage crises, identify system errors, and create safer patient environments. \(^6\) With LPCH’s planned expansion, anesthetizing locations will double in the next few years. NIH-funded pediatric anesthesia research has expanded, particularly with Dr. Greg Hammer’s clinical pharmacology program.

**Multidisciplinary Critical Care**

In the mid-1970s, then Chair Dr. Philip Larson recognized that a multidisciplinary ICU with significant anesthesia leadership was the best way to care for critically ill patients—whether critical illness was due to medical, surgical,
or traumatic etiologies. Dr. Mike Rosenthal was recruited jointly by Anesthesia, Medicine, and Surgery and for 25 years provided leadership in the ICU, training residents and over 100 fellows in diagnosing and treating ICU patients based on their physiology.

At the VA Palo Alto Health Care System, beginning in 1993, Dr. Eran Geller created and led the multidisciplinary, medical-surgical ICU, composed of intensivists from anesthesia, medicine and surgery, ICU-trained nurses, respiratory therapists, pharmacists, dieticians, and social workers. Supported by an analytic database, the MSICU became a national model for improved clinical care and patient outcomes. It also provided a venue for studying the fundamental pharmacokinetics and pharmacodynamics of intravenous sedatives in the ICU. Today, anesthesiologist-intensivists provide 24-hour coverage in multiple ICU locations: the medical-surgical, trauma-general surgical, and cardiothoracic ICUs at Stanford Hospital; PICU at LPCH, and the trauma-anesthesiology ICU at Santa Clara Valley Medical Center. At monthly multidisciplinary ICU conferences, members of all teams share their challenges. Daily critical care lectures cover such topics as shock and sepsis. Stanford now has 14 fellowship positions in critical care medicine. In this fastest growing, most expensive area of medicine, opportunities in critical care abound.

**Leadership**

As chair during the past 12 years, Dr. Ronald Pearl has overseen tremendous growth in all the departmental missions, including clinical care, education, research, and leadership. Reflecting on the first half-century of the department, he noted, “On my fifth birthday, I was told it was a milestone…. a road marker used during the Roman Empire to indicate distance traveled and to confirm one is traveling the right path. On our 50th milestone, what we celebrate is
growth, accomplishments, and potential.” Looking both back and ahead, the department honors the leaders who traveled our road, leaders who recognized that “leadership and learning are indispensible to each other,” and that “opportunities multiply as they are seized.”

Statistics: The 200 Anesthesia faculty members (including 57 women) practice in three hospitals (over 100 operating rooms and procedural suites), five Intensive Care Units, four pre-operative assessment clinics, and three pain management centers. We train 72 residents and 30 fellows per year.


Statistics: Pediatric anesthesiologists at LPCH care for greater than 7,500 infants, children, teens, and young adults per year for organ transplantation, complex cardiac surgery, radiation therapy, and invasive radiological procedures.

Much of this section is based upon Becky Oskin’s “It’s Not Child’s Play,” from Stanford Anesthesia © 2010.


From “From the Chairman,” Stanford Anesthesia © 2010

John Fitzgerald Kennedy

Sun Tzu
Pediatric Anesthesia CME Program

Module 3

This is Module 3 of CSA’s Pediatric Anesthesia Continuing Medical Education Program (CME). To receive CME credit, submit your registration page, answers to the questions, and the evaluation to the CSA office by mail or fax 650-345-3269. Your CME certificate will be mailed to you. Alternatively, the full text of each module will be accessible through the CSA Web site, www.csahq.org, in the Online CME Program section. Instructions to complete Module 3 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 Module 3 must be read and acknowledged before proceeding to the rest of the module. Check the acknowledgement box on the registration page.

Faculty/Disclosures

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

Samuel H. Wald, M.D.
Clinical Professor of Anesthesiology
David Geffen School of Medicine
University of California at Los Angeles

Dr. Wald discloses that his wife is employed by Endo Pharmaceuticals.

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 acknowledging that you have read everything in these introductory pages.

Availability

Module 3: Pregnancy Testing in Adolescents

Release Date: February 28, 2011
Expiration Date: February 28, 2014

CME Sponsor/Accreditation

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

Fees, Target Audience, Evaluation

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

Privacy Policy

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

Objectives

Upon completion of this activity, participants will be able to:
Pediatric Anesthesia (cont’d)

- Evaluate the necessity of pregnancy testing in adolescent patients presenting for anesthesia care
- Cite the legal issues pertaining to pregnancy testing and the disclosure of the results
- Differentiate the ethical concerns for the care of adolescent patients
- Develop a plan for the perioperative care of adolescent patients with a positive pregnancy test

* * * * * *

Pregnancy Testing in Adolescents: Practice, Law and Ethics

By Samuel H. Wald, M.D.,
Clinical Professor of Anesthesiology, David Geffen School of Medicine,
University of California, Los Angeles

Dr. Wald, a faculty member at UCLA for 11 years, is the Associate Director of the university’s Residency Program in Anesthesiology and the Associate Vice-Chair of Education. Within the CSA, he sits on the Board as Director for District #11, is an active participant in both the Educational Programs Division and the Legislative and Practice Affairs Division, and serves as a delegate to its House of Delegates. He is also a delegate to the ASA House. An academic pediatric anesthesiologist, Dr. Wald has been a frequent invited speaker for the California Society of Anesthesiologists, the Society for Pediatric Anesthesia, and the American Society of Anesthesiologists on a number of topics. His research has focused on pediatric thoracic anesthesia and the pediatric difficult airway. Dr. Wald is a member of the ASA Committee on Pediatric Anesthesia.

Introduction

The testing for and the presence of pregnancy in the adolescent patient who presents for anesthesia and surgery is a challenging and controversial issue. There is a high incidence of sexual activity among adolescents and the incidence of teenage pregnancy in the United States is the highest in the industrialized world. Thirty-four percent of young women become pregnant at least once before they reach the age of 20, which equates to approximately 820,000 per year,1 the great majority unintentional. Barriers to the identification of pregnant teenagers include avoidance of medical care, fear of the consequences of the disclosure to family members, and lack of realization that they are pregnant.2
Incidence

A number of institutions have published studies investigating the use of routine preoperative pregnancy testing for human chorionic gonadotropin (HCG) in adolescents. The overall incidence of a positive result in the perioperative period was approximately 1 percent of those tested. Cancellation of anesthesia and surgery for a positive HCG test was inconsistent and dependent on the anesthesiologist, institution and type of surgery. In one study of 207 patients aged 10–20 years, there were five positive results (all of these being 15 years or older). Three postponed surgery; one proceeded with local and no sedation; one did proceed with general anesthesia, but the use of nitrous oxide was specifically excluded. In another study of 532 patients scheduled for orthopedic surgery involving radiation exposure, surgery was cancelled for all patients with positive pregnancy test results. In both of these studies the hospital policy was to test all patients without their explicit consent. An important distinction for the patients in the study in the orthopedic hospital was the likely use of radiation intra-operatively, this posing an additional consideration beyond just the exposure of the fetus to anesthesia and surgery.

The correlation of a detailed history with the results of HCG testing has been inconsistent in published reports. In many of these studies a careful history of the possibility of pregnancy and no recent menstruation did not correlate with positive HCG results. However, although yet to be reproduced in another study, prospective tracking of this correlation in over 500 procedures in adolescent girls found a 100 percent concordance between a suggestive history and the positive test result.

Certain barriers prevent adolescents from obtaining prenatal care. A survey of teenagers who delivered at an urban hospital in an underserved area found that a significant number reported that they first realized that they were pregnant only after someone else told them that they looked pregnant. Given this finding, beyond the assumption of sexual activity, even a good history may not suggest the presence of pregnancy. Additionally, inadequate care in this special population may result from negative attitudes toward physicians as well as an undeveloped appreciation of the importance of early prenatal care. Interestingly, the Centers for Disease Control data on pregnancy rates from 1990 through 2004 show a downward trend in teenage pregnancy in both the 15-17- and 18-19-year-old groups.

Medical Policies, Law and HIPAA

Adolescents older than 14 years have fully developed abstract thought and complex reasoning, and this suggests that anesthesiologists should engage them in decision-making. However, these fully developed cognitive abilities may
not be associated with emotional maturity and hence do not always produce
good decision-making skills. Because adolescents do not fully develop impulse
control and the ability to deliberate sufficiently as regards the potential for long-
term adverse consequences until they reach their early twenties, any health care
decisions that they make involving the possibility of future harm should be
scrutinized by others with more judgment and experience. Nonetheless, the
American Academy of Pediatrics (AAP) policy on informed consent specifies
that the ability to make informed health care decisions may be as well developed
in adolescents as it is in adults. This policy emphasizes the fact that “a respect
of persons involves fully and accurately providing information relevant to
exercising their decision-making rights.” The AAP also urges gaining at least
assent or permission from older children and adolescents when making health
care decisions. Assent involves guiding the patient toward a developmentally
appropriate perception, setting expectations of the proposed care, and assessing
the patient’s understanding of the situation. While inappropriate pressure
should be avoided, it is advised to solicit the adolescent patient’s willingness to
accept the treatment plan.

Indeed, the American Society of Anesthesiologists’ Guidelines for the Ethical
Practice of Anesthesiology (Section I.2) declares that anesthesiologists should
“respect the right of every patient to self-determination … [and] … should include
patients, including minors, in medical decision-making that is appropriate to
their developmental capacity and the medical issues involved.”

Most states have laws concerning minors receiving contraceptives, prenatal
care, sexually transmitted diseases/human immunodeficiency virus (STD/
HIV) treatment, substance abuse treatment, mental health services and abortion
services. States differ in the specific application of those laws and even the age
of majority. Twenty-four states, including California, require parental consent
for abortion, but many (again, including California) do not enforce this law
because of successful court challenges.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Privacy Rule requires that if a person has the right to make health care
decisions, then that person controls the associated information. Usually, the
parents of minors control protected health information (PHI), but the issues
outlined above, including pregnancy, are probable exceptions. More specifically,
parents should not be permitted to have access to their minor child’s PHI under
the following three circumstances:

1. State law does not require parental consent
2. A court of law determines an alternate to the parent
3. The parent agrees to the minor’s confidentiality for health care
In general, HIPAA overrides any contrary state laws except where the state law is “stricter” and provides greater protection. State laws determine the rights of parents to obtain access to and/or control of the disclosure of medical information concerning their children. Practitioners who violate HIPAA by revealing confidential medical information are guilty of unprofessional conduct. This infraction could result in criminal and/or civil liability and put a practitioner’s medical license at risk.9

In summary, parents should have access to their children’s health care information only when that is permitted by state law. When the law is silent, then the professional judgment of the health care practitioner determines whether to grant or deny parental access to a minor's medical information. Additionally, if the health care practitioner has a reasonable belief that information will endanger the minor, then the provider may choose not to disclose certain information. A state-by-state summary can be found at www.ermerlaw.com/PDFs/hipaa_state_law_survey_version_3_0.pdf.

### Table 1. The Jurisdiction of California

<table>
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<th>Service</th>
<th>California Details</th>
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<td>Age of majority:</td>
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<td>Emancipation Methods:</td>
<td>Marriage, Military Service, Leave of Court.</td>
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<td>Contraceptive Services:</td>
<td>Minor may consent independently.</td>
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<td>Prenatal Services:</td>
<td>Minor may consent independently.</td>
</tr>
<tr>
<td>STD/HIV Services:</td>
<td>AIDS: Minor (12 or older) may consent independently, but test results may be disclosed to specified classes of individuals. STD: Minor (12 or older) may consent independently.</td>
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<tr>
<td>Alcohol/Drug Abuse:</td>
<td>Minor (12 or older) may consent to treatment independently, but treatment plan shall involve parent unless the physician determines parental involvement to be inappropriate.</td>
</tr>
<tr>
<td>Mental Health Services:</td>
<td>Minor (12 or older) may consent independently with certain conditions, but parents must be notified unless the physician feels it would be detrimental to the minor.</td>
</tr>
<tr>
<td>General Medical Health Services:</td>
<td>Minor (15 or older) may independently consent if he/she is living separate and apart from the minor’s parents or guardian, and is managing his/her own financial affairs. The physician may inform parents about treatment without minor’s consent.</td>
</tr>
<tr>
<td>Abortion Services:</td>
<td>Written parental consent or court order required. It is common knowledge that this law is widely unenforced.</td>
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</table>
California Law—Consent to Medical Care

California Family Code § 6925 provides:

(a) A minor may consent to medical care related to the prevention or treatment of pregnancy.

(b) This section does not authorize a minor:

1. To be sterilized without the consent of the minor's parent or guardian.
2. To receive an abortion without the consent of a parent or guardian other than as provided in Section 123450 of the Health and Safety Code. However, the California Supreme Court found this Section to be unconstitutional as it violated California's right to privacy provisions.

Section 6925 of the California Family Code has been upheld to find that a minor, regardless of age or marital status, may consent to hospital, medical or surgical care related to prevention or treatment of pregnancy. However, the law does not specify the medical treatments that come within this authorization. While there is extensive legal analysis of the rights to and privacy implications of a minor obtaining an abortion, the authorities do not extend the analysis to other medical procedures or treatment. It is, however, generally assumed by the nonbinding authorities (i.e., California Physician’s Legal Handbook [CPLH], California Health Information Association [CHIA] Consent Manual, Planned Parenthood) on this topic that contraceptive care (including emergency contraceptive drugs), abortion, pelvic exams, pregnancy testing, and prenatal care are common medical procedures related to prevention or treatment of pregnancy (CHIA Consent Manual 2009, 2.18; CPLH 2009, Vol. 1 Consent, 10:65). Also note that under Family Code Section 6920, the consent of a minor’s parent to medical care related to the prevention or treatment of pregnancy is not necessary. Therefore, the “treatment of pregnancy” would reasonably seem to extend to preoperative testing for the existence of pregnancy: after all, treatment cannot begin until the pregnancy is verified. Minors would appear to have the right to exercise informed consent for pregnancy testing without any request being made of the parents. Moreover, in the opinion of CSA Legal Counsel Phillip Goldberg, although not specifically set forth in any binding case law, application of the Family Code sections when combined with the general principles of consent suggest that an anesthesiologist should obtain the patient’s consent prior to proceeding with a pregnancy test. In fact, if the physician were to proceed with pregnancy testing without the minor's or parent's consent, then the physician may be exposed to a claim for battery.

If a minor has the legal right to consent, then that minor generally controls the disclosure of medical information related to that treatment and can refuse to allow disclosure of the information to his or her parents (Health & Safety
Code §§ 123115, 123110). Accordingly, unless otherwise provided by statutes or pursuant to a written authorization signed by the minor, the physician is prohibited from disclosing medical information concerning such care to the minor's parents. This includes seeking payment for services from a parent or the parent's insurer without the minor patient's consent. On the other hand, if the parent is providing consent to the procedure/testing, then the parent is acting as the patient's representative for purposes of accessing the patient's PHI and has a right to review that information, including the testing results.

Although the statutes and authority cited above extend the right of a minor to obtain certain testing and services without parental consent, this is not exclusive authority. California law authorizes a parent or guardian of a minor child (i.e., under 18) to give informed consent for most medical decisions on behalf of a child. Unless otherwise provided by statute, a minor does not have the exclusive authority to consent to a particular treatment; the minor's parents can legally consent to certain treatment even if the minor objects. However, effective medical treatment may be hindered by an objecting patient.

In truth, many salient and related questions have not been directly addressed by the California courts. This fact notwithstanding, analysis of the available authorities suggests that a physician should attempt to obtain a minor's consent to perform pregnancy testing prior to surgery, and this can be accomplished with the minor's consent alone. However, confounding this issue, a physician also can proceed with preoperative pregnancy testing with the parents' consent alone. To re-emphasize a point previously stated, if the patient is asserting her right to provide consent to “treatment of pregnancy,” then the patient retains her right to medical privacy, which prohibits disclosure of her PHI (i.e., test results) to her parents. Again, only if the parents are providing consent are they permitted access to the test results.

An Ethical and Practical Question

In 2003, the American Society of Anesthesiologists Committees on Ethics and on Standards and Practice Parameters formed a joint task force to resolve differences of opinion regarding a statement on testing for early pregnancy that existed in the ASA Practice Advisory for Preanesthesia Evaluation. This task force determined that it may not be ethically justified to test for pregnancy without obtaining informed consent, and this resulted in amending the original Practice Advisory accordingly. Interestingly, as part of the original ASA Practice Advisory, consultants (n=72) and ASA members (n=232) were asked whether or not preoperative pregnancy testing should be routine, performed in selected patients, or not necessary. Eighty-eight percent of the consultants and 78 percent of the ASA members responded that the test should be performed only on
selected patients, with a small minority believing it should be either routine or not necessary.

The information regarding pregnancy status belongs to the patient, and it does not alter her right to proceed with anesthesia and surgery if she so desires. What the ASA advocates is to offer pregnancy testing, but that it should not be required by physicians unless there is a compelling medical reason to know whether the patient is pregnant. Informed refusal of pregnancy testing may be a possible option in this circumstance.

A fact that must be reckoned with is that different states have disparate statutes with respect to the entitlement of parents to the results of their children’s pregnancy test results. An institutional blanket policy to test all adolescents may circumvent a difficult situation in the presence of parents. Also, the possibility exists for parents to be notified of a pregnancy by proxy at the time of medical billing. However, the revised ASA Practice Advisory now warns against such blanket policies to test—and to bill—patients for nonconsented pregnancy testing. Among the several valid reasons for such a shift included the fact that pregnant adolescents could be at risk should there be incest involved in that pregnancy.

A possible alternative for dealing with this ethically and legally challenging situation is the use of a questionnaire to be filled out in the absence of parents. A thorough history from the adolescent on the phone the night prior to surgery or in the privacy of the preoperative area is recommended, although as mentioned above, the information may not be accurate. In this discussion, there should be emphasis on the importance of full disclosure and inclusion of a confidentiality assurance where applicable by state law.

If pregnancy testing occurs and a minor is discovered to be pregnant on the day of surgery, then disclosure of the information to parents or guardians is determined by state law as described above. Where state law does not require disclosure to parents or guardians, the physician must allow the minor to decide if she wishes to inform her parents or guardian. If state law requires disclosure of the pregnancy testing information, then it may be reasonable and ethical to give the patient an opportunity to release the information herself.

Cancellation of Anesthesia and Surgery

It is unclear if surgery and anesthesia during early gestation are hazardous to the developing fetus by an increase in either the likelihood of spontaneous abortion or the risk of congenital anomalies. The most recent literature suggests that women who undergo anesthesia during pregnancy do not have an increased incidence of congenital anomalies. Anesthesia exposure and the
surgery that accompanies it during the first trimester do increase the risk of spontaneous abortion, but this is most likely due to the medical condition necessitating surgery and/or surgical manipulation.\textsuperscript{13}

A systematic review of the English literature attempted to determine the effects of nonobstetrical surgical procedures on pregnancy outcome and fetal risk.\textsuperscript{14} An analysis of 54 articles included more than 1,000 pregnant patients, over 400 of them in the first trimester, which is possibly most relevant to the pregnant adolescent. There was one death overall (0.006%), and a 5.8 percent incidence of miscarriage, but if the first trimester was specified, the rate of miscarriage rose to 10.5 percent. Unfortunately, there is no control group for this type of analysis, so it is difficult to draw a firm conclusion. Also, the rate of major birth defects (not defined) was 2 percent, but in those studies that reported on women undergoing surgery in the first trimester, this incidence also was doubled to 3.9 percent. This finding is not statistically significant because the expected rate in the general population is 1-3 percent.

There is a cost impact from our decisions for preoperative pregnancy testing with some significance to the health care system. What is important is that we have institutional policies that are ethical, responsible and medically sound, but unfortunately there is little evidence-based medicine to guide anesthesiologists. Whatever the policy may be, patients should be given information about the proposed pregnancy test and what the consequences of a positive result will be. The disclosure of information should also be given careful consideration. Chronologic age may not be the factor that determines decision-making ability or consent, and the HIPAA guidelines offer the utmost in protection of patient privacy.

The decision to proceed with anesthesia and surgery should be determined on a case-by-case basis.\textsuperscript{15} Consideration must be given to the necessity of the surgery and an informed discussion with the patient. The risk of maternal death is low, and surgery and general anesthesia are low risk factors for spontaneous abortion or major birth defects during pregnancy.\textsuperscript{14}

References


Pediatric Anesthesia (cont’d)


Questions

1. Common barriers to prenatal care in teenage girls include all of the following except:
   a. Having a friend who has been pregnant
   b. Negative feelings about physicians
   c. Not knowing they are pregnant
   d. Belief that prenatal care is not important

2. The approximate incidence of a positive preoperative pregnancy test is:
   a. 0.01%
   b. 0.1%
   c. 1%
   d. 10%
3. According to the American Academy of Pediatrics, the age at which normal children may have skills as well-developed as adults for making informed health care decisions is:
   a. 12
   b. 14
   c. 16
   d. 18

4. The Health Insurance Portability and Accountability Act denies parental access to their child's protected health information under all the following except:
   a. State law does not require parental consent
   b. A court of law determines an alternate to the parent
   c. The child is over the age of 12
   d. The parent agrees to the minor's confidentiality for health care

5. In the state of California:
   a. A minor may not consent independently to contraceptive or prenatal services
   b. HIPPA does not override the state laws
   c. The provider must disclose the information to the minor's parents at any time the parents sign consent
   d. Providers who reveal confidential information to a minor's parents may be guilty of unprofessional conduct

6. When a minor has a positive pregnancy test, the best immediate course of action is:
   a. Immediately inform the patient's parents without informing the patient
   b. Cancel the surgery
   c. If disclosure is not required by state law, then allow the minor to decide if she wishes to disclose the information
   d. None of the above

7. The most common side effects of anesthesia during pregnancy are:
   a. Unknown
   b. Spontaneous abortion during the second trimester
   c. Congenital anomalies
   d. Pre-eclampsia

8. Pregnancy testing may be offered, but not required, by an anesthesiologist unless there is a compelling medical reason to know whether the patient is pregnant.
   a. True
   b. False

9. Ethical principles of informed consent suggest that an anesthesiologist should obtain consent for pregnancy testing from adolescents as well as adults.
   a. True
   b. False
10. The ASA’s Practice Advisory on Preanesthesia Evaluation states that:
   a. Pregnancy testing should be offered to female patients of childbearing age
   b. Nonconsented pregnancy testing is an ethical approach to avoiding legal
      problems for anesthesiologists
   c. A positive pregnancy test alters the patient’s right to proceed with anesthesia
      and surgery
   d. A first trimester positive HCG result will result in congenital defects

**Evaluation of Module 3**

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

**Pregnancy Testing in Adolescents**

*By Samuel H. Wald, M.D.,*

*Clinical Professor of Anesthesiology,*

*David Geffen School of Medicine,*

*University of California, Los Angeles*

This third module in the Pediatric Anesthesia Bulletin and Online CME Program is now available in this issue. You may complete the module by taking the assessment and faxing a copy to the CSA office at 650-345-3269, or you may go online and take the module in the Online CME section of the CSA Web site (http://www.csahq.org).
Pediatric Anesthesia (cont’d)

Registration

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

Pediatric Anesthesia CME Course, Module 3
Available February 28, 2011, to February 28, 2014

Name _______________________________________________________________ M.D. D.O.

Address _______________________________________________________________________

City/State/Zip __________________________________________________________________

Phone (      ) ____________________________________________________________________

E-mail _________________________________________________________________________

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

Total $_______________

Please charge my:    ❑ MasterCard    ❑ Visa

Card # ___________________________ Exp. Date ____________________

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

Signature: _____________________________________________________________

OR

Mail with a check made payable to California Society of Anesthesiologists

❑ I acknowledge I have read the Introductory Information about Module 3.
Deep Sedation by Non-Anesthesiologist Practitioners: What Has Changed and What Are the Implications?

By Linda B. Hertzberg, M.D., Immediate Past President, Editor of Electronic Media, and Beverly K. Philip, M.D., Professor of Anaesthesia, Harvard Medical School, and Director, Day Surgery Unit, Brigham and Women’s Hospital

On December 11, 2009, the Centers for Medicare and Medicaid Services (CMS) issued revised Interpretive Guidelines (IGs) pertaining to the hospital Conditions of Participation. These revised IGs were subsequently updated and modified by CMS in May 2010, and more recently in January 2011. The most current version of the IGs may be found on the American Society of Anesthesiologists (ASA) Web site at http://www.asahq.org/For-Members/Advocacy/Federal-Legislative-and-Regulatory-Activities/Interpretive-Guidelines.aspx.

In the IGs, CMS reaffirmed its long-standing definition of “anesthesia,” to mean general anesthesia, regional anesthesia, deep sedation/analgesia or monitored anesthesia care. In contrast, the CMS definition of “analgesia/sedation” includes local/topical anesthesia, minimal sedation, and moderate sedation/analgesia (“conscious sedation”). Only qualified personnel are permitted to administer “anesthesia” as defined above. CMS defines those individuals as qualified anesthesiologists, non-anesthesiologist MD/DOs, nurse anesthetists (CRNAs), anesthesiologist assistants (AAs), and dentists, oral surgeons, and podiatrists who are qualified to administer anesthesia under state law.

Moreover, CMS has affirmed that:

The anesthesia services must be under the direction of one individual who is a qualified doctor of medicine (MD) or doctor of osteopathy (DO).

Although CMS does not directly state that the director of anesthesia services must be an anesthesiologist, clearly anesthesiologists are uniquely qualified
to perform this function. It behooves anesthesiologists and anesthesia departments to be proactive in this regard in view of the following statements from the 2011 revision of the IGs:

Consequently, each hospital that provides anesthesia services must establish policies and procedures, based on nationally recognized guidelines, that address whether specific clinical situations involve anesthesia versus analgesia…

Furthermore:

We encourage hospitals to address whether the sedation typically provided in the emergency department or procedure rooms involves anesthesia or analgesia. In establishing such policies, the hospital is expected to take into account the characteristics of the patients served, the skill set of the clinical staff in providing the services, as well as the characteristics of the sedation medications used in the various clinical settings.

In addition, Frequently Asked Questions that accompany the IG regulations include reference to ASA’s sedation guidelines in addition to those of other specialty societies (such as emergency and gastroenterology physicians), and to the range of qualifications of emergency physicians. The ASA is planning to address these concerning issues with CMS. However, in the regulations it is the hospitals and the physician directors of anesthesia services who determine the anesthesia policies and procedures. Decisions on privileging will be made locally.

The practical implication of these updated CMS regulations is that the responsibility for the oversight of the administration of deep sedation falls under the purview of the director of anesthesia services at a hospital or ambulatory surgery center (ASC), whether or not an anesthesiologist administers the deep sedation. This means that while qualified anesthesia personnel, as defined above, may administer deep sedation, the parameters both for privileging of individual practitioners and for the quality assurance of deep sedation care nonetheless are the responsibility of the director of anesthesia services. Because deep sedation and anesthesia in areas of the hospital outside of the surgical suites, such as the emergency department, fall under the purview of the director of anesthesia services, it would seem reasonable that an anesthesiologist, who is uniquely qualified to understand the quality-of-care issues involved, should assume the role of director of anesthesia services.

By creating this oversight responsibility, CMS is forcing anesthesia departments to redefine how they interact with other hospital departments and individual providers who provide deep sedation services. In California for a number of years the reality has been that non-anesthesiologists such as critical care specialists, gastroenterologists, and emergency room physicians have been administering sedation (and frequently deep sedation) for procedures, possibly with minimal input from the anesthesia department regarding privileging or
Deep Sedation (cont’d)

quality assurance. The new IGs essentially mandate that hospitals and anesthesia departments review their policies on deep sedation.

The issue of privileging non-anesthesiologists for deep sedation is certainly not new. In 2005 the CSA presented a resolution to the Annual Meeting of the American Society of Anesthesiologists (ASA) House of Delegates (HOD) asking for assistance in clarifying whether non-anesthesiologists should be privileged to administer deep sedation, and if the answer were affirmative, then how they could be so privileged.

The ASA referred this issue to an ad hoc committee that produced two proposed Statements, one a Statement on Granting Privileges for Administration of Moderate Sedation to Practitioners Who Are Not Anesthesia Professionals and another similar Statement for deep sedation. In 2005, the HOD approved the first document, which subsequently was revised in 2006. However, the latter document proved very controversial and did not pass. In fact, in 2006 the HOD substituted for the original extensive document titled Statement on Granting Privileges to Non-Anesthesiologist Practitioners for Personally Administering Deep Sedation or Supervising Deep Sedation by Individuals Who Are Not Anesthesia Professionals the simple declaration:

Because of the significant risk that patients who receive deep sedation may enter a state of general anesthesia, privileges to administer deep sedation should be granted only to practitioners who are qualified to administer general anesthesia or to appropriately supervised anesthesia professionals.

This attempt to settle the matter at the ASA did not solve the CSA’s practical problem: within California, members still needed guidance on how to respond to their hospitals and medical staffs when asked how non-anesthesiologists could become qualified and privileged to administer deep sedation. Within the CSA, the Legislative and Practice Affairs Division (LPAD) started with the defeated ASA statement on deep sedation and revised its language to reflect the recommendations of the CSA to its members on this topic. The result was the CSA Statement on Deep Sedation by Non-Anesthesiologists, a document that reviewed criteria and guidelines that could be used by a health care facility to privilege non-anesthesiologists to perform deep sedation so as to advance patient safety and high quality care. This document passed the CSA HOD in 2007 and was posted on the CSA Web site for use by members to help guide deep sedation privileging criteria at their hospitals.

With the advent of the 2009 CMS IGs, the CSA document became suddenly obsolete because there were serious inconsistencies between the CSA and CMS documents. Fortunately, ASA leadership recognized both the opportunity and the problem created by the IGs for the ASA. The opportunity was to make recommendations on deep sedation privileging that could fill a void and would be used by hospitals and medical staffs. The problem was that no (ASA)
HOD-approved statement existed that could be used for this purpose. To respond to the need for an updated statement, then ASA President Alex Hannenberg appointed a committee to develop guidelines for deep sedation privileging for non-anesthesiologists that members could use at their facilities. This ad hoc committee, led by Beverly Philip, M.D., used the CSA Statement on Deep Sedation by Non-Anesthesiologists as the starting point for its deliberations. Things now had come full circle, back to the original inquiry to the ASA from the CSA.

After a series of revisions, the ad hoc committee produced a document titled Statement on Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners. The committee worked assiduously to ensure that the guidelines require the most rigorous level of education, training, experience, and quality assurance for non-anesthesiologists to be credentialed as qualified anesthesia professionals. In addition, the document is very specific in mandating specific levels of education and training, the need for ACLS certification, and a high level of proficiency in airway management and intubation should rescue be needed. The statement also provides guidance regarding how best to perform ongoing quality assurance and review of the performance of qualified anesthesia professionals administering deep sedation.

Owing to the changes that have occurred in the medical and political environment in 2010, and the consequent changes in attitudes within the anesthesia community, the statement passed at the ASA HOD with little controversy. This approval reflects the reality that in many practice settings throughout the nation, non-anesthesiologists were already delivering deep sedation. The ASA’s interest in this matter was to create the strongest possible statement to ensure patient safety and proper oversight of deep sedation privileging by anesthesia departments.

The CSA has retired its 2007 Statement on Deep Sedation by Non-Anesthesiologists and replaced it with the ASA 2010 Statement on Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners. CSA leadership recommends that all members become familiar with the contents of the new document. It may be used in its entirety, in part, or adapted as needed for use by hospitals and medical staffs as a definitive guide in privileging non-anesthesiologists to perform deep sedation. Using it in the individual facilities where CSA members practice will help maintain the appropriate involvement of anesthesia department leadership in the oversight of deep sedation by non-anesthesiologists, thus ensuring the safest possible care for our patients. This statement may now be found on the ASA Web site at the link below or on the CSA Web site at the following link: http://www.csahq.org/professional_issues.php?c=13. In addition, all of the ASA documents referred to above are at http://asahq.org/For-Members/Clinical-Information/Standards-Guidelines-and-Statements.aspx.

The 139th Annual Session of the CMA House of Delegates (HOD) was held October 2–4, 2010, in Sacramento. Representing the CSA in CMA’s Specialty Delegation were John McDonald, M.D., Peter Sybert, M.D., and Narendra Trivedi, M.D., while Michele Raney, M.D., represented the Specialty Delegation on the CMA Board of Trustees (BOT). CSA members Virgil Airola, M.D., Lee Snook, M.D., and Robert Wailes, M.D., also participated on the BOT. Other CSA members who represented their delegations included Adam Dorin, M.D., Thelma Korpman, M.D., Dennis Lindeborg, M.D., James Merson, M.D., Sarada Mylavarapu, M.D., Mark Singleton, M.D., Hugh Vincent, M.D., and James Willis, M.D. Paul Yost, M.D., and R. Laurence Sullivan, M.D., contributed to the deliberations of the Organized Medical Staff Section. Also attending were Marie Kuffner, M.D., and Robert Hertzka, M.D., Past Presidents of the CMA. Rebecca Patchin, M.D. (Immediate Past Chair of the AMA BOT), addressed the CMA BOT and HOD on AMA activities and priorities. Although fewer than 5 percent of CMA members designate anesthesiology as their primary specialty, CSA members participate in all aspects of CMA governance, contributing to the CSA’s position as a respected and influential force in organized medicine in California and nationally.

Proceedings of the House of Delegates

Issues considered to be of the highest priority were federal health reform; the responsible development, implementation and monitoring of accountable care organizations (ACOs); preservation of fair and confidential peer review; and continuing Medi-Cal, scope of practice, and public health and safety issues.

Government Health Programs and Health Reform

This issue was ranked as CMA’s highest priority. CMA will continue to take an active role, at both the federal and the state levels, to ensure that implementation of federal health reform is done in a manner that protects and enhances the practice of medicine and protects patients. CMA will continue to work with the Congress to address issues left unresolved by federal health reform or remaining
CMA House of Delegates Annual Meeting (cont’d)

in conflict with existing CMA policy. CMA strongly advocates reinstatement of the Centers for Medicare and Medicaid Services (CMS) Practicing Physicians Advisory Council (PPAC), or a similar committee, to advise CMS on all Medicare and Medicaid issues impacting physicians—including payment, quality, coverage and new delivery models.

Among the Medi-Cal issues addressed were: Medi-Cal should adopt and publish standardized criteria for hospitalization approval; and payments should be increased for physicians practicing in Health Professions Shortage Areas or serving medically underserved populations.

ACOs, Insurance, and Reimbursement

CMA will support legislation that requires that ACOs, now being created as a result of federal health care reform legislation, be permitted to function in California only if they are physician-led organizations established to ensure that quality of care and patients’ interests are the highest priority. CMA will support legislation that prevents any ACO from circumvention of California’s prohibition of physician employment, and will work with county medical societies and physician groups to develop ACOs that are sustainable, equitable, and fair. (A separate report, “Physician-Hospital Alignment TAC Report,” can be accessed through the CMA Web site.)

Health Professions and Facilities

CMA reaffirmed that peer review must be confidential to be effective, and that non-discoverable peer review protections should be included in any proposed legislation that impacts peer review. Ongoing Professional Practice Evaluation data should be treated as peer review information, subject to peer review protections, and the CMA Model Medical Staff Bylaws will be amended to include methods to protect confidentiality.

CMA reaffirmed that CMS and California Department of Public Health surveyors should be licensed physicians and nurses knowledgeable in the areas they are evaluating. CMA will work with all stakeholders to implement a consistent feedback and appeals mechanism as well as to assist in the development of surveyor standards, interpretation and enforcement of regulations.

CMA demands that all laws concerning changes in the scope of practice of allied health professionals be supported by facts, evidence-based data, and quality of care impact studies.

The unabridged report by Dr. Raney appears on the CSA Web site in the electronic version of this Bulletin.
In Memoriam:
Seymour Wallace, M.D.
1929–2010

By Stephen Jackson, M.D., Editor

Seymour Wallace, M.D., Past President of the CSA (1974–75), passed away on August 25, 2010. An exemplary CSA president, Dr. Wallace was an inspirational and determined leader who was instrumental in the victorious battle staged by organized medicine in securing passage of the landmark 1975 MICRA legislation that stands, even today, as the gold standard of tort reform.

Born on June 4, 1929, in New York City, Dr. Wallace attended high school in England. Prior to attending college, he served as a navigation officer for the United States Merchant Marine. He received his pre-medical education at Columbia University and his medical degree from Columbia University College of Physicians and Surgeons Medical School in 1959. He followed his rotating internship at Brooklyn Methodist Hospital with residency training in anesthesiology at Columbia Presbyterian Medical Center from 1960 to 1962. Dr. Wallace joined the faculty in the Anesthesia Department at Stanford before entering the private practice of anesthesiology at El Camino Hospital in Mountain View, Calif. He served two terms as president of the prestigious Northern California Anesthesia Society, and he was a CSA delegate to the ASA House of Delegates.

Dr. Wallace lived in Los Altos, Calif., with his wife, Flora, to whom he was married for over 59 years. Seymour was an avid sailor, stunt kite-flier and horticulturist; electronics and photography were among his other hobbies. A well-known supporter of the arts, Dr. Wallace was a voracious reader, animal lover and advocate, and always acknowledged for his keen sense of humor.
In Memoriam: Wallace (cont’d)

In his memory, his beloved daughter, Linda, offered the following poem by Alfred Lord Tennyson:

**CROSSING THE BAR**

Sunset and evening star,
And one clear call for me!

And may there be no moaning of the bar,
When I put out to sea,

But such a tide as moving seems asleep,
Too full for sound and foam,
When that which drew from out the boundless deep
Turns again home.

Twilight and evening bell,
And after that the dark!

And may there be no sadness of farewell,
When I embark;

*For though from out our bourne of Time and Place*

The flood may bear me far,
I hope to see my Pilot face to face
When I have crossed the bar.
District Director Reports: September 2010

The district director reports that appear below contain personal views expressed by each director, rather than statements made by or on behalf of the CSA.

Stanley D. Brauer, M.D.—
District 2
(Mono, Inyo, Riverside & San Bernardino Counties)

The economic environment continues to be challenging in our district as in much of California. The “Inland Empire” has greater than 15 percent unemployment, and the most recent figures show 28 percent of the population is uninsured.

Prime Healthcare, owned by cardiologist Prem Reddy, has been rebuffed on several fronts. His legal challenges have failed to prevent a rival group from purchasing Hemet & Menifee health care facilities. His attempts to foreclose on a debt obligation from Parkview Hospital in Riverside have been unsuccessful to date.

The front page of the July 25, 2010, Chico Enterprise Record newspaper brought very favorable publicity to our profession. The article details how Dr. Ray Yip, an anesthesiologist, saved the life of an 18-year-patient who developed malignant hyperthermia intra-operatively. Dr. Yip did his residency at Loma Linda University. I cannot help but think most readers would be glad to have a well-trained physician providing their anesthesia and dealing with difficult medical issues.

Hospital construction continues with the replacement and expansion of the Kaiser Fontana facility. A new hospital in Menifee will open shortly, and two different Temecula hospitals are on the drawing board.

Wayne Kaufman, M.D.—
District 3
(Northeast Los Angeles County)

This last quarter, District 3 representatives were busy meeting with our political leaders to advocate for anesthesiologists throughout the state. In Washington, D.C., in June, I met with Congressman Adam Schiff to discuss health care reform and its impact on our
members. He represents the physicians who live—and hospitals located—in the Glendale, Pasadena and Altadena areas of District 3. While Dr. Earl Strum (secretary of the CSA) and I had met with Congressman Schiff several times before the health care reform bill was passed, this was my first opportunity to meet with him after the bill had been signed. We discussed our concerns about the bill as well as the impending standard growth rate (SGR) cut. With respect to the health care bill, for which he voted, he explained that he felt that something had to be done, and that the bill, while not perfect, was better than the status quo. As far as the SGR cut went, he was supportive of a permanent fix, but expressed his doubts that any of his colleagues on either side of the aisle would be willing to set aside the necessary funds to deal with the problem, given the economic issues currently facing our country.

In July, members of our district went to a fundraiser sponsored by Congressman Xavier Becerra. His district, covering downtown Los Angeles through Eagle Rock, includes hospitals in both Districts 3 and 10. Congressman Becerra was very supportive in passing the resident addendum for academic programs. While he did vote for health care reform, he is sympathetic to our concerns about the SGR.

Finally, in October I spent a day at Los Angeles City College meeting with the Medicare Task Force to prevent health care fraud. The government wanted us to understand that they were targeting health care fraud specifically in the Los Angeles area. At the meeting, Eric Holder, U.S. attorney general, Kathleen Sebelius, secretary of Health and Human Services, and a host of local officials from the FBI and the Department of Justice explained their goals for the coming years, as well as their ongoing use of billing data to attempt to ferret out those who would steal from the government. Speaking for physicians from throughout the state were representatives from the CMA and various surgical and medical societies. They made a point of raising physicians’ concerns that the federal government, in aggressively using data (billing) mining to find fraud, would target innocent physicians. The government officials acknowledge that this could be a problem but declared that they would try their best to avoid accidentally targeting innocent physicians. In my small group discussion with a member of the Department of Justice, the government official admitted that this is a real problem, but that it does not outweigh the government’s interest in targeting fraud.

On the local front, the City of Hope legal battle between the hospital, the physicians’ group and the anesthesiology/surgery department continues. It is slowly moving through the courts, and the ultimate resolution is unclear at this time. I should be able to disclose more once the parties settle/resolve their
disagreements. It is tragic that an organization that has seemingly worked so well and done so much good for so many patients is unable to resolve its issues without using our court system. Both the CSA and CMA are monitoring the ongoing situation. I hope that this is not a sign of things to come as health care reform becomes a reality and organizations are forced to reorganize to compete/survive.

John G. Brock-Utne, M.D., Ph.D.—
District 4
(Southern San Mateo, Santa Clara, Santa Cruz, San Benito & Monterey Counties)

It is a great pleasure for me to be your District 4 director, but my successful tenure as your representative will depend largely on you. I need your input, suggestions and advice so that I can serve you better. The outgoing Director, Dr. William W. Feaster, has been invaluable with his advice and guidance. I am very lucky to have him as a colleague in the same hospital.

A large majority of District 4’s members would like to have CME credits for attending district/educational dinner meetings. I am grateful to Dr. Mark Singleton for looking into this and coming up with guidelines that can make it happen. In November 2009 we had a very well attended dinner meeting at the Chantilly Restaurant in Redwood City. Baxter supported this event. Our speaker, Dr. Ted Eger, gave an excellent talk on “Inhalational Anesthesia.” After Dr. Eger’s talk, Dr. Bill Feaster, CSA Assistant Treasurer, gave us an overview of the current state of the CSA, “the opt-out” by the state, and other matters. In May 2010, we had another meeting, equally well attended and again supported by Baxter, at John Bentley’s in Redwood City. Dr. Paul White spoke on “Anesthetic Considerations in the Overweight and Elderly Patient.” It was another excellent program, and Dr. Feaster gave us another overview.

Clifton O. Van Putten, M.D.—
District 5
(Kern, Tulare, Kings, Fresno, Madera, Merced, Mariposa, Stanislaus & Tuolumne Counties)

Working our way up the Valley from to South to North:

A request for proposal was issued by Kern Medical Center, the county hospital in Bakersfield, for provision of anesthesia services. The holder of the contract at that time was Somnia, Inc., an anesthesia management firm based in New Rochelle, N.Y. The contract was again awarded to Somnia, effective June 2010, for the next three years. Kern Medical Center staffs its operating rooms using
the anesthesia care team model (ACT). In its marketing literature, Somnia advertises ACT as “the most cost-effective” manner for covering the clinical obligations of multi-operating room facilities. Other non-Kaiser hospitals in District 5 using the ACT to staff their operating rooms include the hospitals owned by Adventist Health: San Joaquin Community (Bakersfield), Hanford Community and Selma Community.

In July, Baxter and the CSA co-hosted George Mychaskiw, DO, chair of the anesthesiology department at Drexel University in Philadelphia. This evening dinner presentation, held at Slate’s Restaurant in Fresno, touched upon the topic of neuronal apoptosis under general anesthesia in pediatric and geriatric patients.

Other noteworthy items from the Fresno-Madera region include the hiring of new CEOs at both Children’s Hospital of Central California and Saint Agnes Medical Center. James N. Leonard was recruited to Saint Agnes from Sacred Heart Hospital in Spokane, Wash., and Gordon Alexander, Jr., M.D., who was originally trained as an OB/GYN, was brought in from Minneapolis to lead at Children’s Hospital. Children’s and Saint Agnes are collaborating to expand the high-risk OB and perinatology service line at Saint Agnes. To this end, Children’s has recruited two perinatologists. To accommodate the expected increase in patient volume, the labor and delivery unit and operating rooms will likely be relocated to a larger venue within Saint Agnes Medical Center.

Clovis Community Medical Center has embarked upon an ambitious $285 million hospital expansion that will double its inpatient capacity to 205 single-patient beds. The anticipated completion date is the fall of 2013.

Lee-lynn Chen, M.D.—
District 6
(Northern San Mateo and San Francisco Counties)

This is my first quarterly update since becoming District Director. I am not aware of any pressing issues in my district. It is important to maintain our membership and continue to add anesthesiologists to our membership base. Besides representing your interests in Sacramento, and also on a national level at the ASA, the CSA does provide three large-scale educational conferences. A major area of need identified by many of our members is for more access to local CME activities. At UCSF, the anesthesia department sponsors Saturday Grand Rounds four times a year (free to the public), along with several other CME events (Changing Practice in September, OB Anesthesia in March and Critical Care Medicine in June). For details, please see http://anesthesia.ucsf.edu/extranet/about_us/index.php?page=cme_events.
Jeffrey A. Poage, M.D.—
District 7
(Alameda & Contra Costa Counties)

CSA District 7 consists of Alameda and Contra Costa Counties in the East Bay region of Northern California. This includes the cities of Oakland, Berkeley, Walnut Creek, Castro Valley, San Leandro, Hayward, Fremont, San Ramon, Pleasanton, Dublin and Livermore. As of May of this year our District has 214 active members and 49 retired members.

Kaiser Permanente has a major presence in the East Bay. Kaiser opened a new hospital two years ago in Antioch, which serves East Contra Costa County. This was an area in our district hit particularly hard by the subprime mortgage crisis. John Muir Health opened an outpatient facility in East Contra Costa just prior to the current economic downturn.

In July, Kaiser closed its Cardiac Surgery Program in Oakland. It had run the cardiac center out of Alta Bates Summit Medical Center since 2000, but decided not to renew its contract last year. Kaiser will redirect its emergency heart patients to other local hospitals, including Summit. Elective cardiac surgery patients will be transferred to Kaiser facilities in Santa Clara and San Francisco.

Sutter Health facilities in our district include Alta Bates Summit Medical Center (Berkeley and Oakland), Eden Medical Center (Castro Valley) and Sutter Delta Medical Center (Antioch). In July, the Oakland City Council voted to approve a development project for the Oakland campus. Warren Kirk, CEO, Alta Bates Medical Center, said Sutter Health is committed to spending $350 million to upgrade the facility and enhance services. Of note, the California Nurses Association filed an appeal in June, stating that the proposed project did not take into consideration traffic and safety concerns. Nonetheless, the City Council denied the nursing union’s appeal by a vote of 7–0. Seismic retrofitting is a key aspect of the project, as well as a new pavilion and an emergency center.

Despite ongoing litigation with the Eden Township Healthcare District, Sutter says it is committed to a $300 million rebuild of Eden Medical Center in Castro Valley. According to supporters of San Leandro Hospital (SLH), which operates under the same license as Eden Medical Center, Sutter planned to cease operating SLH as a full-service hospital and lease it to the county as an acute rehabilitation facility, effectively replacing the seismically deficient Fairmont Hospital. According to Sutter, SLH was losing up to $600,000 a month—largely due to a poor patient demographic. Nonetheless, Sutter and the Eden District have
reached a ceasefire, as litigation proceeds, and SLH will remain open for the time being.

Sutter Health has come under media scrutiny recently for its practice of “equity transfers”—the pooling of revenues from its better performing facilities. Accordingly, some affiliates like SLH feel that they have not benefitted from Sutter’s accounting philosophy. Recently Sutter Health transferred the control of Marin General Hospital back to its local health district. Sutter allegedly is facing possible litigation over $156 million in equity transfers from Marin General between 2002 and 2009 (according to the North Bay Business Journal).

A noteworthy Bloomberg News article regarding Sutter Health suggests nonprofits such as Sutter are commanding higher reimbursement from insurers via increasing market power and influence. Sutter has acquired more than a third of the market in the San Francisco-to-Sacramento region—including 20 hospital acquisitions—in the past 30 years. While Sutter may have higher unit prices than its competitors, CEO Patrick Fry feels Sutter is not as costly over the long run “because its integration of hospitals and doctor groups allows it to provide more efficient care, cutting down on the number of procedures.” (See the entire article at http://articles.sfgate.com/2010-08-22/business/22230110_1_consumer-prices-market-power-health-care.) Of note, the Federal Trade Commission has ongoing investigations in five states—Connecticut, Massachusetts, Ohio, Pennsylvania and New Hampshire—probing hospital takeovers and contracting practices for antitrust violations. One wonders if nonprofits will also come under increasing scrutiny in the coming years.

**Children’s Hospital Oakland** (CHO) is in the midst of a major restructuring plan. According to the local media, CHO lost $26 million in 2009 and $80 million over the last four years. Dr. Bertram Lubin became the first physician CEO of the medical center last year. CHO’s financial strains have been caused by a number of factors, including poor reimbursement and the economic downturn. Dr. Lubin said reimbursement ranges from 10 to 30 cents for each dollar spent by the hospital. “The pediatric healthcare system is broken, and rather than being rewarded for our commitment to children, we are being financially penalized.” Medi-Cal reimbursement in California is among the lowest in the nation, ranking 49th out of 50 states.

**John Muir Health** (JMH) in Contra Costa County is nearing the end of a billion-dollar expansion. A new five-story, 380,000-square-foot tower will open next March at the Walnut Creek Campus. A new cardiac institute, 172,000 square feet, will open at the Concord Campus sometime next year. With regard to surgery, JMH has experienced a 5 to 10 percent decrease in its surgical caseload.
since January. This probably reflects the trend of most non-Kaiser facilities in our demographic.

My thoughts: It seems to me hospital administrators and nursing managers are leaving “no stone unturned” in their efforts to rein in costs and find more efficiency in the workplace. They seem to be in “survival mode” as they await the feared consequences—and further economic squeeze—of government health care reform. I suspect the OR arena is a favorite target of cost cutting measures despite the fact that surgical services often generate a significant portion of hospital profits. Certainly, some patient care continues to shift to off-site centers as some doctors perceive that hospitals are less interested in their concerns.

Jeffrey Uppington, MBBS—
District 8
(Alpine, Calaveras, Amador, Sacramento, San Joaquin, Placer, Yuba, El Dorado, Yolo, Sutter, Nevada, Sierra and East Solano Counties)

Hospital building dominates the health care scene, at least in Sacramento. UC Davis Medical Center is about to open its new Surgery and Emergency Services Pavilion. The pavilion is a 472,000-square-foot building that houses 24 new operating rooms, a new emergency room and several new intensive care units. There is also new radiology and cardiology space. The whole building represents a modest expansion of operating rooms—two—a very large expansion of the emergency room, and a doubling in size of the burn unit. New cardiothoracic and neurosurgical critical care units complete the surgical expansion. Costing about $420 million, the pavilion increases the number of jobs by about 150. In addition, renovations are planned for the old intensive care units and the old operating rooms, with a projected expansion of six or so new operating rooms in the next 12–18 months. Seismic safety mandates will require certain parts of the hospital to be demolished in a few years’ time.

Seismic considerations will also require Sutter Health to demolish its hospital in East Sacramento. This has meant a giant expansion of downtown Sutter General, at a cost expected to top $460 million.

Kaiser Permanente is expanding its hospital in south Sacramento. A new five-story tower is planned with 136 more beds. The hospital also intends to expand its outpatient surgery center at a projected cost of about $300 million.

Anesthesia positions in the city will expand. This is good news for graduating residents as well as for anesthesiologists interested in new positions.
The district had one unofficial meeting at which Fospropofol was discussed. While there was interest in the new pro drug, there did not seem to be great enthusiasm for trying it out. I think its place will be defined quite slowly.

John S. McDonald, M.D.—
District 12
(Southeastern Los Angeles County)

There have been relatively few events important to anesthesiology in District 12 this past quarter. Construction continues in the area on new/upgraded facilities and parking structures. Of particular importance, the University of California Regents and the County of Los Angeles announced the board of directors for the new not-for-profit venture to reopen the much needed Martin Luther King facility.

If members in District 12 have news they find important to the anesthesia community, please forward it to me at mcdonald215@yahoo.com. Please put “District 12” in the subject line of your e-mail.

T. John Hsieh, M.D.—
District 13
(Orange County)

In general, surgical volumes throughout Orange County appear to be steady. As with the past years, I am expecting the volume to increase as we approach the end of the year.

The overall impact of the “opt-out” of physician supervision of CRNAs for Medicare patients has been minimal, or no impact at all.

St. Jude Medical: The surgical case volume has decreased slightly, but the group has brought in new physicians in anticipation of increasing demand for operations. The group has been using electronic anesthesia records and submitting billings electronically. Moreover, performance measurements are in place and compliance is excellent. The group also started using ePreop, which is a Web-based preoperative check-in system capable of generating preoperative protocols.

St. Joseph’s/Children’s Hospital of Orange County (Allied Anesthesia Medical Group): Volumes are stable. The group has been partnered with the group from Hoag in staffing the newly opened Hoag Orthopedic Institute. The group also
is enthusiastic about and getting prepared for the opening of the new CHOC in the next few months.

**Mission Hospital:** Volumes have gone up. Performance measures are in place, including those for beta blocker administration. St. Joseph Health System is working with the group in establishing electronic anesthesia recording.

**Hoag Hospital** (Newport Harbor Anesthesia Consultants): With the opening of the new Hoag Hospital Irvine and Hoag Orthopedic Institute, the group has seen an increase in the number of cases. The group has recruited several anesthesiologists to expand its coverage. Performing well on the quality improvement measurements, it also continues to staff the pre-admission screening clinic to minimize last-minute cancellations.

**Kaiser:** Volume has been stable. There is no impact of California opt-out at this time as the CRNAs are employed by the physician foundation.

**Rima Matevosian, M.D.—District 14 (Northwestern Los Angeles County)**

New CMS requirements state that anesthesia services throughout the hospital must be organized into one service, and not separated into OR, obstetrical suite, etc. All areas such as radiology, emergency department and procedure areas are included. Additionally, the anesthesiology department will be responsible for supervising conscious sedation, including the decision on which health care providers, in addition to the anesthesiologists, are permitted to administer these medications. The proper policies, procedures and implementation will be a challenge for many departments. [For more information on these requirements, see pages 40–46 and 72–75.—Ed.]

It has come to our attention that in recent surveys California Department of Public Health pharmacists have queried whether areas outside of the operating room have knowledge and availability of drugs to treat malignant hyperthermia (MH). Because MH may occur in other areas, each anesthesia department is encouraged to have a training module so that areas where MH could occur are provided an in-service. This would include signs and symptoms, treatment modalities, and the location of the “malignant hyperthermia cart” (situated in the OR) that contains dantrolene and associated medications.
Medication shortages continue, with many hospitals having difficulty obtaining propofol, thiopental, and many other medications commonly required to be available for the anesthesiologist.

Los Angeles County continues to have a severe budget shortfall, which affects the hospitals of the LA County Department of Health Services. However, because of the economic situation, the county hospitals have seen an upswing in the number of patients who have lost their health insurance and are utilizing the county hospital for the first time. The emergency room has a significant wait time at Olive View, which soon may be alleviated with the anticipated opening of a new freestanding emergency room.

While the CSA has many excellent courses available for continuing medical education, we would like to remind our district members that the UCLA Simulation Center is offering courses that will meet the Maintenance of Certification in Anesthesiology (MOCA) Part IV simulation requirement. [For more information on MOCA, see pages 36–39—Ed.]

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Call for Submission of Resolutions to the CSA House of Delegates

Any CSA member may submit a resolution to the House of Delegates (your elected representatives) on any issue that he or she deems important to the membership. A resolution is a proposal that the CSA undertake an activity related to a current issue of concern to anesthesiologists. For example, a resolution might recommend that the CSA develop social networking capabilities for the members. For assistance in formulating a resolution, please contact Johnathan L. Pregler, M.D., Speaker of the House of Delegates, at jpregler@mednet.ucla.edu.

The House of Delegates will meet on Saturday, May 14, 2011, as part of the CSA Annual Meeting at the Fairmont Hotel in San Jose, Calif. A Reference Committee meets prior to the House of Delegates to hear testimony on all matters to be considered by the House. For more information, contact the CSA office at 650-345-3020.

The deadline for submissions is April 15, 2011.
California and National News

Expansion of Non-Physician Practitioners’ Scope of Practice Proves Unsafe: An 87-year-old veteran recently received a $250,000 settlement from the federal government after he became legally blind, allegedly as a result of negligent treatment of his glaucoma at the Veterans Affairs Health Care System in Palo Alto, Calif. He was one of eight patients with glaucoma (or at risk for such) who allegedly had received improper care at the hospital that may have caused loss of vision. The improper care was provided by optometrists who practiced without oversight and review by an ophthalmologist. As a result, the optometry section was placed under the direct supervision of the department of ophthalmology. It is of note that proposed regulations to permit optometrists to treat glaucoma are in the final stages of approval in California. Optometrists do treat glaucoma in other states.


Schwarzenegger Once Again Thumbs His Nose at Anesthesiologists: In his final, retaliatory “terminator salute” to anesthesiologists, “Governator” Arnold Schwarzenegger (GAS) appointed one of his staffers, Jennifer Kent, to the Medical Board of California. GAS’s deputy legislative secretary, Kent just happened to have furtively conducted the office “research” that led to his signing the CRNA opt-out letter in June 2009. Among her previous qualifying “experiences” for such an important public health matter was working for the California Optometric Association. In further odious “GASsy” fashion, the outgoing governor also handed out paid jobs on state commissions to other members of his staff and to three former state senators, including Carole Migden, a San Francisco Democrat, who became part of the Agriculture Labor Relations Board for a mere $128,000 yearly salary.

Survey of California Employer Health Benefits: Employer-sponsored health insurance coverage is the leading source of health care insurance in California as well as the nation. The availability and affordability of health insurance are influenced by employee cost sharing, changes in rates offered by employers, and increases in premiums. Current estimates are that the cost of employer-sponsored health care coverage will continue to increase faster than inflation, affecting companies as well as workers. There have been major
alterations of premiums and benefits design over time. The following is a capsule of important findings regarding California health insurance, from a 2010 survey by the California HealthCare Foundation:

1. Single coverage premiums average $5,500 annually, significantly more than the national average of $5,000. Average premiums for family coverage were $14,400!

2. Enrollment in plans with a deductible of $1,000 or more for single coverage has increased 27 percent (up from 7 percent in 2006), this being especially significant for workers in small firms (399 employees).

3. Four percent of California employers say they are “very likely” to drop coverage completely, this compared with 1 percent in 2008.

4. Twenty-eight percent of California firms either reduced benefits or increased cost sharing for employees as a result of the economic downturn, a dramatic increase from the 15 percent in 2009.

5. Twenty-four percent of California employers indicate that they are “very likely” to increase the amount that employees pay for health insurance in 2011.

6. In the past 10 years, premiums have increased 134 percent, which represents more than 5 times the 25 percent increase in California’s overall rate of inflation.

California HealthCare Foundation, December 2010.

Medicare to Reimburse Physicians for End-of-Life Discussions:
New Medicare guidelines will permit reimbursement for physicians who have voluntary end-of-life discussions during annual primary care evaluations. More extensive consultations appearing in the original draft of last year's congressional health reform legislation were withdrawn before the measure passed due to controversy that included the term “death panels.” That rejected proposal included advance care planning that would have provided specific instructions about what physicians should discuss with patients, such as palliative care and hospice—items that potentially would avoid non-beneficial and costly medical treatment that prolongs the dying process, as is so often encountered with many critically ill patients lingering in intensive care units. (See “The Elephant in the Room,” pages 33–35, for a commentary by Karen S. Sibert, M.D., on treatment in such situations.) The new Medicare rule, however, is less prescriptive, as it defines advance care planning to include discussion of establishing an advance directive and also “whether or not the physician is willing to follow the individual's wishes as expressed in an advance directive.”
In fact, in 2008 then President George W. Bush signed legislation establishing guidelines allowing for Medicare to reimburse physicians for end-of-life consultations for newly entering Medicare patients (“welcome to Medicare”). The 2010 legislation signed by President Barack Obama now additionally permits the discussions “to happen in the context of the annual wellness visit,” not only at the “welcome visit.” It is significant that former New York Lt. Gov. Betsy McCaughey, a critic of the initial draft legislation, approved of the final language, stating “government should never prescribe what is discussed between doctor and patient, or pressure doctors financially to push their patients into living wills and advance directives.”


**Medical Board of California Wellness Committee:** The Wellness Committee of the Medical Board of California (MBC) called a meeting of interested parties to discuss “best practices” in hospital wellness committees and to explore what the MBC could do to encourage such committees. The MBC emphasized that it wants to differentiate “wellness” from “well-being.” Wellness is the active seeking of health, whereas well-being is more related to monitoring of health. Kaiser physicians described their program, which seemed quite sophisticated and mature. A number of next steps were discussed, including generating guidelines for educational purposes and programs for outreach to organizations.

Jeffrey Uppington, MBBS, Director, CSA District 8
New CSA Members

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

### Active Members

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### Resident to Active Members

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### Retired Members

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<td>Mark Hilberman, MD</td>
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<tr>
<td>Andrew Olesijuk, MD</td>
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Winter 2011
Mark Your Calendar

2011

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

YOUR CSA

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

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

CSA Today
Today, the elected officers and Board of Directors are individuals
dedicated to the preservation of the unique specialty of anesthesi-
ology. CSA works closely with ASA to protect the interests of all
anesthesiologists, on the national, state and local levels.
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.

Delegates
1. Stanley D. Brauer, M.D. (13)
2. Edgar D. Canada, M.D. (11)
3. Michael W. Champeau, M.D. (12)
5. Christine A. Doyle, M.D. (12)
6. William W. Feaster, M.D. (13)
7. James W. Futrell, Jr., M.D. (12)
8. Steven D. Goldfien, M.D. (12)
9. Linda B. Hertzberg, M.D. (11)
10. Stephen H. Jackson, M.D. (13)
11. Patricia A. Kapur, M.D. (11)
12. Norman Levin, M.D. (11)
13. Edward R. Mariano, M.D., MAS (11)
14. Robert D. Martin, M.D. (13)
15. James M. Moore, M.D. (13)
16. Manuel C. Pardo, Jr., M.D. (12)
17. Rebecca J. Patchin, M.D. (13)
18. Kenneth Y. Pauker, M.D. (13)
19. Johnathan L. Pregler, M.D. (13)
20. Michele E. Raney, M.D. (12)
21. Stanley W. Stead, M.D. (13)
22. Earl Strum, M.D. (13)
23. Peter E. Sybert, M.D. (11)
24. Narendra Trivedi, M.D. (12)
25. Samuel H. Wald, M.D. (13)
26. Paul B. Yost, M.D. (12)
27. Mark I. Zakowski, M.D. (11)

Alternate Delegates
Eugene L. Bak, M.D. (11)
Jonathan F. Barrow, M.D. (11)
John G. Brock-Utne, MBChB (11)
Jonathan S. Jahr, M.D. (11)
Uday Jain, M.D. (11)
Wayne A. Kaufman, M.D. (11)
Thelma Z. Korpman, M.D. (11)
John S. McDonald, M.D. (11)
Rima Matevosian, M.D. (11)
Marco S. Navetta, M.D. (11)
Dennis M. O’Connor, M.D. (11)
Jeffrey A. Poage, M.D. (11)
Michelle Lynn Schlunt, M.D. (11)
Nitin K. Shah, M.D. (11)
Karen S. Sibert, M.D. (11)
R. Lawrence Sullivan, Jr., M.D. (11)
Sydney I. Thomson, M.D. (11)
Judi A. Turner, M.D. (11)
Jeffrey Uppington, MBBS (11)
Clifton O. Van Putten, M.D. (11)
Patricia A. Dailey, M.D. (11)
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IN MEMORIAM

Upon notice that a CSA member is deceased, a donation is sent to the Arthur E. Guedel Memorial Anesthesia Center in their memory.
LAUGHING GAS

Light travels faster than sound, and this is why some people appear bright until you hear them speak.

Knowledge is knowing that a tomato is a fruit. Wisdom is not putting it into a fruit salad.

The evening news is where the broadcaster begins with “Good Evening,” and then tells us why it isn’t.

Exaggeration is a billion times worse than understatement.

How is it that one careless match can start a forest fire, but it takes a whole box to start a campfire?

A current-day bank is a place that will lend you money if you can prove that you don’t need it.

When I fill out an application, on the line where it asks whom to notify in case of an emergency, I write “Doctor.”

A clear conscience usually is the sign of a bad memory.

You do not need a parachute to skydive, but you do need a parachute to skydive twice.

Hospitality is making your guests feel like they’re at home, even if you wish they were.

Some people cause happiness wherever they go. Others whenever they go.

I used to be indecisive. Now I am not sure.

Nostalgia isn’t what it used to be.

Change is inevitable, except from a vending machine.
## CSA District Directors and Delegates

<table>
<thead>
<tr>
<th>District Director/Delegates</th>
<th>Email Address</th>
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<tbody>
<tr>
<td>1. Gregory Gullahorn, M.D. (12)</td>
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<td>Vanessa J. Loland, M.D. (12)</td>
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<td>Adam F. Dorin, M.D., MBA (13)</td>
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<td>Lise R. Wiltse, M.D. (13)</td>
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<td>John J. Peckham, M.D. (11)</td>
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<td>Dalia A. Banks, M.D. (13)</td>
<td>[vacant] (13)</td>
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<tr>
<td>2. Stanley D. Brauer, M.D. (12) (<a href="mailto:sbrauer@llu.edu">sbrauer@llu.edu</a>)</td>
<td>Lawrence M. Robinson, M.D. (13)</td>
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<td>James H. Daniel, M.D. (13)</td>
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<td>4. John G. Brock-Utne, MBChB (12) (<a href="mailto:brockutn@leland.stanford.edu">brockutn@leland.stanford.edu</a>)</td>
<td>Frank A. Takacs, M.D. (13)</td>
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<td>Vivekanand Kulkarni, M.D. (13)</td>
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<td>5. Clifton O. Van Putten, M.D. (13) (<a href="mailto:vps5@comcast.net">vps5@comcast.net</a>)</td>
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<td>Barry P. Kassels, M.D. (13)</td>
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<td>7. Jeffrey A. Poage, M.D. (13) (<a href="mailto:jeff_md@mac.com">jeff_md@mac.com</a>)</td>
<td>Brian L. Pitts, M.D. (13)</td>
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<td>Jason B. Lichtenstein, M.D. (12)</td>
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CSA Continuing Medical Education

Free CME Program for CSA Members
CSA CME Critical Care Program, Modules 1–8
CSA CME Obstetric Anesthesia Program, Modules 1–4
CSA CME Pain Management and End-of-Life Care, Modules 1–12
CSA CME Pediatric Anesthesia Program, Modules 1–3
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