

# Editor's Notes

By Stephen Jackson, M.D., Editor

This issue of the *Bulletin* offers a potpourri of informational items, but I want to direct you to several areas of interest that might not otherwise attract your attention.

The first is the new California law that regulates the nurse-patient ratios. These regulations derived from the legislative activism of the largest nursing union in California (California Nurses Association) and, on their surface, they are intended to enhance the quality of patient care, as well as to retain and bolster recruitment and return of registered nurses (RNs) to the nursing profession. The CNA claimed that forcing RNs to care for more patients than RNs thought safe was a key factor in both diminution of quality of nursing care and RN dissatisfaction and burnout. Stress-related on-the-job nursing issues had, it seemed, led to an exodus of RNs from hospitals to venues outside of the traditional bastion of nursing opportunities. The new regulations demand that the nurse-patient ratio be maintained *at all times*, including bathroom and eating breaks. These rigid regulations yield no allowance for acuity of care, flexibility of needs, or for ratio averages over a given day. Rather than increasing the number of RNs in hospitals, these regulations may worsen the already existing nursing shortage. The CNA is pushing—unsuccessfully to date—for steep fines for any infractions by the hospitals.

The fallout has been significant. I informally have surveyed most of the hospitals in Santa Clara County, and there have been major bed shortages that are directly related to maintaining the mandated nurse-patient ratios. These “out-of-service” beds ultimately have, in some hospitals, led to backups in operating room schedules, but even more importantly, to crowded emergency departments, where patients are being held for as much as two to three days awaiting admission to intensive care units or wards. In some instances, hospitals have been forced to close their ERs and divert

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emergency vehicles elsewhere. Yet, walk-ins—the vast majority of ER visitors—cannot easily be diverted. As physicians, we can remain impartial with respect to the battles between the hospitals and nurse unions, but we must remain as the ultimate advocates for our patients, adhering to our ethical obligation to try to champion what is in the best interests of patients' while this newest of healthcare crises plays itself out.

Secondly, I want to call your attention to the Legislative and Practice Affairs Division (LPAD) section in which CSA's outstanding legislative advocates, William Sr. and William Jr. Barnaby ("Team Barnaby"), explain in detail all of the tasks and duties through which they, as lobbyists, represent California anesthesiologists before the government of our State.

Further along in the LPAD section are two articles that address the Knox-Keene Act and the seemingly irresponsible behavior of the Department of Managed Health Care (DMHC). For historical background, the Knox-Keene Health Care Service Plan Act was enacted in 1975, updating the Knox-Mills Act of 1972. It authorized the Department of Corporations to license and regulate managed care plans such as Blue Cross, Blue Shield and Kaiser Permanente. Indemnity health insurance plans were—and to this day remain—under the regulation of the Department of Insurance. In 1999, jurisdiction over Knox-Keene was transferred to the then newly created DMHC. Then, in 2000, Assembly Bill 1455—jointly sponsored by the California Medical Association and the California Healthcare Association (the hospitals' equivalent organization)—was proposed for the purpose of setting prompt payment requirements for managed health plans. Initially opposed by the DHMC, a compromise version of AB 1455 finally passed. Regulations implementing AB 1455 nonetheless have been a point of contention between the DMHC and providers, especially with regard to non-contracting physicians. The two articles bring you up-to-date on issues related to the billing of patients by non-contracting physicians.

Later in this *Bulletin* you will find information on the Legislature's solution to a uniquely Californian practice management issue: the phasing out of the inhibitory influence of triplicate prescriptions on pain management (a particular issue for our specialty in the outpatient postanesthetic period), and its replacement with a new security paper prescription system. And you can receive CME credit for this educational piece (see below).

Finally, we turn to environmental health. As you might recall, the 2002 *Bulletins* featured articles on "the greening" of American medicine, this referring to the enhanced awareness and activism of physicians with respect to how the

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practice of medicine, especially in hospitals, can and does adversely impact the environment and its inhabitants, specifically, our patients. This year, we shall feature educational articles on the **global water crisis**. Why water?

Here are some sobering, if not startling, facts. Global consumption of water is doubling every 20 years, more than twice the rate of human population growth. Today, more than one billion people on our planet lack access to fresh drinking water. The minimum daily water requirement per person for drinking is 1.3 gallons, and the figure for all domestic needs (drinking, cooking, bathing, sanitation) is 13 gallons. The average domestic water consumption per person per day in the USA is 72 gallons, whereas in the Netherlands it is 27 gallons, and in Somalia only 2 gallons. Should present consumption patterns persist, two out of three people on earth will live in “water-stressed” conditions by 2025! More than 5 million people, most of them children, die every year from illnesses caused by drinking poor quality water, and over half of the world’s hospital beds are occupied by people suffering from water-borne diseases. Eighty-five percent of the developing world’s diseases and deaths are attributable to preventable water-borne diseases. Furthermore, access to water may become the single biggest cause of conflict and war in the Middle East and Northern Africa.

So, with these grim facts in mind, I encourage you to become more knowledgeable about water and its threat to the health of this planet and its inhabitants in this ensuing year’s *Bulletins*.

### ***Bulletin* Provides “Painless” Way to Obtain California’s Mandatory Pain Management Continuing Medical Education (CME) Credits**

Beginning with this issue and through the end of 2006, your *Bulletin* will provide CSA members—free of charge—with the opportunity to obtain CME credits that can be applied to the mandatory 12 CME credits for pain management and end-of-life care required of all California physicians by 2006. Joshua Prager, M.D., will serve as the coordinator of this educational series. On pages 46-52, you will find a condensed article on pain management, the full version of which, along with references, can be accessed on the CSA’s Web Site at **[www.csahq.org](http://www.csahq.org)**. This web site also contains questions to be answered and submitted to the CSA for your CME credit.