Less pain. Less opioids. From the start.

**OFIRMEV** provides significant pain relief*•
- OFIRMEV 1 g (Q6h) + patient-controlled analgesia (PCA) morphine demonstrated significant pain relief vs placebo + PCA morphine (P<0.05 over 6 h)
- OFIRMEV 1 g (Q6h) + PCA morphine showed greater reduction in pain intensity over 24 h (SPID24) compared to placebo + PCA morphine (P<0.001)*

**OFIRMEV reduces opioid consumption**•
- OFIRMEV 1 g (Q6h) + PCA morphine significantly reduced morphine consumption vs placebo + PCA morphine (~46% over 6 h, P<0.01; ~33% over 24 h, P<0.01)*
- The clinical benefit of reduced opioid consumption was not demonstrated

**OFIRMEV from the start**
- Consider administering the first dose of OFIRMEV PreOp or post-induction
- Schedule OFIRMEV Q6h for first 24 h and continue as clinically warranted

---

**Indication**
OFIRMEV is indicated for the management of mild to moderate pain, the management of moderate to severe pain with adjunctive opioid analgesics; and the reduction of fever.

**Important Safety Information**
OFIRMEV is contraindicated in patients with severe hepatic impairment, severe active liver disease or with known hypersensitivity to acetaminophen or to any of the excipients in the formulation. Acetaminophen should be used with caution in patients with a history of severe hepatic impairment.

Do not exceed the maximum recommended daily dose of acetaminophen. Acetaminophen may cause severe hepatic injury, including the risk of severe hepatotoxicity and death.

OFIRMEV should be administered only as a 15-minute intravenous infusion.

*Randomized, double-blind, placebo-controlled, single- and repeated-dose 24-hour study (N=151). Patients received OFIRMEV 1 g + PCA morphine vs placebo + PCA morphine (1 mg/kg bolus every 10 minutes following bolus) for knee replacement surgery. Primary endpoint: pain relief measured on a 0-100 mm visual analog scale over 48 h. Morphine was administered as needed.

**SPID24** = sum of pain intensity difference, based on VAS scores, from baseline at 0 to 24 h.

**References:**

**Discontinue OFIRMEV immediately if symptoms associated with allergy or hypersensitivity occur. Do not use in patients with acetaminophen allergy.**

The most common adverse reactions in patients treated with OFIRMEV were nausea, vomiting, headache, and insomnia in adult patients and nausea, vomiting, constipation, pruritus, agitation, and asthenia in pediatric patients.

OFIRMEV is approved for use in patients ≥2 years of age.

The antiproteinic effects of OFIRMEV may mask fever in patients treated for postsurgical pain.

To report SUSPECTED ADVERSE REACTIONS, contact Cadence Pharmaceuticals, Inc. at 1-877-647-2239 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

Please see Brief Summary of Prescribing Information on adjacent page or full prescribing Information at OFIRMEV.com.
<table>
<thead>
<tr>
<th>District Director/Delegates</th>
</tr>
</thead>
<tbody>
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<td>Monica Harbell, M.D. (12)</td>
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<td>Erica Klaus, M.D. (12)</td>
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CSA Bulletin and CSA Website (www.csahq.org)

October 29–November 2, 2012
CSA Fall Hawaii Anesthesia Seminar
Mauna Lani Bay Hotel & Bungalows
Kona, Hawaii

January 21–25, 2013
CSA Winter Hawaii Anesthesia Seminar
Hyatt Regency Maui Resort & Spa
Ka’anapali Beach, Maui
Brief Summary (For full prescribing information refer to package insert.)

INDICATIONS AND USAGE
- OXYFEN® (acetaminophen) injection is indicated for:
  - the management of moderate to mild pain
  - the management of moderate to severe pain with adjunctive opioid analgesics
  - the reduction of fever.

CONTRAINDICATIONS
- Acetaminophen is contraindicated in:
  - patients with known hypersensitivity to acetaminophen or to any of the excipients in the intravenous formulation.
  - patients with severe hepatic impairment or severe active liver disease.

WARNINGS AND PRECAUTIONS

Hepatic Injury
- Administration of acetaminophen in doses higher than recommended may result in hepatic injury, including the risk of severe hepatocellular death. Do not exceed the maximum recommended daily dose of acetaminophen.

The caution when administering acetaminophen in patients with the following conditions: hepatic impairment or active hepatic disease, alcoholism, chronic malnutrition, severe hypoxemia (e.g., due to denitration or blood loss), or severe renal impairment (creatinine clearance ≤ 30 ml/min).

Allergy and Hypersensitivity
- There have been postmarketing reports of hypersensitivity and anaphylaxis associated with the use of acetaminophen. Clinical signs included swelling of the face, mouth, and throat, respiratory distress, urticaria, rash, and pruritus. There have been infrequent reports of life-threatening anaphylaxis requiring emergent medical attention. Discontinue OXYFEN immediately if symptoms associated with allergy or hypersensitivity occur. Do not use OXYFEN in patients with acetaminophen allergy.

ADVERSE REACTIONS
The following serious adverse reactions are discussed elsewhere in the labeling:
- Hepatic Injury
- Allergy and Hypersensitivity

Clinical Trial Experience
- Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed cannot be directly compared to rates in other clinical trials and may not reflect the rates observed in practice.

Adult Population
- A total of 1039 adult patients have received OXYFEN in clinical trials, including 37.3% (n=380) who received 5 or more doses, and 17.9% (n=173) who received more than 10 doses. Most patients were treated with OXYFEN 1000 mg every 6 hours. A total of 13.1% (n=134) received OXYFEN 650 mg every 4 hours.

- Adverse reactions that occurred in adult patients treated with either OXYFEN or placebo in repeated dose, placebo-controlled clinical trials at an incidence ≥ 3% and at a frequency greater than placebo are listed in Table 1. The most common adverse events in adult patients treated with OXYFEN (incidence ≥ 5% and greater than placebo) were nausea, vomiting, headache, and insomnia.

Table 1: Treatment- Emergent Adverse Reactions Occurring ≥ 3% in OXYFEN and at a Greater Frequency Than Placebo-Controlled, Repeated Dose Studies

<table>
<thead>
<tr>
<th>System Organ Class</th>
<th>Preferred Term</th>
<th>OXYFEN (N=467)</th>
<th>Placebo (N=378)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal Disorder</td>
<td>Nausea</td>
<td>38 (8)</td>
<td>15 (2)</td>
</tr>
<tr>
<td></td>
<td>Vomiting</td>
<td>15 (4)</td>
<td>12 (1)</td>
</tr>
<tr>
<td>General Disorders and Administration Site Conditions</td>
<td>Paresthesia</td>
<td>22 (5)</td>
<td>52 (14)</td>
</tr>
<tr>
<td>Neurologic System Disorder</td>
<td>Headache</td>
<td>36 (8)</td>
<td>69 (18)</td>
</tr>
<tr>
<td>Psychiatric Disorders</td>
<td>Insomnia</td>
<td>30 (7)</td>
<td>21 (6)</td>
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</tbody>
</table>

* Paresthesia adverse reaction frequency data is included in order to alert healthcare practitioners that the antipyeretic effects of OXYFEN may mask fever.

Other Adverse Reactions Observed During Clinical Studies of OXYFEN in Adults
- The following additional treatment-emergent adverse reactions were reported by adult subjects treated with OXYFEN in all clinical trials (n=1020) that occurred with an incidence of at least 1% and at a frequency greater than placebo (n=525):
  - Blood and lymphatic system disorders: anemia
  - General disorders and administration site conditions: fatigue, infusion site pain, edema peripheral
  - Investigations: aspartate aminotransferase increased, breath sounds abnormal
  - Metabolism and nutrition disorders: hypokalemia
  - Musculoskeletal and connective tissue disorders: muscle spasms, fraxinus
  - Psychiatric disorders: anxiety
  - Respiratory, thoracic and mediastinal disorders: dyspnea
  - Vascular disorders: hypertension, hypotension

Pediatric Population
- A total of 335 pediatric patients (47 neonates, 64 infants, 171 children, and 73 adolescents) have received OXYFEN in active-controlled (n=240) and open-label clinical trials (n=255), including 59.7% (n=212) who received 5 or more doses and 43.1% (n=150) who received more than 10 doses. Pediatric patients received OXYFEN doses up to 15 mg/kg on an every 4 hours, every 6 hours, or every 8 hours schedule. The maximum exposure was 7.7, 6.4, 6.8, and 7.1 days in neonates, infants, children, and adolescents, respectively.

The most common adverse events (incidence ≥ 3%) in pediatric patients treated with OXYFEN were nausea, vomiting, constipation, pruritus, agitation, and anorexia.

Other Adverse Reactions Observed During Clinical Studies of OXYFEN in Pediatrics
- The following additional treatment-emergent adverse reactions were reported by pediatric subjects treated with OXYFEN (n=335) that occurred with an incidence of at least 1%:
  - Blood and lymphatic system disorders: anemia
  - Cardiovascular disorders: tachycardia
  - Gastrointestinal disorders: abdominal pain, diarrhea
  - General disorders and administration site conditions: injection site pain, edema peripheral, pruritus
  - Hematopoietic disorders: neutropenia
  - Metabolism and nutrition disorders: hypoglycemia, hypokalemia, hyponatremia, hypophosphatemia, hyperuricemia
  - Musculoskeletal and connective tissue disorders: muscle spasms, pain in extremity
  - Nervous system disorders: headache
  - Psychiatric disorders: insomnia
  - Skin and subcutaneous tissue disorders: pruritus edema, rash
  - Vascular disorders: hypotension, hypertension

DRUG INTERACTIONS
- Effects of other Substances on Acetaminophen
  - Substances that induce or inhibit hepatic cytochrome enzyme CYP2E1 may alter the metabolism of acetaminophen and increase its hepatotoxic potential. The clinical consequences of these effects have not been established. Effects of ethanol are complex, because excessive alcohol use can induce hepatic cytochromes, but ethanol also acts as a competitive inhibitor of the metabolism of acetaminophen.

Anticoagulants
- Chronic oral anticoagulation use at a dose of 4000 mg/day has been shown to cause an increase in international normalized ratio (INR) in some patients who have been stabilized on sodium warfarin as an anticoagulant. As no studies have been performed evaluating the short-term use of OXYFEN in patients on oral anticoagulants, more frequent assessment of INR may be appropriate in such circumstances.

USE IN SPECIFIC POPULATIONS
- Pregnancy Category C
- There are no studies of intravenous acetaminophen in pregnant women; however, epidemiological data on oral acetaminophen use in pregnant women show no increased risk of major congenital malformations. Animal reproduction studies have not been conducted with IV acetaminophen, and it is not known whether OXYFEN can cause fetal harm when administered to a pregnant woman. OXYFEN should be given to a pregnant woman only if clearly needed.

- The results from a large population-based prospective cohort, including data from 26,424 women with live born singleton who were exposed to oral acetaminophen during the first trimester, indicate no increased risk for congenital malformations, compared to a control group of unexposed children. The rate of congenital malformations (4.3%) was similar to the rate in the general population. A population-based, case-control study from the National Birth Defects Prevention Study showed that 11,610 children with prenatal exposure to acetaminophen during the first trimester had no increased risk of major birth defects compared to 4,500 children in the control
group. Other epidemiological data showed similar results.

While animal reproduction studies have not been conducted with intravenous aminophylline, studies in pregnant rats that received oral aminophylline during organogenesis at doses up to 0.83 times the maximum human daily dose (MHDD) = 4 grams/day, based on a body surface area comparison showed evidence of macronychia (reduced fetal weight and length) and a dose-related increase in bane variations (reduced ossification and rudimentary rib changes). Offspring had no evidence of external, visceral, or skeletal malformations. When pregnant rats received oral aminophylline throughout gestation at doses of 1.2 times the MHDD (based on a body surface area comparison), awake of miscarriage occurred in both the liver and kidney of pregnant rats and fetuses.

In a continuous breeding study, pregnant mice received 0.25, 0.5, or 1.0% aminophylline via the diet (357, 715, or 1360 mg/kg/day). These doses are approximately 0.4, 0.8, and 1.7 times the MHDD as assessed by a body surface area comparison. A dose-related reduction in body weights of fourth and fifth litter offspring of the treated mating pair occurred during lactation and post-weaning at all doses. Animals in the high dose group had a reduced number of litters per mating pair, male offspring with an increased percentage of abnormal sperm, and reduced birth weights in the next generation pups.

Labor and Delivery

There are no adequate and well-controlled studies with OFIRMEV during labor and delivery; therefore, it should be used in such settings only after a careful benefit-risk assessment.

Nursing Mothers

While studies with OFIRMEV have not been conducted, aminophylline is secreted in human milk in small quantities after oral administration. Based on data from more than 13 nursing mothers, the calculated infant daily dose of aminophylline is approximately 1% to 2% of the maternal dose. There is one well-documented report of a rash in a breastfed infant that resolved when the mother stopped aminophylline use and when she resumed aminophylline use. Caution should be exercised when OFIRMEV is administered to a nursing woman.

Pediatric Use

The safety and effectiveness of OFIRMEV for the treatment of acute pain and fever in pediatric patients ages 2 years and older is supported by evidence from adequate and well-controlled studies of OFIRMEV in adults. Additional safety and pharmacokinetic data were collected in 125 patients across the full pediatric age strata, from premature neonates (at least 32 weeks post menstrual age) to adolescents. The effectiveness of OFIRMEV for the treatment of acute pain and fever has not been studied in pediatric patients under 2 years of age.

Geriatric Use

Of the total number of subjects in clinical studies of OFIRMEV, 15% were age 65 and over, and 5% were age 75 and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients. But greater sensitivity of some older individuals cannot be ruled out.

Patients with Hepatic Impairment

Aminophylline is contraindicated in patients with severe hepatic impairment or severe active liver disease and should be used with caution in patients with hepatic impairment or active liver disease. A reduced total daily dose of aminophylline may be warranted.

Patients with Renal Impairment

In cases of severe renal impairment (creatinine clearance < 30 mL/min), longer dosing intervals and a reduced total daily dose of aminophylline may be warranted.

OVERDOSAGE

Signs and Symptoms

In acute aminophylline overdose, dose-dependent, potentially fatal hepatic necrosis is the most serious adverse effect. Other less frequent effects, hypoglycemia coma, and thrombocytopathy may also occur. Plasma aminophylline levels > 150 mcg/mL at 4 hours after oral ingestion were associated with hepatic damage in 90% of patients; minimal hepatic damage is anticipated if plasma levels at 4 hours are < 150 mcg/mL or < 37.5 mcg/mL at 12 hours after ingestion. Early symptoms following a potentially hepatotoxic overdose may include nausea, vomiting, diarrhea, and general malaise. Clinical and laboratory evidence of hepatic toxicity may not be apparent until 48 to 72 hours after ingestion.

PHARMACOKINETICS

The pharmacokinetics of OFIRMEV have been studied in patients and healthy subjects from premature neonates up to adults, 60 years old. The pharmacokinetic profile of OFIRMEV has been demonstrated to be dose proportional in adults following administration of single doses of 500, 650, and 1300 mg.

The maximum concentration (Cmax) occurs at the end of the 15 minute intravenous infusion of OFIRMEV. Compared to the same dose of oral aminophylline, the Cmax following administration of OFIRMEV is up to 70% higher, while overall exposure (AUC) under the concentration time curve (AUC0-24) is very similar.

The pharmaco kinetic exposure of OFIRMEV observed in children and adolescents is similar to adults, but higher in neonates and infants. Dosing simulations from pharmacokinetic data in infants and neonates suggest that dose reductions of 33% in infants 1 month to < 2 years of age, and 50% in neonates up to 28 days, with a minimum dosing interval of 6 hours, will produce a pharmacokinetic exposure similar to that observed in children age 2 years and older.

NONCLINICAL TOXICOLOGY

Carcinogenesis

Long-term studies in mice and rats have been completed by the National Toxicology Program to evaluate the carcinogenic potential of aminophylline. In 2-year feeding studies, F344/N rats and B6C3F1 mice were fed a diet containing aminophylline up to 6000 ppm. Female rats demonstrated equivocal evidence of carcinogenic activity based on increased incidences of mammary gland hyperplasia at 0.8 times the maximum human daily dose (MHDD) of 4 grams/day, based on a body surface area comparison. In contrast, there was no evidence of carcinogenic activity in male rats (0.7 times) or mice (1.2-1.4 times) the MHDD based on a body surface area comparison.

Mutagenesis

Aminophylline was not mutagenic in the bacterial reverse mutation assay (Ames test). In contrast, aminophylline treated positive in the in vivo mouse lymphoma assay and the in vivo chromosome alternation assay using human lymphocytes. In the published literature, aminophylline has been reported to be clastogenic when administered a dose of 1500 mg/kg/day to the rat model (3.6 times the MHDD, based on a body surface area comparison). In contrast, no clastogenicity was noted at a dose of 750 mg/kg/day (1.8 times the MHDD, based on a body surface area comparison), suggesting a threshold effect.

Impairment of fertility

In studies conducted by the National Toxicology Program, fertility assessments have been completed in Swiss mice via a continuous breeding study. There were no effects on fertility parameters in mice consuming up to 1.7 times the MHDD of aminophylline, based on a body surface area comparison. Although there was no effect on sperm motility or sperm density in the epididymis, there was a significant increase in the percentage of abnormal sperm in mice consuming 1.7 times the MHDD (based on a body surface area comparison) and there was a reduction in the number of mating pairs producing a litter at this dose, suggesting the potential for cumulative toxicity with chronic administration of aminophylline near the upper limit of daily dosing.

Published studies in rodents report that oral aminophylline treatment of male animals at doses that are 1.2 times the MHDD and greater (based on a body surface area comparison) result in decreased testicular weights, reduced spermato genesis, reduced fertility, and reduced implantation sites in females given the same doses. These effects appear to increase with the duration of treatment. The clinical significance of these findings is not known.

OFIRMEV (aminophylline) injection

Manufactured by:
Cadence Pharmaceuticals, Inc.
San Diego, CA 92130

Revised 11/2010
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U.S. PATENT NUMBERS: 6,028,222; 6,992,218

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CSA Bulletin
<table>
<thead>
<tr>
<th>Page</th>
<th>Section</th>
<th>Title</th>
<th>Authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Editor’s Notes</td>
<td>Thank You and Farewell</td>
<td>Stephen Jackson, M.D.</td>
</tr>
<tr>
<td>7</td>
<td>On Being an Editor</td>
<td></td>
<td>Mark Twain</td>
</tr>
<tr>
<td>8</td>
<td>Letters to the Editor</td>
<td>Danielle Reicher, M.D., Clair Steven Weenig, M.D., and John Hattox, M.D.</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>President’s Page</td>
<td>Cur Vexatum</td>
<td>Kenneth Y. Pauker, M.D.</td>
</tr>
<tr>
<td>18</td>
<td>ASA Director’s Report</td>
<td>ASA Continues to Prepare for the Future of the Society and Our Specialty</td>
<td>Mark Singleton, M.D.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Insurance and Indemnity: What Anesthesiologists Need to Know</td>
<td>Phillip Goldberg, CSA Legal Counsel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Report from the Legislative and Practice Affairs Division (LPAD)</td>
<td>Paul Yost, M.D.</td>
</tr>
<tr>
<td>28</td>
<td>I Want Your Practice!!</td>
<td>(and I am taking it with help from your CEO and surgeons…)</td>
<td>Keith Chamberlin, M.D., MBA</td>
</tr>
<tr>
<td>33</td>
<td>The Art of Laszlo Gyermek</td>
<td></td>
<td>Stephen Jackson, M.D.</td>
</tr>
<tr>
<td>36</td>
<td>Peering Over the Ether Screen</td>
<td>The “Dumbing Down” of American Medicine</td>
<td>Karen S. Sibert, M.D.</td>
</tr>
<tr>
<td>40</td>
<td>A Trio of Commentaries on Preoperative Fasting Guidelines</td>
<td>Practice Guidelines for Preoperative Fasting</td>
<td>Thelma Z. Korpman, M.D., MBA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>It Is Time to Abolish the Phrase “NPO After Midnight”</td>
<td>Mark Singleton, M.D.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NPO Guidelines for Obstetric Patients</td>
<td>Mark Zakowski, M.D.</td>
</tr>
<tr>
<td>46</td>
<td>Laughing Gas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Arthur E. Guedel Memorial Anesthesia Center</td>
<td>Induction Rooms</td>
<td>Merlin Larson, M.D., and Mert Senturk, M.D.</td>
</tr>
<tr>
<td>55</td>
<td>2012 CSA Fall Hawaii Anesthesia Seminar Brochure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>CSA Bulletin Survey 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>58</td>
<td>2013 CSA Winter Hawaii Anesthesia Seminar Brochure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Infection Control</td>
<td>Synopsis from the ASA Recommendations for Infection Control for the Practice of Anesthesiology</td>
<td>Robin Stackhouse, M.D., and Stephen Jackson, M.D.</td>
</tr>
<tr>
<td>66</td>
<td>The Ethics of Ending Life: Euthanasia and Assisted Suicide, Part 2:</td>
<td>Ethical Questions in Euthanasia and Assisted Suicide</td>
<td>Gail Van Norman, M.D.</td>
</tr>
<tr>
<td>73</td>
<td>Breaking the Ice:</td>
<td>An Anesthesiologist Searches for Medical Clues in the Antarctic</td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>Routine Preoperative Laboratory and Diagnostic Screening</td>
<td></td>
<td>Thelma Z. Korpman, M.D., MBA</td>
</tr>
<tr>
<td>81</td>
<td>ACOs: The Last Best Hope to Retain Pluralism</td>
<td></td>
<td>George Lundberg, M.D.</td>
</tr>
<tr>
<td>83</td>
<td>Obstetric Anesthesiology: Practice Guidelines and You:</td>
<td>How to Avoid Surprises and Improve Outcomes</td>
<td>Mark Zakowski, M.D.</td>
</tr>
<tr>
<td>89</td>
<td>Informed Refusal</td>
<td></td>
<td>James W. West, M.D.</td>
</tr>
<tr>
<td>98</td>
<td>The CSA Has a New Emblem!</td>
<td></td>
<td>Karen S. Sibert, M.D.</td>
</tr>
<tr>
<td>104</td>
<td>Book Reviews</td>
<td>“C-Section: How to Avoid, Prepare for and Recover from your Cesarean”</td>
<td>Mark Zakowski, M.D., and “Your Medical Mind: How to Decide What Is Right for You” by Jerome Groopman, M.D., and Pamela Hartzband, M.D.</td>
</tr>
<tr>
<td>107</td>
<td>California and National News</td>
<td></td>
<td></td>
</tr>
<tr>
<td>112</td>
<td>Memories of a Former Patient</td>
<td></td>
<td>Danielle Reicher, M.D.</td>
</tr>
</tbody>
</table>
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Editor’s Notes

Thank You and Farewell

By Stephen Jackson, M.D., Editor

This is my “farewell” editorial for your Bulletin and concludes my serving as editor for these past 15 years. As one looks back on the history of Bulletin editors, it is noteworthy that Dr. Gil Kinyon served with excellence for an extended time, as did Dr. Art McGowan, under whose leadership and mentorship I served as an assistant editor. When Dr. McGowan retired from his distinguished and innovative editorship in 1997, Dr. Kent Garman and I assumed his position on a shared basis. Soon thereafter, Kent asked me to assume full responsibility. Since then I have tried to remain faithful to the Bulletin’s mission to communicate, educate, illuminate and stimulate, all pointed toward enhancing and advancing the specialty of anesthesiology.

Over time, I have been given the opportunity to shape the content, eclectic character, focus, and even size and shape of the Bulletin in a manner that I believed would best serve to inform CSA members about issues that are pertinent to the viability of our specialty and practice. Indeed, as the Bulletin historically had been the CSA’s sole vehicle for communication with its membership, and continued to function as such for the initial decade of my editorship, I tried to enhance its mission by engaging, in some small way, each CSA member. Yes, we added “Laughing Gas” humorous prose and cartoons, “Tips From the Top,” the arts and humanities in medicine, medical ethics, environmental health, physician health and well-being, continuing medical education programs, front (and even back) cover art and photography, and just about any eclectic material that I hoped might capture the fancy of our readers. But we also continued with the traditional reports and commentary by a broad spectrum of CSA’s leadership, legislative and practice affairs by Bill Barnaby and Bill Jr. and Dave Willet, history of our specialty (especially in California), book reviews, letters to the editor, and capsules of informative state and national news.

Key to our success, I believe, was bolstering all that with a myriad of “one of a kind, offbeat” articles ranging from how to make a slide whistle from a syringe; to interviews with the anesthesiologists who captured “The Amazing Race,” won the U.S. Figure Skating Championship, served as a physician to the 2002 Winter Olympics, scaled the summits of the highest mountains on all seven continents, and published research as an etymologist on crickets; to
commentaries by literary icons such as Ayn Rand, Atul Gawande, Mark Twain and Stephen Jay Gould; to reports on anesthesiologists who anesthetized Koko the gorilla and other exotic zoo animals; to chapters from books authored by prominent physicians such as Jerome Groopman and Naomi Remen; to other “scoops” and stories not to be found in any other publication. Of note, just as we have printed selected material from sources extraneous to the CSA, we also granted permission to other medical publications to reprint many articles from our Bulletin.

In the end, it always has been the content of the Bulletin that has been its distinguishing virtue and strength. The articles provided in-depth and well-developed analyses of important issues facing our specialty for those interested in delving beneath the surface. Each and every piece was deliberated, dissected, debated, scrutinized, reworked and reviewed by a diligent and responsible editorial board. All the while, a reasonable degree of editorial independence and prerogative were honored.

And, for those with an economic bent, amateur salesmen as we were, we nonetheless attracted a goodly amount of unobtrusive advertisements so as to make the Bulletin, in significant degree, self-sustaining.

In truth, this “job” has been a most delightful, stimulating and challenging opportunity for me, and one for which I am deeply grateful to the CSA. I believe that I have been able to hone and expand the scope and quality of my writing and editing skills from the realm of a research academician to that of the arts and humanities. I also more fully developed my nascent skills of mentoring, encouraging, suggesting, persevering, patiently coaxing, and even “nudging” to a level that I personally never had even considered. And, just as I have attempted to instill a gestalt of excellence, camaraderie and collegiality within CSA’s journalistic community, so have I benefitted and grown from my association with my co-editors. Indeed, I treasure my editorship as having been another blessing and gift—even another long-standing love—in my life.

During the past decade there has been, appropriately, considerable change and growth within the CSA as an organization, and especially in its potential to communicate with our members electronically as well as through the storied medium of print. Perhaps now, at this crossroads of organizational and even generational transition, it is the proper time to consider possible shifts in the role, nature and character of the Bulletin. As the philosopher Heraclitus once is alleged to have declared (no, he didn’t have Facebook, Twitter or CSA Online First), “You can never step into the same river twice.” Yes, gentle souls, change is inevitable, and the Bulletin is subject to that truism. And to that point, I wish my successor, Dr. Michael Champeau, the fullest of success and joy as he takes over the helm.
Assuredly, it is difficult even for me to comprehend that for this past decade and a half, every single day of mine has, at least somewhat, been consumed or involved with the *next Bulletin*. As such, it admittedly is with mixed emotions that I am, in fact, “retiring,” and with this I bid you all good health and “farewell.”

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Every now and then, we invite guest authors to pontificate or opine on a subject near and dear to them. In this Bulletin, we are pleased to have Samuel Clemens offer his commentary on serving as an editor, as he briefly (one week, as a substitute) did in the early part of the 1860s for the Virginia City Territorial Enterprise (for the most part, he was employed as a reporter). This “Guest Editorial” is excerpted from *Roughing It*, a book of semi-autobiographical travel literature written by Mark Twain—Samuel Clemens first used his famous pen name in February 1863 in Virginia City. *Roughing It* follows his travels and adventures in this gold and silver prospecting/mining region of the Wild West during 1861–1867. Should you wish to read about Mark Twain and his opinions on medicine as it was practiced in the later part of the nineteenth century, then I would suggest to you the scholarly and entertaining book *Mark Twain and Medicine* by K. Patrick Ober, M.D., professor of internal medicine and associate dean for education at Wake Forest University School of Medicine. —Stephen Jackson, M.D.

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On Being an Editor

*By Mark Twain*

Nobody, except he has tried it, knows what it is to be an editor. It is easy to scribble local rubbish, with the facts all before you; it is easy to clip selections from other papers; it is easy to string out a correspondence from any locality; but it is unspeakable hardship to write editorials. Subjects are the trouble—the dreary lack of them, I mean. Every day, it is a drag, drag—think, and worry and suffer—all the world is a dull blank, and yet the editorial columns must be filled. Only give the editor a subject, and his work is done—it is no trouble to write it up; but fancy how you would feel if you had to pump your brains dry every day in the week, fifty-two weeks in the year. It makes one low-spirited simply to think of it. The matter that each editor of a daily paper in America writes in the course of a year would fill from four to eight editor's pages.
bulky volumes like this book! Fancy what a library an editor’s work would make, after twenty or thirty years’ service. Yet people often marvel that Dickens, Scott, Bulwer, Dumas, etc., have been able to produce so many books. If these authors had wrought as voluminously as newspaper editors do, the result would be some thing to marvel at, indeed. How editors can continue this tremendous labor, this exhausting consumption of brain fiber (for their work is creative, and not a mere mechanical laying-up of facts, like reporting), day after day and year after year, is incomprehensible. Preachers take two months’ holiday in midsummer, for they find that to produce two sermons a week is wearing, in the long run. In truth it must be so, and is so; and therefore, how an editor can take from ten to twenty texts and build upon them from ten to twenty painstaking editorials a week and keep it up all the year round, is farther beyond comprehension than ever. Ever since I survived my week as editor I have found at least one pleasure in any newspaper that comes to my hand; it is in admiring the long columns of editorial, and wondering to myself how in the mischief he did it!

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**Letters to the Editor**

To the Editor:

I want to share some of my reflections upon reading Dr. Sibert’s opinions in the Spring/Summer 2011 issue of the *CSA Bulletin*. I do commend her on her courage and leadership in tackling contemporary issues that deserve discussion. As both she and I received our board certification in 1987, perhaps I may represent the admittedly smaller “control” group of physicians who have chosen to work part-time, which I have done for 25 years, sharing a full-time equivalent with another female anesthesiologist.

A major reason that many physicians work excessively long hours is economic, some of which may reflect the need to repay large debts accrued by the time of completion of their medical education. Perhaps society needs to make medical education less expensive, more affordable and less impoverishing. Perhaps we will see duty-hour restrictions in private practice as patient safety becomes increasingly scrutinized.

Part-time anesthesiologists allow greater flexibility in scheduling for others as well as themselves. When an anesthesiologist is ill or has other problems, who is likely to be available for backup? As for the younger generation of physicians not wanting to work to the point of sleep deprivation and physical/mental fatigue, perhaps this is the savvy and safe answer to much of the prevailing personal and professional dysfunction and even impairment of many physicians.
Dr. Sibert writes about being present for her kids even though she worked long and hard hours, and she is to be commended on fulfilling that priority in her personal life. However, having just lost my mother to Alzheimer’s and my sister to breast cancer, I had challenging off-duty responsibilities in addition to child-rearing. Because you are a physician does not automatically abdicate you from your other responsibilities, especially in the “sandwich” generation of having to care for parents as well as children.

I further want to say that the Bulletin is an absolutely fantastic publication, with outstanding writing in a broadly interesting and highly pertinent range of articles. Indeed, I believe that the Bulletin is the most valuable and enjoyable anesthesiology reading that I do.

Danielle Reicher, M.D.

To the Editor:

I congratulate you on your excellent and courageous article on “A Societal Pot Hole in Need of Repair” in the Winter 2012 issue. It was useful factual information, and nonpartisan: Neither the devil nor the saints were conjured up. Seldom does one find an article on this subject as well balanced, and therein you provided a true service. Over the years you have been a superb editor, and I admire that you can write as well as you do, time after time. As a retired Clinical Professor Emeritus at UCSF, I have a deep appreciation of our specialty, my colleagues and the CSA.

Clair Steven Weenig, M.D.

To the Editor:

Steve, this is a good opportunity to thank you for an absolutely wonderful job as Editor of our Bulletin. I know that it is a labor of love because you do it so well. I certainly enjoyed your last piece on pot as it was beautifully done and a reflection of my own thoughts about this troublesome problem. Thanks again for your years of service to our specialty.

John Hattox, M.D.
President’s Page

Cur Vexatum

By Kenneth Y. Pauker, M.D., President

The CSA cares about the opt-out because our ethical obligation is to protect patients—not only our current patients, but also generations yet to come—by placing their interests foremost.

Justice on Trial

The opt-out lawsuit in California, *CSA and CMA v. Schwarzenegger*, is entering a new and critical stage. We, who were plaintiffs in the Superior Court, morphed into appellants before the California Court of Appeal, wherein again, unfortunately and outrageously, we unjustifiably did not prevail. The unanimous decision by the three-judge panel was handed down on March 15, 2012, and becomes final after 30 days. Immediately thereafter, there is a ten-day window in which a petition for review by the California Supreme Court can be filed.

*Justice, and only justice, you shall pursue…*

Deuteronomy 16:20

Perspectives on Filing a Petition for Review

A review by the California Supreme Court is by no means automatic, or even very likely. Overall, the Supreme Court accepts a mere 3 percent of cases presented to it. This rises to 10 percent if it is a published opinion, which is the case for our lawsuit. However, this case presents important and complex issues that have never been adjudicated at a Supreme Court level in any state, and which may have far-reaching implications for medical care not only in California, but nationally as well. Thus, the probability of the court accepting our request for review may be as high as 40 to 50 percent.

The significance of our litigation is that it stands at the cutting edge of a controversial and as yet poorly addressed national health care issue. Simply stated, the debate is over whether physician supervision of advanced practice nurses (and other allied health care practitioners) should be preserved. How is the imperative—like that pontificated *without* an evidence base by the Institute of Medicine—that “nurses should practice to the full extent of their education and training” (with its intention of advancing nurses’ scope of practice) to be balanced against protecting the safety of the public from potential degradation
in the quality of care rendered by practitioners who are less educated and
trained than are physicians? How is “the full extent” defined and who is the
definer? Is it ethical to force such an upheaval of our health care system without
evidence supporting and moreover justifying doing so? Do the benefits of such
a change outweigh its risks? How is this question to be answered—and by
whom? The crux here is how one measures both the economic costs to society
and the quality of health care for our citizenry, and then weighs—with imperfect
information and under conditions of uncertainty—one against the other.

Ultimately this is a societal decision, but for now the courts are the proxy
decision-makers. At the Supreme Court level, the justices often decide cases
not merely based upon narrow questions of semantics, but rather by analyzing
issues within a broader context. As practicing physicians, we value, promote,
and appreciate logic and science and evidence. Yes, we are horrified by the fact
that single-minded self-interest groups like the American Association of Nurse
Anesthetists disingenuously employ faulty reasoning to mislead the public as
they persist in their campaign to validate independent practice by nurse anest-
ethetists and pervert what physicians have, for millennia, steadfastly held as our
ethical creed—to place patients’ interests foremost.

If this case were not accepted for review, then that would put the lid on
litigation for the CSA at this time, but by no means would this signal the end
of litigation in this pressure-cooker arena. The impetus to pursue justice will
intensify and continue to demand action, be it in the courts or through the
legislative process.

Making the Decision to Proceed

Our various options and strategies were discussed and debated at the March
meetings of CSA’s Legislative and Practice Affairs Division and Board of
Directors. The CSA Executive Committee (EC) then assembled an “army” of
legal experts—our lead appellate attorney, Curtis Cole; CMA counsel Long Do;
our CSA lobbyists, the Barnabys; CSA counsel from the Superior Court lawsuit
Tom French; ASA attorneys from its Governmental Affairs Office, Ron Szabat
and Lisa Albany—plus the ASA Vice President of Professional Affairs, Norm
Cohen, to join in the deliberations on how best to proceed.

The EC was understandably concerned that there be a substantive change in
our approach, lest we suffer from “déjà vu all over again.” Both the superior and
appellate courts have declined to declare that Schwarzenegger’s opt-out decision
constitutes an abuse of discretion. In effect, they ceded to him a wide berth
to declare what California law is, based upon his abiding formulaically by the
letter, but certainly not the intent/spirit of federal regulations. Both courts found
the absence of the word “supervise” in the California Nurse Practice Act to be
dispositive—meaning being decisive for the resolution of the case—rather than considering the entire body of California laws and regulations as they apply to this issue. This is a systematic failing of the courts. Many sections of the applicable codes, written over many years and never revised into a coherent whole, are peppered with the specific phrases “order by” and “under the direction of,” and this language has been understood by legislators, the California Attorney General, and the California Legislative Counsel (the attorney who represents individual California legislators when they request it) to denote supervision for many decades.

Moreover, legislative intent appears not to have been given any weight by the courts in their deliberations. The historical fact is that in the past there were some legislators who unsuccessfully pursued scope-of-practice enhancements for nurses, failing three times to remove physician supervision imperatives. Presiding Justice Ignazio Ruvolo of the First Appellate District, Division Two, California Court of Appeal, who declared that these failures could not be used as evidence of legislative intent, imperiously dismissed this important portion of legislative history! This is turning logic on its head: if three failed attempts to pass enabling legislation cannot be used to establish intent to keep supervision intact, then neither should it be used to facilitate independent practice. How can the opt-out be consistent with California law, given that the law is, at best, unclear or even equivocal? Constitutionally, the courts are not to write the law, but only to interpret it. Both court decisions suggested that we might better turn to the legislature to remedy what amounts to an egregious disregard of the potential serious adverse consequences to the health of the citizens of California.

The EC carefully deliberated upon our options, ranging from passive abject surrender and then moving on to deal with the consequences of a “brave new world,” to continued vigorous pursuit of what we believe to constitute our ethical obligation to pursue justice for our patients and our profession. This includes the necessity of refining our tactical approach and substantive arguments for the next higher judicial level. Also taken into account was CMA’s offer to share the costs of the petition for review, as well as the likelihood of financial support from other sources, including the ASA, should the Supreme Court accept this case. The potential state and national consequences of not proceeding weighed heavily in our conversations. Ultimately, the EC decided unanimously to authorize our legal team to write a petition for review by the Supreme Court and, if it is granted, to litigate our case to its ultimate resolution.

**Process, Arguments, and Issues**

Part of what persuaded the EC was that the process of how the appellate decision was reached was flawed in several major areas. It certainly was disappointing
that many of our arguments were totally ignored by the appellate court, even though it is not obliged to respond to all, or even any, of our logic or theory! The appellate court was, however, absolutely obliged to address issues of substance brought before it. Our arguments and theory are our side’s perspective and interpretation of the facts of the case. The issues are the legal questions and conundrums that are raised in a legitimate manner by either side, and the appellate court must address and decide these.

The overriding issue (and the subsidiary aspects of this one issue) brought forth by us as plaintiffs at the Superior Court level, and thereby appropriate for consideration by the appellate court in this matter, was whether Schwarzenegger’s opt-out was consistent with California law. Why or why not? Issues of public safety, economics, access, quality, or even whether he legitimately followed the other requirements of the federal opt-out regulations were not and cannot, according to the rules of the appellate process, now be part of the case. The Intervener, the California Association of Nurse Anesthetists (CANA), has tried to add many new issues for the courts to consider, and has pushed to make this case about economics, which it is not. Nonetheless, for the appellate court not to comment upon and decide legitimate issues is a defect in the substance of the appellate decision. A higher court should address this defect.

The first serious and problematic flaw with the appellate decision is that it ignores the disingenuously camouflaged illegal process whereby CANA, aided and abetted by Schwarzenegger and the courts, was able to expand the scope of practice of nurse anesthetists through the vehicle of “underground regulation.” Their process disregards the legal requirement to adhere to the Administrative Procedure Act, and therefore is illegitimate and illegal under California law.

Second, the appellate decision mistakenly and misleadingly minimizes the physician supervision issue to one of pure economics, an argument once again disingenuously proffered by the CANA attorney and manipulated to their advantage. Contrary to his assertion, nowhere in the federal regulation on opting out is there any mention of payment for services. The presumption always has been, although not stated explicitly, that supervision, an integral part of the Medicare regulations since their inception, was required as a matter of patient safety and physician responsibility. Making the decision primarily on economics fails to clarify whether the opt-out is consistent with California law, and thereby hinges on an extraneous and erroneous argument made by CANA. This taints the legitimacy of the appellate decision, which should be overturned.

The third problem that needs to be addressed is that the court’s opinion focuses on its determination that the word “supervision” is not in the Nurse
Practice Act (section 2725 b), and further, that the word “order” does not imply supervision. In actual fact, the word “supervise” does specifically appear in the regulations of the Department of Public Health concerning trauma patients, and this issue was another key matter not considered by the courts. The ostensible omission in the Nurse Practice Act is a defect that must be addressed. California statute and regulation in this area have not been revised for almost 40 years, and hence are not consonant with the complexities of modern medicine. Indeed, they do not serve public safety. As ASA Director Dr. Mark Singleton so eloquently explains:

In the days when giving an anesthetic meant dropping ether onto a gauze mask and measuring and recording vital signs, that might have been adequate, but “giving anesthesia” now has become one of the most complex activities in medical practice. Even in other critical care settings where highly skilled and experienced registered nurses provide complex patient care involving autonomous judgments, there are protocols to follow and the ultimate responsibility and oversight rests with a physician.

Yes, nurse anesthetists are registered nurses, and should be held to common-sense rules (and associated limitations) that mandate this “ultimate responsibility and oversight” to the purview of physicians. This responsibility/oversight/supervision/direction is epitomized by the level of education and training mandated by society only for physicians, which is the justification for why this oversight should remain solely within the province of the profession and practice of medicine and its accompanying ethical responsibilities to society.

Potential Legislative Remedies and Initiatives

Beyond our battle in the courts, the CSA and CMA are contemplating the need for various potential legislative remedies and initiatives:

1. One might attempt to clean up the language of the Nurse Practice Act (section 2725 b) such that nurse anesthetists remain subject to the same physician supervision requirements as are all other advanced practice nurses in California. Instead of the implication of supervision, which is very apparent to us and, as yet, not as clearly obvious to the courts, the actual word “supervision” could be installed, a remedy suggested by both the superior and appellate courts.

2. The CANA counsel made much hay of his opinion that surgeons are not vicariously responsible for the malpractice of nurse anesthetists working with them. Mr. Cole, however, pointed out that there are even more court decisions finding that surgeons are in fact vicariously responsible. One might consider introducing legislation making it explicit that surgeons are
insulated from vicarious responsibility in this situation. What would the various parties, including the public, think of such a law?

3. Given known problems with various health care practitioners—and especially registered nurses—diverting drugs, it may be useful to tighten up the rules for dispensing narcotics in California, so that nurse anesthetists cannot employ anesthetics and Category II controlled substances unless they themselves are specifically licensed to do so by the federal Drug Enforcement Administration (DEA). It is notable that the DEA in the past made a somewhat unusual regulatory decision in this regard, holding that nurse anesthetists can dispense drugs under a facility’s narcotic number, and without the necessity for their own narcotic control number. Surely this modus operandi could and should be tightened up to require individual DEA registration for drug administration in California.

4. “Truth and transparency” legislation, already California law, requires health practitioners to display their licensure on their name badge. As an extension of this philosophy, one might attempt to enact legislation requiring a practitioner administering anesthesia and/or sedation to obtain written informed consent that stipulates whether they are an anesthesiologist, an advanced practice nurse, or other practitioner (registered nurse, or perhaps in the future, an anesthesiologist assistant). A patient would be given the choice of whether to accept that practitioner and proceed with the surgery or procedure, or to choose someone with different credentials. If a physician were desired and none were available at that facility, then the patient could choose to have the surgery/procedure performed where an anesthesiologist could care for him/her.

5. As alluded to in #4, anesthesiologist assistants (AAs) always work within an anesthesia care team and never without supervision. Consideration should be given to initiating an AA training program here in California, and thereafter seeking enabling legislation for their licensure.

Medical Staff Initiatives

Another important strategy beyond the courts and legislature is to urge medical staff at all facilities to require supervision of registered nurses, which, according to federal regulation, is an option in any opt-out state. A curious logical consequence of the appellate decision is that if nurse anesthetists are independent practitioners in California and because all registered nurses in California have the same scope of practice, then all registered nurses may be unsupervised. Therefore, critical care (ICU) nurses, endoscopy nurses, and even floor nurses could also function unsupervised by a physician. Of course, some medical
stiffs would restrict this situation, but it is not difficult to imagine that some facilities might promote this, likely for local economic considerations.

**Threats by the Federal Trade Commission and PPACA**

Moreover, we should all have a real concern about what has emerged as a disturbing national trend, wherein the Federal Trade Commission has opined that limiting the scope of practice of allied health practitioners by some medical boards, because these boards declare certain acts and procedures to be the practice of medicine, may possibly constitute antitrust violations! Furthermore, the antidiscrimination provisions in the federal Patient Protection and Affordable Care Act (PPACA), unless the United States Supreme Court invalidates the law, raise the specter of federal civil rights investigations or civil lawsuits, should some classes of health care practitioners feel discriminated against with respect to being able to render care for which they claim to be qualified. As noted above, additional litigation as a subsidiary issue within the overriding question of the requirements for supervision may rise through the courts, as this area of law remains unsettled.

**Taking It to the Public**

Finally, we members of the CSA must redouble our efforts to communicate with our patients and their families and friends, the public, legislators, regulators, and the press about the realities of anesthesia practice. This then is one more prong in our integrated strategy to try to influence and redirect the mounting trajectory of decisions by others concerning how we practice anesthesiology. Some of what we might say could incorporate the following thoughts:

“Ordering” an anesthetic is not the same as ordering a milkshake. We do not “order” intensive care unit nurses to cure a patient in septic shock, but rather supervise, even direct the details, including diagnostic tests and doses of medications, which by their very nature are integral to the practice of medicine. Lawyers do not “order” paralegals to take charge of litigation. It is for very good reasons that architects supervise builders.

When we compare outcomes between various types of anesthetic practitioners, science and logic dictate that we must employ risk adjustment and correct the results for the very different complexities of the cases performed. That is the egregious flaw in the articles appearing in supposedly credible periodicals that purport to show equivalence of outcomes between anesthesiologists and nurse anesthetists in opt-out states. The kinds of cases in those “reports” are very different, as anesthesiologists are more likely to be involved with the care of the more complex and sicker patients. Yet, while gross administrative statistics seemingly show the same mortality rate between the two kinds of practitioners,
nurse anesthetists caring for simpler patients should be expected to have lower mortality rates. That they do not speaks volumes. *Administrative* data can distort or disguise many complications and undesired outcomes. *Clinical* data gathered at the point of care is what speaks most persuasively, but there is precious little of it. With the advent of the Anesthesia Quality Institute and the National Anesthesia Clinical Outcomes Registry, our earnest hope is that justice, ethics, reason and safety of patients will prevail.

We care about Ethics because they are fundamental to our professionalism as physicians. We care about Justice because it represents an ideal of fairness aspired to by free people everywhere. As we labor to preserve what is good and noble in the profession we have chosen, we seek, in our tenacious efforts to improve safety, Justice on behalf of our patients. However, Ethics and Justice are subject to interpretation by different people, with diverse perspectives and motivations, in evolving times and changing circumstances. We would like to believe that, ultimately, the Law is sharply defined and dispassionately applied, but it appears that reality may fall short of this hopeful belief in achieving Justice, as to date we have learned as parties to this litigation.

*Truth is mighty and will prevail. There is nothing the matter with this, except that it ain't so.*

Mark Twain

The CSA has fought this opt-out from its inception, almost three years ago. We are not done with this matter, and we are resolved to do whatever it takes to confront the dumbing down of American medicine.

**References**

1. From the Latin: “Why should we bother?”

2. This article presumes an understanding of the basic facts of *CSA and CMA v. Schwarzenegger*, and analyzes the current situation of the opt-out litigation at a more advanced level. The possible motivations for why the disgraced former governor executed the opt-out are discussed in the Barnaby article referenced below. For a summary of the basics see:

3. For a complete compendium of all of the briefs in this case, please see http://www.csahq.org/legislative.php (log in to access this area of the CSA website).
ASA Director’s Report

ASA Continues to Prepare for the Future of the Society and Our Specialty

By Mark Singleton, M.D., ASA District Director

The ASA Board of Directors (BOD) met on March 4, 2012, at the Intercontinental O’Hare Hotel on a typical gray and cold late-winter Chicago weekend. Who knew that only a few weeks later Chicagoans would be cavorting in crazy 80-degree flip-flop weather? In addition to myself and Alternate Director Mike Champeau, Drs. Ken Pauker, Johnathan Pregler, James Moore, Peter Sybert, Paul Yost, Zeev Kain, Stan Stead, and Linda Mason represented the Californians. The March ASA BOD meeting is an “interim” meeting; the August BOD is designated as the “annual” meeting. Thus the number of committee and component society reports is relatively small in March. Much of the meeting concerned the ongoing evaluation of the internal governance and restructuring of the ASA and the projections and ambitions for the future success and growth of the organization. In many ways these considerations and decisions parallel what we currently are doing at the CSA.

Search for the Top Staff Executive

As I reported in the previous Bulletin, the ASA BOD approved a national search for an ASA Executive Staff Officer (in effect, a CEO). The first steps in this process, forming a search committee and selecting a professional search firm, have been accomplished. The ad hoc search committee is chaired by ASA Past President Gene Sinclair and includes our own Linda Mason among its four-officer/four-director membership. The BOD also approved a $250,000 “initial outlay” for this search process. In addition to having identified a search firm, the selection process will include the input of a consulting firm specializing in “industrial psychology” that has demonstrated an impressive ability to ensure greater than 90 percent long-term success of the selected executive. The ultimate cost of the search will reflect a percentage of the individual’s negotiated compensation package. A great deal of discussion has been ongoing over the relative role of the BOD in this process, with some arguing that the BOD should be involved in selecting the candidate among several finalists, while the President and the Administrative Council (AC = officers) believe that this would be unworkable due to required confidentiality guarantees to the candidates. The administrative procedures...
language currently empowers the AC to select, and the BOD to approve or disapprove, the selection of the CEO. This process is expected to be complete by the time of the August BOD meeting.

Many Other ASA Initiatives

The ASA Committee on Future Models of Anesthesia Practice has been given a $30,000 budget to “further access, and possibly submit, a CMS Center for Innovation grant related to the Surgical Home model.” The ASA still is seeking a Director of Health Policy and Research, a search begun last year that is ongoing, the price tag for this position guesstimated to be $94,000.

The journal *Anesthesiology* has been allocated $72,000 to support the evaluation and potential contract renegotiations for production of two issues of the journal per month. In response to questions from many who voiced difficulty keeping up with reading just one issue per month, the Editor-in-Chief, Dr. James Eisenach, presented the rationale for these considerations as allowing the journal to publish more content of practical relevance to the practicing anesthesiologist, while at the same time becoming more profitable to the Society.

The BOD also approved efforts by ASA’s official delegation to the World Congress of Anesthesiologists (WCA) in Buenos Aires the last week of March 2012 to attempt to win approval for the WCA to be held in San Francisco in 2020 (there was strong competition for this from other world capitals). Dr. Gelb, one of those lobbying for San Francisco, reports that we unfortunately lost out to Prague. Dr. Pauker had been influential in efforts to have this honor directed toward our state, and CSA presumably would have had an important role.

Further information was provided to the BOD on the “land use” considerations that I mentioned in my last report. A 6.6-acre vacant parcel had been identified as the potential future new location for the ASA headquarters, in Schaumburg, Ill., and negotiations had been in progress for its purchase. The final contract was signed March 21, 2012. Schaumburg is about 8 miles northwest of O’Hare Airport, near the intersection of two major freeways, and Motorola and IBM are leading employers in the community. Other national medical professional organizations, including the American Academy of Pediatrics and the American Society of Neurological Surgeons, are located close by. The disposition of the existing property where ASA is currently headquartered will await the next several years.

Relationships with Allied Organizations

It is noteworthy that there has been ongoing dissatisfaction expressed for the past several years by some of the subspecialty organizations that are
administratively managed by ASA. This has involved many issues, including the increase in ASA management fees and complaints from the subspecialty organizations regarding timeliness and competency of the management services provided. The American Society for Regional Anesthesia (ASRA) and the Society for Neuroscience in Anesthesiology and Critical Care (SNACC) have decided to contract with other management service providers, leaving the ASA. This actually will have the effect of improving the ASA's balance sheet, as expenses were greater than revenue for these activities. The ASA has expressed a desire to fill a role as “incubator” for small subspecialty or special-interest organizations related to anesthesia, but recognizes that at some point they may be better off on their own. ASA leadership and staff are, however, addressing and correcting the problems identified in these management duties.

A contentious discussion took place regarding a proposal from the ASA Committee on Regional Anesthesia to endorse a joint project from the committee and ASRA. The proposed “Ultrasound-Guided Regional Anesthesia (UGRA) Education and Clinical Training Portfolio” was initiated as a resource for granting medical staff privileges in UGRA. The specific objections to details in the document are beyond the scope of this report, but there was general agreement that such a resource would be valuable. It should be noted that this certainly will come up again at the August BOD and at the HOD in October.

I would also like to announce that Dr. Michael Champeau was elected by the BOD to fill a vacant position as one of ASA’s two representatives on the important joint ASA-ABA-AMA committee, which makes significant advisory decisions regarding the American Board of Anesthesiology.

**Future ASA Leadership**

Finally, there will be a contested election for ASA First Vice President between Dr. Arthur Boudreaux (current Secretary) and Dr. John Abenstein (current Speaker of the House) in October. Other candidates have been rumored to be considering seeking ASA office, which may result in a robust election process.

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**MARK TWAIN’S WIT AND WISDOM**

*It is better to keep your mouth shut and appear stupid than to open it and remove all doubt.*

Always do right. This will gratify some people, and astonish the rest.

The best way to cheer yourself is to try to cheer somebody else up.
On Your Behalf …
Legislative and Practice Affairs Division

Election Reform 2012—A New Political Environment?

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

The 2012 election could be a seminal event in the evolution of California politics. Taking effect for the first time are two basic electoral reforms, and combined, they could calm the overheated partisanship that has paralyzed state government policy-making for the past several decades.

New Districts and New Ballots

Ending legislative gerrymandering has produced a number of competitive “swing” state legislative and congressional districts that can be won by either party. At the same time, allowing primary election voters to choose candidates without regard to party affiliation will encourage appeals to moderates and independents in the middle of the political spectrum, rather than to the party activists, at the two opposite ends. All candidates will be listed on the same ballot as there no longer will be a separate Democratic or Republican primary ballot. The two candidates receiving the most primary votes will face off in the November election regardless of their party membership. Taken together, citizen redistricting and the open “top two” primary hopefully would produce a new environment for cooperative bipartisan problem solving.

Both reforms were put in place by voter-approved ballot measures, and both have survived court challenges. Even so, the new State Senate districts being used for the 2012 election cycle will be the subject of a referendum in the November general election. The Citizen Redistricting Commission’s redrawn Senate maps were upheld by the California Supreme Court in late January before a sufficient number of voter signatures were tabulated to qualify the referendum. If voters were to reject the new Senate maps in November, then the Supreme Court might have to order a special master (an expert appointed by the Supreme Court to carry out an order or an action on behalf of the court, as has occurred in the past to carry out redistricting when legislative remapping was vetoed by a sitting governor) to produce yet another set of Senate
boundaries for future elections. However, some insiders question whether funding this referendum campaign will be possible.

**Impact on 2012 Campaigns**

The reforms delayed the start of many campaigns. Until all the new districts were confirmed by the January court ruling, many incumbents and other candidates were uncertain which office to seek or even whether to run. Campaign announcements were fast and furious right up to the deadline for filing official candidacy declarations.

One unexpected decision not to seek re-election came from Assembly Member Linda Halderman, M.D. (R–Fresno). Although finishing just her first term in elective office, she has been a forceful and effective voice for physicians. The CSA has been among Dr. Halderman’s strongest supporters and we are disappointed that she has chosen to exit the Legislature. Despite working on health policy as an elected legislator and, earlier as a Senate staff consultant, she felt compelled to return to medical practice.

**New Faces in the State Legislature and Congress**

The reforms will bring an unprecedented degree of change among state legislative and congressional officeholders. More than half of the 80-member State Assembly will be brand-new lawmakers. Of 40 State Senate seats, as many as 10 could have new occupants. Of the 53-member California congressional delegation, 10 or more incumbents could be gone due to retirements or defeats in newly aligned districts. Some of the departing congressional incumbents are longtime veterans whose seniority and clout will be missed.

Despite their importance to the Golden State, the potentially transformational California electoral changes might be overshadowed by 2012 being a presidential election year. Yet the electoral reforms could result in equally important alterations to the state’s political landscape, as did Proposition 13 (property tax limits) in 1978 and Proposition 20 (state elective office term limits) in 1990.

**GASPAC**

We interview candidates for state legislative offices. Some of the interviews are conducted independently, others in conjunction with the California Medical Association or the MICRA coalition, the Californians Allied for Patient Protection. The CSA traditionally has not “endorsed” candidates but has evidenced its support through GASPAC contributions. In that connection, CSA/GASPAC member recommendations are invited and are helpful.
Insurance and Indemnity: What Anesthesiologists Need to Know

By Phillip Goldberg, CSA Legal Counsel

Last year California Medical Association (CMA) chief executive Dustin Corcoran sent a letter to Catholic Health Care West (CHW) chief executive Lloyd Dean about troubling provisions CHW was including in its service contracts with hospital-based physicians. One of the provisions was a requirement that hospital-based groups’ malpractice coverage limits be increased to $2 million per claim and $6 million annual aggregate. The other provision required the hospital-based groups to indemnify the hospital for claims brought against the hospital arising out of the group’s conduct. Although the provision on higher malpractice limits is far less common than the contractual indemnity provision, this article will discuss both, and what anesthesia groups can do when presented with a contract that includes either.

Higher Malpractice Coverage Limits

The fact that CHW has even asked for limits of $2 million/$6 million indicates that not much thought has been given to the provision, because not all malpractice companies even offer these. The more common higher limits above the standard $1 million/$3 million usually are $2 million/$4 million. The reason that the hospital asks for the higher ones is obvious: It wants another deep pocket to share the cost of defending and resolving malpractice claims when both the hospital and the hospital-based group are named as defendants.

There are very good economic reasons for declining to accept a higher-limits contract provision. The premium for $2 million/$4 million limits is likely to be 20 percent to 30 percent higher than the premium for $1 million/$3 million limits. This will hit the group’s bottom line immediately. From discussions with underwriters at malpractice companies in California, I understand higher limits are offered but are not necessarily encouraged by the companies. Studies have shown that malpractice claims resulting in payments in excess of $1 million are rare, although not unheard of. Thus, an anesthesia group may conclude that higher limits impose an additional cost without offering correspondingly greater benefits. On the rare occasion that a hospital contract has included a provision with higher malpractice limits, I have advised my
client to decline to accept the term. Anesthesia groups need to know they have the ability to negotiate hospital contract terms. Although I do not think it is necessary or appropriate to increase limits, an anesthesia group that wants to accommodate the hospital’s proposal might agree to accept the higher limits on the condition that the hospital reimburse the additional premium.

**Indemnifying the Hospital**

Whereas, in my experience, the higher malpractice limits provision in hospital contracts is rare, contractual indemnity provisions are almost universal, and further, hospitals are less willing to eliminate indemnity provisions altogether. Although increased limits create an immediate and certain cost to the anesthesia group, the contractual indemnity provision creates only a potential cost, but one that could be significantly greater. The risk that the group assumes with the contractual indemnity provision is best explained by way of an example. Consider the situation where a bad outcome occurs, and a lawsuit ensues with both the group and the hospital as defendants. If the case proceeds to a judgment where the hospital is exonerated but the group is found liable, then the hospital may well have incurred costs of $200,000 or more in successfully defending itself. If the anesthesia group has a contractual indemnity obligation to the hospital, it may find itself presented with a bill for the hospital’s costs. If the group passes that bill to its own malpractice company, then the claim will be denied as a contractually assumed indemnity obligation. The exclusion for contractual indemnity is virtually universal in professional liability policies because it necessarily increases the risk insured. This means that the contractual indemnity provision makes the anesthesia group assume a potential liability against which it cannot effectively insure.

In my experience, contractually assumed indemnity provisions are often mutual. That is, the hospital agrees to defend, indemnify and hold the group harmless where the hospital is the cause of the claim, just as the group agrees to do so for the hospital when the situation is reversed. This does not make the provision more fair and even-handed. Most physician malpractice coverage is “first dollar” coverage, so that all costs of defense and indemnity payments within limits are paid by the insurance company, while the insured group pays nothing. By contrast, most hospitals have either self-insured programs, where they may pay most or all of the costs of defense and payments to claimants, or high deductibles or self-retention amounts. Accordingly, the hospital is much more likely to have an incentive to make the indemnity demand on the anesthesia group than the other way around. The anesthesia group, by contrast, has no practical benefit from the indemnity claim against the hospital. Anesthesia groups confronted with a contractually assumed indemnity provision might simply suggest that both parties rely on their
own insurance coverage to provide defense and indemnity for both valid and specious claims, and not look to each other to serve as insurance companies.

The leverage that an anesthesia group has with the hospital in contract negotiations varies significantly from contract to contract and hospital to hospital. There are a multitude of factors that need to be considered when increased limits or contractual indemnity are included in the contract the hospital presents to a group. Anesthesia groups need to understand they have the right to negotiate terms with the hospital and need to consider how important the insurance and indemnity provisions can be.

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**Report from the Legislative and Practice Affairs Division (LPAD)**

*By Paul Yost, M.D., Chair, Legislative and Practice Affairs Division*

**Federal Issues**

The more things change, the more they stay the same: The Sustainable Growth Rate (SGR)—which has to be the greatest oxymoron, because it is neither sustainable nor a growth rate—remains in place. The U.S. Congress passed up another opportunity to permanently repeal the SGR in favor of passing another temporary 10-month “doc fix.” This latest act of kicking the can down the road averts the 27 percent cut to physician payments, for now. However, until Congress repeals the SGR, we will have to continue to discuss this issue.

On a related matter, the bill to repeal the Independent Payment Advisory Board (IPAB—a group of non-elected, unaccountable individuals who will decide upon future Medicare cuts, with minimal, if any, Congressional oversight) portion of “Obamacare” passed out of the House of Representatives in late March on a highly partisan vote (seven Democrats voted with the Republicans), and almost certainly will not be approved by the Democratic-controlled Senate. The ASA has supported repeal of the IPAB and is a strong advocate for H.R. 452, “The Medicare Decisions Accountability Act.”

**State Issues**

U.S. District Court Judge Christina Snyder blocked the State of California from implementing a 10 percent MediCal reimbursement rate cut to physicians and
hospitals. The CMA successfully argued that decreasing the already abysmally low MediCal payments would further harm access to care for California’s most vulnerable population.

**LPAD Meetings**

At a meeting in late 2011, we discussed a situation in which a national anesthesia provider replaced an existing anesthesia group. Dr. Keith Chamberlin has written an excellent article on this matter that appears in this Bulletin (see pages 28–32). In January, we discussed a disturbing trend of hospital systems requiring hospital-based physician groups to increase their medical malpractice coverage limits from the current standard of $1 million/occurrence and $3 million/year to $2 million and $6 million respectively (see the excellent piece on this matter by CSA Legal Counsel Phillip Goldberg, preceding).

**Website Update**

I hope you will visit the “Practice Resources” section of the website, which we continue to expand. Note that in addition to providing many useful documents, it has open groups containing discussions of key issues.

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**CSA Bulletin Cover for Volume 61, Number 2 “Bird and Blossoms”**

The cover photograph of this Bulletin issue was taken in the photographer’s backyard in 2012. The birds were flying in and out of the the fruit tree for hours. The image was captured with a Canon 7D DSLR and processed in Photoshop and Silver Efex Pro.

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What is great service? For NORCAL Mutual insureds, just 1 phone call is all it takes for great service. That means calling during business hours and immediately reaching a live, knowledgeable, friendly expert. After hours, it means promptly receiving a call back from a professional qualified to help with your issue. No automated telephone tango. Questions are answered and issues resolved – quickly. We’re on call 24 hours a day, every day of the year. Great service brings you peace of mind.

Great service 24/7. Hard-working numbers you can count on.
I Want Your Practice!!
(and I am taking it, with help from your CEO and surgeons...)

By Keith Chamberlin, M.D., MBA

I know, I know, the above is a bold statement that does not apply to your particular anesthesiology group at your particular practice. Sorry. Read on:

The following is an accurate, true-to-life phone call between the national sales director of a national anesthesia company and your hospital’s CEO or CMO.

“Hi, Mr. CEO. I am Dr. So-and-So, from Anesthesiology Blah-blah-blah, the leading national provider of professional anesthesiology services in the United States. I am calling to make sure you are completely satisfied with your anesthesiology providers.

“Oh good, I am glad you are. So many CEOs whom we call are not satisfied. They do not have anesthesiology groups that will not only save money for their hospitals, but even make money for their hospitals. We know how hard a job you have, with less than a 4 percent margin, and most anesthesia groups do nothing to help contribute to that. Oftentimes we are called when hospitals are reviewing the groups that they supplement and stipend, and are asked how we can help. You are one of the few—what? What do I mean by anesthesia helping make money for the hospital?

“Well, pardon me, but I assumed that if you were happy with your group, then they must help substantially with the new value-based purchasing (VBP) and do everything possible to avoid taking a stipend from your facility. We know the financial difficulties facing hospitals everywhere (through our local California and national experience) and do everything we can to assist you in maximizing your deserved collections from the government and private payers. In addition, we really do not want a stipend if we can avoid one legally (Medicare anti-kickback, etc.) and still recruit and retain high-quality providers. We are able to reduce substantially any stipend via excellent management of the expensive and rare resources available to you.

“I’m sorry? How do we do that? Frankly, we place medical directors with substantially advanced management experience in operating room (OR) management roles. We require our OR medical director to have a management degree or to undergo our own unique management training. This course assists them with group management in an adverse economic environment, and gives them the skills to manage and evaluate group performance for both quality and financial success. All of our medical directors have these skills or degrees—I am concerned that yours do not.
“If I may, I would like to send you a copy of our quarterly financial analyses that we use to judge how we are doing in terms of hospital financial performance, as well as group performance, because we know that without a financially successful hospital we cannot have a financially successful group. The hospital should never pay any money to anyone to make up for sloppy management and poor collection procedures, and you deserve to see reports that reflect excellence in these processes, which is routine for us.

“A lot goes into a successful group, as you know. Pardon—such as? Well, of course quality is number one, but we define quality way beyond sitting on a stool giving anesthetic gases. Often anesthesia professionals forget their professional roles by arriving late wearing shorts or blue jeans, and leaving early and having minimal contact with patients outside the OR. We require our professional anesthesia employees to contact patients via phone preop if they are outpatients, or see them in the hospital if they are inpatients, and also make personal or telephone postop rounds. This shows up quite distinctly in our patient satisfaction survey, which is both Internet- and postal-based. We are able to get extremely rapid feedback, and we deal with any patient dissatisfaction virtually immediately. Naturally, we are active members of the American Society of Anesthesiologists’ Anesthesia Quality Institute, so we can compare ourselves to other groups on a local, state and national basis. In addition, this preop excellence prevents day-of-surgery case cancellations, and we report that monthly to you. This is a huge money saver for the hospital, and huge in increasing patient satisfaction.

“Surgeon satisfaction is equally important to us, and we have a dedicated surgeon quality survey, done every quarter, as I am sure your group does. Oh? Well, we would be happy to send you our reports and quality dashboard for demonstration purposes.

“We realize that the department of anesthesiology is the lynchpin for most hospital procedures, both in and out of the OR, and we sit on all committees that could potentially involve us, looking for efficiencies and cost savings, after we make certain that perfect quality is achieved. In fact we require committee participation on hospital committees such as quality assurance, pharmacy and therapeutics (where we have been able to discover over $50,000 per year in savings by having the anesthesia provider prepare and administer the preop antibiotics instead of the pharmacy), OR management, trauma, and medical executive. We also have our MBA directors (or management-trained directors) sit on the hospital finance committee because we recognize (as do you) that the OR is the source of greatest profit and expense of all departments. In addition, our members sit on many boards of the local IPA and physician groups and, in fact, one of our members is the chairman of the task force for the newly developing accountable care organization in her community. We believe that as
a department, we are your partner in business, and that the hospital is a partner in the community, and we support both concepts fully.

“So please let me send you some information—what, excuse me? Of course I can explain further.

“Many CEOs and hospital boards look at anesthesiology groups—unlike surgeons—as having no cash value, because we do not bring patients to the hospital (excluding pain patients). The truth is that nothing is further from that truth. A well-run, professionally managed anesthesiology department can be responsible for avoiding the loss of hundreds of thousands of dollars, and can frankly encourage current and new surgeons to bring new business to our facility—through excellent management of OR time, on-time starts, permission for late and weekend cases, and in general, a smiling, cooperative face encouraging new surgical business whenever possible, as well as reducing unnecessary waste and expense.

“Look at VPB. The core is accountability and attention to core measures. Anesthesia has a direct impact on 33 percent of the Fiscal Year 2013 Process of Care measures (prophylactic antibiotic measures, beta blockade in the periop period, cardiac surgery patients with 6 a.m. postop operative serum glucose, and surgery patients who receive appropriate venous thromboembolism prophylaxis within 24 hours). Hospitals are going to have substantial monies (starting with $850 million) withheld from DRG payments, but can recoup those funds and more by meeting quality and patient satisfaction measures. We are dedicated to ensuring full compliance and detailed reporting so our facilities can earn back more than they contributed.

“Patient experience of care is one of the three legs of the Institute of Medicine and Center for Medicare and Medicaid Services philosophies, and we agree. Thus we have a short but informative patient satisfaction survey that we report to you quarterly. (We review it daily, as it is Internet-based.) We know this is also part of the …

“I'm sorry, sir, what was that? Surgeon satisfaction? Great question. We know no anesthesiology change is possible without surgeon support, which is why we strive to hire the current qualified anesthesiology staff at some percentage of their current earnings. We know surgeon satisfaction in terms of service and availability is critical, and we also survey the surgical and operative staff for levels of satisfaction.

“We are able to operate more cost-efficiently by using both board-certified anesthesiologists and highly trained CRNAs under the close supervision of
those physicians. We place a high priority on the care team model, placing patient safety and quality care above all else.

“For us, professional leadership, professional management, close and cordial relationships with your payers, excellent responsiveness to your surgical staff (no arguments in the OR or the scheduling office), superb dashboard reporting of OR efficiencies, and active involvement in hospital committees and functions are the only way a serious anesthesiology service can make your job easier, help the hospital to function at its highest level, and respond instantly to our rapidly changing environment.

“May I send you some sample dashboard reports, testimonials, and some blinded financial projections? Excuse me, a presentation to your board of directors? Of course…”

If you think that I fabricated the above, then think again. Virtually all the information was taken from current white papers by national companies.

So what is to be done? Here is yet another checklist you will find very useful. Understand that there are two components here—acting like a “doctor” and being a business partner with the hospital. Aligned incentives is a key phrase—you and the hospital are operating a business together—that underlies all your actions. Understand that, and the rest will fall into place. Specifically:

1. Become indispensible. Half of anesthesia is turning dials in the OR, the other half is the medical-school-educated physician who contributes to the overall medical care of the patient. Show what you can do that others cannot.

2. Develop an excellent relationship and communication with your CEO and CMO. Nothing works as well as having friends in high places; getting early warning that something is amiss in your group and giving you time to fix it is invaluable.

3. Collect data. It is no longer good enough to just be clinically good enough. You must measure it, collect it, dashboard it, and show it to your hospital, payers and the government.

4. Act professional. Show up for work as the professional that you are. Dress like you want to be treated.

5. Act like a physician. Call patients the night before their procedure, and find a way to talk with them postop, even if it is by phone. Patients love this, and it counts!
6. Become a member of the CSA and the ASA. And ask them for assistance if you get into trouble. We have excellent resources that can both rescue a group and get it prepared for negotiations—you do not have to be alone!

7. Become involved in your hospital’s key activities. At a minimum, secure appointments on the following committees:
   • OR management
   • quality improvement
   • Surgical Care Improvement Project (SCIP)
   • pharmacy and therapeutics
   • emergency/trauma
   • critical care

If you have someone with some experience or knowledge, try for finance board committees and hospital board committees (quality, etc.) Take the lead when there is a problem.

8. Find a way to save the hospital money, and tell them you are doing it. Use the concept of VPB and your group’s commitment to that concept.

9. Send a member of your group to the ASA’s Certificate in Business Administration Course. This demonstrates your commitment to better organization, enhanced communication, and more efficient resource utilization.

10. Inform the hospital about all that you do now that saves money—continuous peripheral nerve blocks, pain consults, and other clinical activities that allow patients to discharge earlier and improve the patient’s experience of care.

11. Develop a satisfaction survey for patients and surgeons and share it with the hospital, including action taken to improve any deficiencies (they will discover these anyway, so you might as well be the first to mention them).

12. Be perfect on quality metrics—antibiotics, temperature control, beta blockade—and communicate to the hospital administration how well you are doing!

13. If you receive a stipend, make sure you have an outside consultant, hired by you, to do the math and analysis of what the hospital wants, what it needs, and what it can afford. Let the facility know you are aware of your responsibilities and obligations.

In summary, the threat is very real, and it’s happening in your backyard. You can stop it. Get involved, get off the stools, get on the committees, and support your societies.
First-time visitors to the Palos Verdes home of anesthesiologist Laszlo Gyermek might easily imagine that they have entered an art gallery. Throughout the residence, walls are lined with handsomely framed works of Old Masters, Impressionists and Post-Impressionists—all produced by Laszlo Gyermek, M.D., Ph.D., who has been interested in copying art since he was a boy of 16 in his native Hungary. Artists represented in his collection of over 400 pieces are primarily the French Impressionists and Post-Impressionists: Monet, Manet, Marquet, Matisse, Cézanne, Gauguin, Van Gogh and Van Dongen. Also represented are Italian Renaissance masters such as Botticelli, Raphael, della Francesca, Lippi, Uccello and Ghirlandaio, along with the 17th-century Vermeer and Rembrandt, among others. He amusingly states that he has what is likely one of the largest “fake” Monet collections in the Western world.

Contemporary abstract art has no attraction for him. “I don’t understand ultra-modern paintings, maybe because as a scientist, I don’t see reasons beyond the bizarre extravagance and occasional bravura.”

Gyermek refers to the majority of his paintings as “studies,” rather than copies. Sometimes the paintings are the same size as the originals, but usually the size is altered. “I don’t want to be accused of making a fake.” He sees copying art as a way to bridge the gap between the largely unavailable classic originals and the mass-produced printed or even “hand-painted” reproductions. There is a tradition of rich collectors commissioning high-quality copies of art because they are afraid to display their original paintings. “For such people it’s a wonderful and practical solution. For others, a near ‘perfect’ copy may also fulfill an aesthetic experience and desire.” Of note, he admires the draftsmanship—but not the ethics—of some of the famous forgers, particularly the notorious Hungarian painter Elmyr de Hory, who drifted into forgery when he was unable to sell his own artworks. When his deceit was discovered in the U.S., de Hory “had to leave...
the U.S. very quickly.” The fact remains, however, that in an ill-defined and commercial art world, huge emphasis is placed on a famous signature in determining the “value” of a given painting. “For instance, an unsigned Monet (and some do exist) has a vastly lesser economic value than a signed one.”

In research for his studies, Gyermek has visited many art museums in this country and abroad, analyzing different artists’ techniques. Having little opportunity to work from originals, he usually relies on reproductions for his models, finding that “it makes a good deal of difference what kind of reproductions you use.” With the color in books and posters often distorted, he frequently has come home to touch up and alter his study painting after having seen the original in a museum. For his study of the large-scale painting Battaglia di San Romano by Paolo Uccello, Gyermek had to work on a billiard table. He used egg tempera, a “wonderful material that dries quickly and can be over-painted.”

Gyermek grew up in a family of artists. His father, Laszlo II, also a physician, was an accomplished aquarellist (watercolorist) and photographer. His grandfather Laszlo I, a professional painter of religious art, designed stained-glass windows and mosaics for churches in Europe. The monumental mosaics of Mexico City’s Fine Arts Palace (Palacio de Bellas Artes) originated in his workshop. Gyermek’s great-grandfather, Janos, started in porcelain painting and became a teacher of drawing and design in Hungary. And Gyermek’s only brother, Stephen, also an expatriate, is a graduate of the Academy of Fine Arts in Amsterdam and was a professor of art history at San Joaquin Delta College in Stockton, as well as being a highly respected artist.

Gyermek, who received his early medical training in Hungary at the Semmelweis University Faculty of Medicine in Budapest, came to the U.S. in 1957 shortly after the 1956 Hungarian uprising and became a U.S. citizen in 1962. He first worked as a research pharmacologist. Then in 1968, he started his anesthesiology training at Stanford. He later practiced anesthesiology and obtained faculty positions at Stanford, the University of California, Davis, and at Harbor-UCLA Medical Center in Torrance. His research focused primarily on the pharmacology of “antagonist drugs” (e.g., anticholinergics), tricyclic antidepressants, antiserotonin agents, hypnotics and muscle relaxants, and this body of work is reflected in numerous publications, including major reviews, and his book Pharmacology of Antimuscarinic Agents (Handbooks in Pharmacology and Toxicology, 1997). He is still actively involved in research on the shortest-acting nondepolarizing muscle relaxants ever synthesized, exemplified by TAAC3, a derivative of the early “succinyl-tropine” molecule, which Gyermek and Nador developed in 1952. However, TAAC3 has been found to be nephrotoxic in certain animal species and has been abandoned.
It should be noted that in 2005, Dr. Gyermek was elected to membership of the Hungarian Academy of Science. A fuller history of his scientific achievements can be found in the 2004 Yearbook of the Collegium Internationale Neuropsychopharmacologicum.

Retired nine years ago, the now Professor Emeritus of Anesthesiology at Harbor-UCLA Medical Center has used his newly found time “to take refuge in painting as a serious hobby and sort of second profession.” Indeed, he recently completed copying and interpreting Claude Monet’s 30 Rouen Cathedral paintings, setting the stage for two local exhibits. Despite his artistic endeavors, he still devotes some time to self-supported laboratory research at the Los Angeles Biomedical Research Institute with the aim of possibly improving the above-mentioned TAAC3-type agents.

He and his wife, Emilia Bathory-Rausch, are about to celebrate their 60th wedding anniversary in September. They lived in Portola Valley and Los Altos before moving to Rancho Palos Verdes in 1986. They have two sons, Laszlo IV, a talented chef living with his family in Colorado, and Francis, a movie industry consultant who resides with his family in California.

Gyermek’s original artworks (watercolors, oils and photographs) have received awards in physician-artist exhibits internationally (see, for example, CSA Bulletin, January–March 2004) and have been exhibited in several locations in California. Some of his paintings are available for purchase. Additional information about Gyermek’s works is available at www.monetpaintingsreplicas.com and www.monetsrouencathedrals.com. He can be contacted at: laslogy3@gmail.com.

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Have You Changed Your Email Address Lately?

Please send the CSA an email with your new email address or go online at the CSA website, www.csahq.org, to update your profile if you wish to receive up-to-date information. The monthly Gasline newsletter is now sent by email only.
If Dr. Ezekiel Emanuel gets his wish, tomorrow’s physicians won’t deserve to be paid as well as physicians today because they won’t be as well educated and trained.

Dr. Emanuel, a brother of Chicago Mayor Rahm Emanuel and a chief apologist for the Patient Protection and Affordable Care Act, is the lead author of a startling opinion column in the March 21, 2012, *Journal of the American Medical Association*. He argues that there is “substantial waste” in the current medical education system, and—in a time when medicine gets more complex every day—advocates cutting the education and training period for young physicians by no less than 30 percent.

Dr. Emanuel’s plan would reduce the time spent both in medical school and in residency training, which (as every physician knows) is the period of three to seven years that a new graduate physician spends learning to practice a specialty, even the “non-specialty” of family practice.

Many people don’t realize that residents already receive less training than they used to, because stringent limits have been set on the amount they are permitted to work. Since the duty-hour rules were rewritten in 2003, residents are limited to 80 hours a week in the hospital, which includes overnights on call when they may be asleep (what the rules refer to as “strategic napping”).

Many senior physicians are concerned that today’s residents aren’t seeing enough patients. Evidence suggests that board examination scores are on the decline in fields from neurosurgery to pediatrics, as reported in the *Accreditation Council for Graduate Medical Education Bulletin* in 2009. The American Board of Internal Medicine reports that the passing rate for first-time exam takers slipped from 94 percent in 2007 to 87 percent in 2010. Unfortunately, there’s no evidence that residents are choosing to spend their increased off-duty hours in the pursuit of either knowledge or sleep. There’s no evidence that patient care has improved, or that complications and medical errors are fewer.

Now Dr. Emanuel thinks that even this amount of training is too much. “For internal medicine, pediatrics, and similar 3-year residencies,” his article claims, “the third year is not essential to ensure competent physicians.” And in surgery,
“subspecialist surgeons could be trained to achieve clinical competence without spending several years performing general surgery.”

What’s the real agenda here? If you believe that a young surgeon doesn’t need to learn to tie a perfect surgical knot on a simple wound before moving on to brain surgery, then no argument can convince you otherwise. But what Dr. Emanuel really wants to do is cut down drastically on the amount of money that the federal government spends on Medicare support of teaching hospitals—about $6.4 billion in 2011. The easiest way to do that is to reduce the length of medical training, whether or not that’s good for physicians and patients.

This threat to professional standards in medicine makes sense, in a perverse way—if we diminish the status of physicians by training them less, then we can justify slashing their payments from Medicare or government-run insurance exchanges. And that’s exactly what Dr. Emanuel and his co-author would like to do. In their words, less education would “enable physicians to recognize their limitations as well as their competencies,” and no doubt agree meekly to pay cuts.

If new physicians have less training, Dr. Emanuel argues, they will “become comfortable with group decision making, standardization of practices, task shifting to nonphysician providers”—in other words, they’ll lack confidence in their own judgment. They won’t have the scientific background to inform their decisions. They’ll like the protection of the herd. The new physicians will be content to practice medicine by cookbook, which is a sure path toward having the federal government write the recipes for everyone’s health care.

The arguments in favor of physician supervision of nurse anesthetists, nurse practitioners, and physician assistants are founded on the fact that physicians undergo far more education and training. If we allow our educational standards to fall, we will tacitly allow mid-level health care personnel to take over our work. We will complete the transformation of physicians as a class from professionals to shift workers.

Every physician practices as part of a care team, whether we work in offices, clinics, hospitals or operating rooms. The point is that every team needs leadership. Excellent physicians help the whole team to excel and take pride in their work. This is the opposite of the Emanuel vision, which is best described as a planned descent into mediocrity.

The Emanuel article proposes further that a college degree shouldn’t be required for entrance to medical school. Certainly you don’t need classes in English literature to practice medicine. But it would be a travesty for students not to learn to think critically and write clearly before they begin their medical training.
Consider instead the enlightened view of Shirley Tilghman, the president of Princeton University, who told a class of incoming freshmen that the purpose of their education “is most decidedly not to prepare you for one profession, but for any profession, including ones that have not yet been invented.”

While the process of medical education warrants critical review, Emanuel’s disingenuous prescription for cutting it by 30 percent would inflict great harm to medicine as a profession, and threaten the health care of our citizens. Instead, his prescription for the health of American medicine should be to support medical education at every level, uphold the practice of medicine, and inspire the brightest young students to undertake the long, difficult, yet rewarding work of becoming physicians.

MARK TWAIN’S WIT AND WISDOM

Heaven goes by favor. If it went by merit, you would stay out, and your dog would go in.

Out of the public school grows the greatness of a nation.

Against the assault of laughter nothing can stand.

Humor is mankind’s greatest blessing.

There isn’t any way to libel the intelligence of the human race.

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A Trio of Commentaries on Preoperative Fasting Guidelines

Three experts on our editorial board have been asked to present a compendium of the current status of preoperative fasting (nil per os—NPO: nothing by mouth) guidelines. Dr. Thelma Korpman summarizes and comments on the ASA’s current practice guidelines for preoperative fasting, while Dr. Mark Singleton adds his commentary regarding the commonly used terminology “NPO after midnight,” and then Dr. Mark Zakowski completes this triad with his recommendations on oral intake in obstetric anesthesia practice.

ASA Practice Guidelines for Preoperative Fasting

*By Thelma Z. Korpman, M.D., MBA*

I have been in the practice of anesthesia for over 30 years and have rewritten NPO guidelines for my institution at least once for every year in practice. Usually what prompts the rewriting is the cancellation or delay of a patient who did not follow current recommendations. The affected surgeon demands that from now on all patients should abstain from any food or drink after midnight regardless of whether the surgery is at 8:00 a.m. or 5:00 p.m. the following day. The surgeon demands that the OR Committee review the NPO instructions and change them so he or she never has another cancellation due to the NPO status, and unfortunately there are anesthesiologists who go along with this approach. The American Society of Anesthesiologists (ASA) Guidelines, which are based on a synthesis and analysis of the current literature, expert and practitioner opinion, open forum commentary, and clinical feasibility data, are recommendations to assist the practitioner and patient in making health care decisions. They currently read:

<table>
<thead>
<tr>
<th>Ingested Material</th>
<th>Minimal fasting (hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear liquids</td>
<td>2</td>
</tr>
<tr>
<td>Breast milk</td>
<td>4</td>
</tr>
<tr>
<td>Infant formula</td>
<td>6</td>
</tr>
<tr>
<td>Nonhuman milk</td>
<td>6</td>
</tr>
<tr>
<td>Light meal (toast and clear liquid)</td>
<td>6</td>
</tr>
<tr>
<td>Regular meal</td>
<td>8</td>
</tr>
</tbody>
</table>

They guarantee no specific outcome if followed. If these guidelines are not followed, then the practitioner should compare the risks and benefits of proceeding. These guidelines are written for healthy patients of all ages undergoing elective procedures.

The ASA periodically reviews its guidelines and revises them and then disseminates the new guidelines to the anesthesia community.
The definition of clear liquids is water, fruit juices without pulp, carbonated beverages, clear tea and black coffee. This seems simple enough, but unless your patients are different from mine, confusion arises with black coffee and fruit juice without pulp. How patients can read this instruction and still put cream or milk in their coffee or drink orange juice with pulp is, perhaps, just another inexplicable and potentially self-harmful aspect of human behavior. Experiencing such behaviors has led me to the conclusion that patients really do not take this as seriously as we do and do not understand why we demand adherence to these guidelines. We must consider who tells the patient what the NPO orders mean and why we are asking them to follow these orders. Patients get different instructions from various sources (surgeon, scheduler, medical assistant, nurse, etc.) and the result is an occasional cancellation.

Risk of Aspiration

Published clinical evidence is insufficient to address the relationship between fasting times for clear liquids and the risk of emesis/reflux or pulmonary aspiration. We need to recognize that longer fasts are not better, that changes in schedule are not generally affected by clear liquids up to two hours before surgery, and that the current ASA guidelines do not expose us to increased liability.

It is well recognized that the risk of perioperative pulmonary aspiration of gastric contents resulting in morbidity or mortality is relatively low. Prolonged fasting (over eight hours for food and liquids) is not necessary and in fact leads to irritability, headache, dehydration, and hypovolemia as well as thirst. These strict NPO guidelines probably lead to the lack of compliance with preoperative fasting orders because of the discomfort experienced. The ASA guidelines have become more liberal over the years in addressing the negative effects of prolonged fasting, yet NPO after midnight has not been abolished in many institutions. Fasting for any amount of time is no guarantee that the stomach will be empty at the time of surgery, nor does it ensure that the gastric contents will be less acidic. Those of us who have practiced for a while have witnessed the regurgitation of an undigested meal in patients who have abstained from solids or liquids for eight hours and we are grateful for the fact that aspiration is a rare event. Conditions such as pain, anxiety, diabetes, gastroesophageal reflux disease (GERD), and the effect of opioids can increase the risk of pulmonary aspiration of gastric contents regardless of the number of hours the patient has been NPO. And those five conditions are seen every day in our practice.

I am sure you have heard a surgeon suggest a regional or spinal anesthetic or monitored anesthesia care (MAC) when a patient did not follow the NPO instructions. For over 30 years I have heard surgeons suggest that as long as it is not a general anesthesia it is all right not to follow the NPO guidelines.
Anesthesia providers generally follow the same NPO guidelines for elective cases regardless of the type of anesthetic.

On the other hand, procedural sedation and analgesia (PSA) is being administered in the Emergency Department (ED) by the ED physicians without regard to pre-sedation fasting guidelines for either liquids or solids. The ED Clinical Practice Advisory states that there is insufficient evidence to support specific fasting requirements before PSA, regardless of depth achieved or agent administered. Propofol and ketamine are often used for PSA, so a patient might undergo a reduction of a joint dislocation in the ED in an unfasted state, receiving propofol as PSA. Were he to be taken to the operating room he would need to be fasted and/or he would have a rapid induction and possibly cricoid pressure with insertion of an endotracheal tube. Are the ASA guidelines too conservative, or are the ED guidelines not strict enough? Were a surgeon to operate in Germany, he would find anesthesiologists following liberalized recommendations that allow solid food up to six hours prior to elective surgery rather than the eight hours recommended by the ASA. How can we blame the surgeon who does not understand why we cannot do a MAC case for a patient who had a teaspoon of milk in his coffee when we are not really sure ourselves if indeed his aspiration risk is increased?

The literature is not strong in determining how many hours of NPO of solids is safe, and it is doubtful that controlled studies will be done. I suspect that eight hours NPO of solids will be the recommendation for a long time to come unless the ED physicians publish a report of their experience using their more liberal guidelines.

What if there were a way to assess gastric content and volume and thus assess perioperative aspiration risk? Anahi Perlas, M.D., and associates at the University of Toronto reported in Anesthesiology in 2009 on the use of bedside ultrasound to assess gastric content and volume, noting that the gastric antrum provided the most reliable information for gastric volume. Dr. Perlas suggested that bedside gastric ultrasonography can provide both gastric content and volume. More research was needed at that time because studies had been conducted only on healthy normal adults. Lionel Bouvet, M.D., and associates published in Anesthesiology 2011 a study of 180 patients whose antral cross-sectional area was evaluated ultrasonographically to assess solid particles and/or gastric fluid volume. A “risk stomach” was defined by the preinduction presence of solid particles and/or a gastric fluid volume greater than 0.8 ml/kg. Three of the original study patients could not have their antral area assessed because of obesity in two and significant gas in the stomach of the third. Further studies are needed to assess the usefulness of ultrasonographic measurement of the antral cross-sectional area in preventing pulmonary aspiration of gastric contents. There is also the issue of gastric pH, an important determinant of damage when aspiration occurs.
Commentaries on Preoperative Fasting Guidelines (cont’d)

The ASA Guidelines do not recommend routine preoperative use of gastrointestinal stimulants to decrease the risk of pulmonary aspiration in patients with no apparent increased risk. Furthermore the ASA does not recommend medications to block gastric acid secretion to decrease aspiration. It does not recommend antacids except for nonparticulate antacids in selected patients for purposes other than reducing the risk of pulmonary aspiration. Routine antiemetics and anticholinergics to reduce aspiration are also not recommended.

The Preoperative Assessment

There are no controlled trials addressing the impact of the preoperative assessment (e.g., history, physical examination, patient survey/questionnaire) on the frequency or severity of pulmonary aspiration of gastric contents. There are, however, studies with observational findings suggesting that predisposing conditions such as age and co-morbid disease may be associated with the risk of pulmonary aspiration. The ASA members surveyed agree that a review of the pertinent medical records, a physical examination, and patient interview should be part of the preoperative evaluation as well as verification of patient compliance with fasting guidelines. This evaluation should include assessment for GERD, other gastrointestinal disorders, potential for difficult airway management, and metabolic disorders such as diabetes mellitus that may increase the risk of regurgitation and pulmonary aspiration.

The incidence of perioperative pulmonary aspiration is very low; however, once it occurs it is associated with significant pulmonary morbidity and mortality. The ASA Practice Guidelines are recommendations to assist the practitioner in making important health care decisions leading to enhanced quality and efficiency of anesthesia care. Newer means of assessing gastric volume are being evaluated and more liberal guidelines are being tested by other groups as we strive for safety as well as patient comfort.

It Is Time to Abolish the Phrase “NPO After Midnight”

By Mark Singleton, M.D.,

The phrase quoted above is one of the most common in medicine. It is present not only in physicians’ preoperative orders, but repeated by nurses, ward secretaries and dietary workers. Indeed NPO may be one of the oldest phrases in the western medical lexicon. Where did the midnight part come from and does it still serve us, and our patients? I believe it does not, and should be replaced by more meaningful, understandable, and evidenced-based instructions.

In the olden days, patients having almost every kind of elective surgery requiring general or regional anesthesia, even the most minor, were admitted to the hospital (the only kind of institution where surgery was performed) the night before the
scheduled procedure. The nursing staff prepared them that evening in appropriate ways for the morning procedure and understood that the goal of “NPO after midnight” was to ensure an empty stomach. Patients were taken to the OR in the morning directly from their ward rooms. In the days of ether and before the advance of intravenous inductions, inhalation inductions often added to the risk for aspiration, and airways were not as protected as in today’s practices.

Nowadays, patients sleep at home or in a hotel the night before surgery, get up in the morning at an hour that only farmers and fishermen would find reasonable, and arrive at the hospital or surgery center several hours before their scheduled procedure. Many of these patients have been told by the surgeon’s office staff, or the surgery center pre-op phone caller: “Be sure not to eat or drink anything after midnight.” I’m sure I’m not the only anesthesiologist to discover that my 7:30 a.m. patient, who slept barely four hours, had a substantial meal at 11:45 p.m., much of which is still settled uncomfortably in their stomach. When I ask if they normally eat at that hour, the reply is something like, “No, but they told me nothing after midnight and I thought that would be my last meal for quite a while.” There may be an ominous truth to that, which of course is completely beyond the patient’s understanding. This never happened in the olden days, but that’s why we shouldn’t be living in the past, and should adopt protocols that work in today’s world.

I try to call my patients the night before surgery, which is pretty much a routine in my group’s practice, and when we get to the NPO part, they often ask something like: “So I shouldn’t eat anything after midnight?” I reply: “You should have a regular dinner at the normal time, unless your surgeon has given you other special instructions, and then don’t eat anything after that. If you are thirsty any time in the night you can have water to drink. Please don’t eat or drink anything once you get up in the morning before coming for surgery.” If they are scheduled for later than the first case, I tell them they can have small sips of water until they leave home. Most of us who have patients scheduled for surgery after 3 p.m. tell them they can have a light breakfast before 7 a.m., but there are surgeons who, when cancellations of earlier cases occur, will be upset that these patients can’t be moved to an earlier-than-scheduled operative time. You have to know how much to trust your surgical schedule and the surgeons with whom you work.

Dr. Korpman’s important article (preceding) points out how much of an influence—often unhelpful—surgeons and others have on these issues, and gives us a clear iteration of the ASA recommendations for fasting before elective anesthesia. These unfortunately become almost irrelevant if the patient hears from the surgeon’s office staff and the facility staff that they should “not eat or drink after midnight.” It’s always best for an anesthesia provider to give patients their individualized NPO instructions, another reason that we should endeavor to
communicate with our patients, at least the day prior to surgery. We have to improve the way patients receive this important information and the reasons for it. I would rather have the non-anesthesia advisors tell patients: “Don’t eat or drink anything after dinner,” and leave midnight for sleeping.

**NPO Guidelines for Obstetric Patients**

*By Mark Zakowski, M.D.*

**Oral Intake During Labor**

For healthy patients undergoing elective procedures, the 2011 American Society of Anesthesiologists (ASA) guidelines state that *nil per os* (NPO) should be two hours for clear liquids, six hours for a light meal, and eight hours for a fatty meal.¹ The ASA NPO guidelines from 2007 state that during labor, oral intake of modest amounts of clear liquids may be allowed for uncomplicated laboring patients.² Solid foods should be avoided in labor.² For medically complicated patients at increased risk for aspiration (e.g., morbid obesity) or when fetal heart rate tracings change (current terminology—Category II or III),³,⁴ no food or drink should be allowed.

**Postpartum Tubal Ligation**

A postpartum tubal ligation (PPTL) within eight hours of delivery does not increase maternal complications. However, even a woman with a pre-existing epidural needs to meet full NPO guidelines if the PPTL is elective—no solids for six to eight hours and no clear liquids for two hours.² One should consider that gastric emptying is delayed in parturients who have received opioids during labor, and that a labor epidural extended for a PPTL may be more likely to fail with longer post-delivery time intervals.

**References**


LAUGHING GAS
Parachute Approach to Evidence-Based Medicine

By Stephen Jackson, M.D.

(The following is a summary of an article by C. Smith and J. Pell that appeared in the British Medical Journal in 2003—BMJ:327; 1459–1461—and the responses to it published in 2006 by M. Potts, N. Prat, J. Walsh, et al.—BMJ:33; 701–703—as well as letters to the editor—BMJ:333; 807–808—later published in that respected journal.)

A widely accepted truism in medicine is that a medical intervention justified by observational data should be verified by a randomized controlled trial (RCT). In 2003, an article was published in British Medical Journal that looked humorously and seriously at RCTs. Specifically, the authors reflected on those situations where this rigor of investigation is not necessary, such as the use of parachutes to prevent death and major trauma related to gravitational challenge. The question the authors posed is whether policies can be established without RCTs, but nonetheless based on reasonable science. This may be of particular significance and appropriate for nations with severely limited health care resources for situations with high mortality and in which simple interventions (without RCTs) can have a major beneficial impact. Indeed, evidence-based medicine and RCTs are not synonymous.

Up front, the article offered that parachute use for recreational, voluntary and military sectors does reduce the risk of serious injury after “gravitational challenge,” most frequently when encountered in jumping from an airplane. The authors claimed that belief in this successful intervention stems largely from anecdotal evidence. Given this, the paper attempted to systematically review RCTs that deal with the use of parachutes. It proposed a definition of parachute intervention as involving “a fabric device, secured by strings to a harness, worn and released by the participant (either automatically or manually) during free fall with the purpose of limiting the rate of descent.” Studies without a control group were excluded, and the “clinical outcomes” sought were death or major trauma. Not surprisingly, the resultant meta-analysis failed to find a single RCT.

In the discussion section, the authors indicated that observational studies have been subject to “data dredging, confounding and bias,” not to mention fraudulent research (that our own specialty has been uncovering with disturbingly increased frequency). Then, they continued, one must consider the natural history of gravitational challenge. In truth, the deployment of parachutes has led to morbidity and mortality due both to failure to deploy correctly and to iatrogenic complications. Because free fall without parachutes does not inevitably have serious adverse effects, the effectiveness of a parachute does have to be judged relative to the failure to use one.
The authors went on to inform us that those who would jump from airplanes without a parachute might well have a high prevalence of psychiatric illness, while those who do use parachutes not only are less likely to suffer from such, but also may differ in other demographic categories. Therefore, the supposed protective effects of parachutes may be a manifestation of the “healthy cohort” effect, and therefore would require observational studies to try to adjust estimates of relative risk for any such biases. No such analyses exist.

Then again, might utilization of parachutes represent physicians’ obsession with preventive medicine and, in fact, be a misplaced belief in unproven technology to protect against occasional adverse events? But why stop here? What about the military-industrial complex and the profits made from companies that sell parachutes to those of that complex who have been convinced that parachutes are effective? Would they insist on first testing parachutes with an RCT, and, if they did, would it be wise to believe an RCT that declared parachutes safe?

The authors then spoke to the two options that remain for society: 1) common sense might instruct us as to the potential risks and benefits of parachutes; or 2) we might continue searching for “exclusively evidence-based interventions and preclude parachute use outside the context” of an RCT. The article concluded with the following: “The dependency we have created in our population may make recruitment … to such a trial difficult. If so, we feel assured that those who advocate evidence-based medicine and criticize use of interventions that lack an evidence base will not hesitate to demonstrate their commitment by volunteering for a double-blinded, randomized, placebo controlled, crossover trial.”

Mark Singleton comments that while it may well appear to be ridiculous or even absurd to require “proof” of the seemingly obvious and indisputable in our medical practices, this thought process is not the same as further developing, improving and even innovating the very things we “know” to be truths. After all, the world was once flat, malaria caused by bad swamp air (“mal aria”), bleeding and purging effective treatment modalities, and gastric ulcers caused by stress and acid (bacterial infection not considered). Indeed, Einstein commented on scientific research by declaring that “information is not knowledge,” and “imagination is more important than knowledge.”

A Realistic Visual Chart for Postoperative Pain

A new way for visual reporting of postoperative pain follows, modified from the entertaining chart in the humorous and witty website/blog “Hyperbole and a Half” (hyperboleandahalf.blogspot.com). Clinically, this “tongue-in-cheek” chart is perhaps more realistic and of greater diagnostic and therapeutic value for our patients’ assessment of their postoperative pain.
0. Hi. I am not experiencing any pain at all. I don’t even know why I am here. And, by the way, am I really supposed to feel pain after a surgery?

1. I am completely unsure whether I am experiencing pain or itching, or maybe I just have a bad taste in my mouth.

2. I probably just need a Band-Aid, my comforter, or even a Bink.

3. This is distressing. I don’t want this to be happening to me at all. Should I still be smiling?

4. My pain is not fooling around.

5. Why is this happening to me? Am I deserving of this? Do I need to use this visual chart?

6. Ow! Okay, my pain is super-legit now. Forget about this chart. Maybe a Tylenol? Maybe a more advanced chart?

7. I see the Lord coming for me, and I am scared. Maybe two extra-strength Tylenol?

8. I am experiencing a disturbing amount of pain. In fact, I might actually be dying. Please help.

9. I am definitely dying.

10. I am actively being mauled by a bear, or is it an alligator? Help!

11. Blood is going to explode out of my face at any moment.

Too serious for simple numbers. How about “infinity and beyond”!?!
Cruise Ships and Hotel/Motel Chains—Cheaper Alternative to Traditional Assisted-Living and Retirement Facilities

The cruise ship industry, especially since the recent debacle of the cowardly captain, might well find a new source of “customers”—the elderly seeking affordable assisted-living facilities. It has been labeled as “cruise ship care,” perhaps soon to become a corollary of the Obamacare concept. It would involve converting cruise liners (well, maybe not the Disney-themed ones) into “floating assisted-living centers.” The costs? They might be competitively priced with those of land-based facilities. In a 2004 article in the Journal of the American Geriatrics Society, it was estimated that a 20-year prepaid cost for such assisted-living facilities would be approximately a quarter of a million dollars, pretty much identical to that of the traditional assisted-living facility. Cruise ships have many of the traditional services such as housekeeping, laundry, socialization opportunities, and even a currently sought-after benefit—a full-time physician! Yet this is not the only potential boon for retirees!

What about your favorite modestly priced motel/hotel chain as a replacement for a nursing home? Again, in 2004, it was estimated that with a combined long-term discount and senior discount, the cost at one of these chains would amount to about $50 a day. Given the average cost of a nursing home in 2004—about $190 a day—this would leave about $140 a day for food, laundry, gratuities (enough to make the help quite happy) and even new movies on the cable TV! Moreover, there are amenities such as daily housekeeping, heated swimming pools, exercise rooms, regular cable TV, laundry facilities (if you choose to do it yourself), free repairs (TV broken, light bulb not working, mattress not feeling good?), security, room service, and even free toothpaste, soap, shampoo, coffee and tea. Most hotel/motel chains are located on city bus lines, but there usually are free municipal transportation services for seniors, and of course, the airport shuttles would be available should one desire a mini-trip for a change of scenery. But that change in scenery can be even more varied and exiting: you might want to move around from one city to another, perhaps in Hawaii, Florida, California, Europe or elsewhere. Wherever the hotel/motel may be, it likely would be an enticement for the grandkids (or even children) to visit, sort of a destination holiday for the family or old friends. And some even permit pets.

Adapted from a November 2004 article by Mark Ingebretsen in The Wall Street Journal and another flight of fantasy from an anonymous source the same year.
The butcher in the emergency room had backed up against the meat grinder and got a little behind in his work.

When chemists die, they barium.

I had a patient who was addicted to brake fluid; however, he claims he can stop at any time.

The patient says she recognized me from the vegetarian club, but I’d never met herbivore.

I was so engrossed in reading a physics textbook about anti-gravity that I couldn’t put it down.

The patient received a letter that she had type-A blood, but it was a type-O.

I didn’t like my beard at first, but then it grew on me.

Bladder infections mean urine trouble.

Great Britain has no kidney banks, but it does have a Liverpool.

The toilets in the police station were stolen. The police had nothing to go on.

A hole was found in the nudist camp wall. The police are looking into it.

When the smog lifts from Los Angeles, UCLA.

She was only a whiskey-maker, but he loved her still.

The guy who fell onto an upholstery machine was fully recovered.

A person who jumps off a cliff jumps to a conclusion.

A theatrical performance based on the above puns would be a play on words.

*Well, dear readers, in their fascinating book on using humor to reverse-engineer the mind (Inside Jokes, The MIT Press, 2011), the renowned philosopher Daniel Dennett and his co-authors, Matthew Hurley and Reginald Adams, Jr., state that “puns are a notoriously weak form of humor. Occasionally we find a shockingly good one, but it is usually shockingly good because it is a pun, and the expectation is that puns are weak. ... It is a minimal kind of humor.” —Ed.*
A conspicuous failure in our present anesthesia practice is the lack of induction or block rooms. Although such rooms are routine in some countries, they are not common in the United States. This room would be adjacent to the operating rooms and provide space for placing peripheral nerve and neuraxial catheters. It is now becoming clear that properly conducted regional anesthesia provides long-term benefits to the patient, but the pressure to “get the case started” or “keep it simple” places undue pressure on the anesthesiologist and adds stress to the normal workday.

When one reviews the origin of our specialty, it seems that this room was there from the beginning but somehow was eliminated from hospital architecture sometime between the origin of the hospital concept and the 21st century. It certainly was not developed in America, even after the successful introduction of regional anesthetics in the late 19th century.

The idea of hospitals arose in the Byzantine Empire and was perpetuated and improved as the Turks conquered Asia Minor. One of the first hospitals was built in the Roman city of Caesarea in the fourth century. When the eastern portion of the Byzantine Empire fell to the Seljuk Turks, Caesarea grew in importance because of its strategic position on the Silk Road. Its name was changed to Kayseri. Kayseri, now a city of 600,000 people, is renowned as the principal entry port to Cappadocia, a popular tourist destination in central Turkey.

Although it is commonly known that the scientific principles of observation and documentation begun by the Greek and Roman physicians were kept alive by Islamic scholars, it is less well known that the advancement of the “hospital concept” is considered one of the great achievements of medieval Islamic society. They also developed an extensive pharmacopoeia based upon herbalism and elementary chemistry, and improved methods of anesthesia begun by the Greeks and by physicians in the Indian subcontinent.

Kayseri is of special importance because of its medical center hospital, which was built in the year 1206. This was an institution of learning and healing, much like our university medical centers today. Many medical historians label
Prominent physicians who practiced at Gevher Nesibe included Ebubekir, Gazanferi and Seyit Samit. Remarkably, this hospital is intact today and has been transformed into a museum, the History of Gevher Nesibe Medical Museum. A tour of this facility gives us a glimpse into the treatment of the surgical patient in the Middle Ages of Asia Minor.

The hospital was named after a Seljuk princess, Gevher Nesibe, who conceived and willed the institution on her deathbed. Scholarly medical treatments at Gevher Nesibe were based upon the study of the great Greek, Roman and Islamic physicians. A plaque in the entrance to the hospital shows images of Hippocrates (460–370 B.C.E.), Galen (130–200 C.E.), and Avicenna (980–1037 C.E.). Although the Seljuks were brutal conquerors, once the society stabilized in the early 13th century, physicians of all religious faiths were allowed to practice in a secular society. Consequently, Jewish, Christian and Muslim physicians worked cooperatively in the hospital.

![Diagram of Gevher Nesibe Hospital](image)

**Figure 1:** Floor plan of the Gevher Nisibe Hospital. The induction room is #12, operating room #13, History of Medicine Room #15, and History of Pharmacy and Medicine Preparation Room #11. Copied from the museum brochure, 2005.

The plan of this hospital is shown in Figure 1. The operating room was illuminated by a hole in the ceiling (Fig. 2), similar to the lighting in the hallway (Fig. 3) that separated the patients' rooms. One small (8 feet square) room near the operating room was devoted entirely to the study of the history of medicine. Presumably there was no lack of reading material. The Hippocratic
corpus is 30 volumes. Galen wrote nearly 200 books on medicine (seven on the pulse alone) and Avicenna’s *Canon*, a book that Osler called “the most famous medical textbook ever written,” contains more than a million words. Galen’s work would be a useful reference for the surgeons because much of his work was on treatment of the wounds of the Roman gladiators. His observations, made in the Roman city of Pergamon, about 800 miles east of Kayseri, were written nearly a thousand years before the founding of the Gevher Nesibe Hospital.

**Figure 2** (at right): Looking directly upward in the operating room, one sees the hole in the ceiling that acted much like a spotlight on the center of the room. At midday the light fell directly onto the operative site so most operations were performed at that time. At other times, lighting was provided by candles and oil lamps. Kayseri has little rainfall during most of the year. Photograph by the author, 2005.

**Figure 3** (at left): The hallway between the patients’ rooms was illuminated by holes in the ceiling; electric lights are turned on when visitors arrive to tour the museum. Gevher Nesibe’s will directed that patients would not have to pay for treatments given at the hospital, as was the custom in many of the hospitals built by the Caliphs. Photograph by the author, 2005.

Of special interest in the museum is the large anesthesia induction room next to the small operating room (see Fig. 4 on next page). They presumably did not use the term “anesthesia induction” but rather something like “soporific induction.” The idea for this room seems obvious when one considers the slow-onset drugs that were used during this preparatory period before the operation was begun. The anesthetic potion described by the Greek physician Dioscorides (40–90 C.E.) in the first century consisted of *Mandragora* (mandrake) and wine, but Avicenna and others improved the formula. By the 13th century it consisted of multiple ingredients, including opium, *Mandragora, Hyoscyamus*, mulberry juice, lettuce seeds, *Lapathum* seeds, and climbing ivy. The drugs were administered orally, by inhalation, or through the skin (ointments). The History of Pharmacy and Medicine Preparation Room is conveniently located next to the induction room.
It seems clear that the combination of opium, scopolamine, *Mandragora* and other additives, given properly, would produce a somewhat tranquil patient who might struggle during a short operation but might not remember much of the struggle. The key phrase is *given properly*, because the drugs are lethal if given carelessly. If we give these physicians due credit, then it seems possible that with adequate induction time and skilled anesthetists, oral inhalation and possibly transcutaneous administration of these drugs would produce a suitable anesthetic. A recent assessment of this anesthetic concoction concluded that it was indeed efficacious, but the correct formulation(s) and method(s) of administration were gradually lost through time.

**Figure 4:** The anesthesia induction room, shown here, is the largest room in the hospital. Photograph by the author, 2005.

In Europe between the 16th and the 18th centuries, there was almost no effective attempt to control pain during surgery. *Mandragora* and henbane mixtures had passed into the realm of witchcraft and the church strictly prohibited their use. Physicians in Europe and America knew about these drugs in the early 19th century, but they were not skilled in their administration. The personal accounts from those patients who survived operations described terrifying pain, and it appears there was no concerted effort to control it. Mesmerism was largely ineffective, and alcohol/opium appeared to be mostly self-administered. The account of surgery by Ms. Fanny Burney, who had her breast removed in 1811 by the celebrated surgeon Dominique J. Larrey (1766–1842), is typical. The procedure was performed in her home and required not only the surgeon and his assistant, but also six strong men who were in attendance to hold her steady while the operation went forward.

Luckily, American physicians discovered the magic of inhalation vapors, but the idea of an induction room remained in the dustbin of history. It is true that holding a mask on an anesthetized patient while waiting for the operating room to become available does seem cumbersome. However, the rapid development of regional anesthesia in the early 20th century might have been a good time to realize the benefit of this 800-year-old idea. Recent articles have promoted the use of special rooms for the placement of regional blocks, so perhaps we will eventually reestablish this old custom that seems to have been present from the very origins of our specialty.

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We would appreciate your input on our plan to modify the CSA Bulletin in order to maximize the benefits of this publication. Please complete this brief survey by circling your answers. You may fax (650-345-3269) or mail your completed survey to the CSA office. Participants will be entered into a drawing for two $50 gift cards to Amazon.com (please supply phone number or email address).

1. In how many of the last four issues of the CSA Bulletin have you read at least 25 percent of the content?
   a. 0 b. 1 c. 2 d. 3 e. 4

2. How thoroughly do you typically read the Bulletin?
   a. I read it cover to cover.
   b. I skim through the entire publication.
   c. I read entire articles that interest me.
   d. I skim through articles that interest me.
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3. In which format(s) do you want the Bulletin to be available?
   a. Print only
   b. Electronic only
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4. What is your preference for the size of the printed Bulletin?
   a. Digest (current) size (8.5 x 5.5)
   b. Full size (8.5 x 11)

5. What is your preference for the length of the printed Bulletin (assuming it remains in the current digest size)?
   a. 25–50 pages
   b. 50–75 pages
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6. What is your preference for the frequency of the Bulletin?
   a. 2 issues per year
   b. 4 issues per year
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   d. 12 issues per year

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   a. 1–2 pages
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8. How relevant is the Bulletin content to your practice?
   1 = Minimally useful  2  3  4  5 = Very useful
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   c. CSA Bulletin content is less valuable than that of the ASA Newsletter.

10. How often do you read each of the following items in the Bulletin?

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11. What is your age?
   a. <30        d. 50–59
   b. 30–39      e. 60+
   c. 40–49

12. Do you have any additional comments or feedback regarding the Bulletin?

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Infection Control
Synopsis from the ASA Recommendations for Infection Control for the Practice of Anesthesiology (Third Edition, 2011)*

By Robin Stackhouse, M.D., and Stephen Jackson, M.D.

Introduction

Recognition of the importance of infection-control risks in health care settings is a major element in endeavors to enhance the quality of medical care. It is estimated that 5 to 10 percent of the hospitalized patients in the U.S. acquire one or more health care-associated infections (HAIs), which are a contributory cause in more than 90,000 deaths and result in excess health care expenditures of $4.5–$5.7 billion a year. The four most prevalent infections, responsible for greater than 80 percent of HAIs, are: urinary tract infections (35 percent of cases, generally catheter-associated); surgical site infections (20 percent of cases, but accounts for one third of the costs associated with HAIs); bloodstream infections (15 percent, the majority being intravascular-catheter-related); and pneumonia (15 percent, usually ventilator-associated, but to which is attributed 25 percent of HAI-associated mortality). Significantly, the etiologic organisms in 70 percent of these infections are resistant to one or more antibiotics. However, appropriate anesthesia practices can reduce the incidence of infection related to these and other causes of HAI.

The ASA Task Force on Infection Control has analyzed the current scientific data and national guidelines on infection control. Its synopsis of this data is intended to inform us of those practices that have been shown to alter the incidence of infection transmission in health care settings. In recognition of the infectious risks to both the patient and the anesthesiologist, the document is organized into

*Developed by the ASA Committee on Occupational Health Task Force on Infection Control, chaired by Robin Stackhouse, M.D., Professor, Department of Anesthesia and Critical Care, University of California, San Francisco

Spring 2012 59
two broad categories: the prevention of occupational transmission of infection to the anesthesiologist and the prevention of HAI in patients.

**Prevention of Occupational Transmission of Infection to Anesthesiologists**

**Preventing accidental needle-sticks and other sharp-object injuries**

Injuries to anesthesiologists from needles and other sharp objects have been associated with transmission of human immunodeficiency virus (HIV), hepatitis B virus (HBV), and hepatitis C virus (HCV). The greatest risk of transmission of blood-borne infections is from a blood-contaminated percutaneous injury with a hollow-bore needle. The degree of risk depends on the type of pathogen and the quantity of the viral inoculum. Higher viral titers in the source patient pose a greater risk of transmission. For HIV, this occurs with acute or terminal illness. For HBV, hepatitis B e-antigen or precore mutant positive blood is associated with far higher transmission rates. For HCV, the risk is increased with higher HCV RNA titers. An elevated risk for transmission of all three of these viruses occurs with deep injury and/or one involving a needle that had been intravascular in the source patient’s vein or artery (a hollow-bore needle). For HIV, there is data that correlates the presence of visible blood on the sharp device with an increased risk.

The cumulative risk of occupational infection with blood-borne pathogens depends on the 1) number and type of exposures to patients’ blood or body fluids; 2) prevalence of infected patients; and 3) risk of infection transmission after each pathogen-contaminated exposure.

To minimize the risk of transmission from sharp devices, it is recommended that contaminated needles never be bent, recapped, or removed from syringes unless such action is required by a specific procedure or has no feasible alternative. If a needle must be recapped, a mechanical device or a “one-handed” technique should be utilized, but perforation of the cap by the needle is possible with either recapping technique. A puncture-resistant leakproof container for the disposal of used needles, syringes, scalpel blades, and other sharp items should be located as close as is feasible to the immediate area where the sharps are used. Sharps containers must be sealed and replaced before becoming completely filled.

*The injury rate for straight suture needles is more than seven times the rate associated with conventional instrument-held curved suture needles.* Use a curved needle with a needle holder for suturing rather than holding a straight needle by hand, and avoid holding patient tissues with fingers when suturing or cutting. Double gloving offers increased protection from penetrating injuries to the hands, as the innermost gloves reduce perforation of the skin. The use of gloves may also
decrease the risk of infection by decreasing the inoculum size from some types of needle-stick injuries.

**Blood-borne Pathogens—HBV, HCV, HIV**

**Recommendations**

- Unless otherwise contraindicated, all anesthesiologists should be vaccinated and have documented immunity to HBV. The table at right, on protection conferred by immunization as a function of the number of doses, is from the Centers for Disease Control and Prevention (CDC).

- Serologic testing for evidence of conversion should be performed one to two months after the third dose of the HBV vaccination process. Non-responders to the first series have a 30 to 50 percent chance of responding to a second series.

- Strict adherence to standard precautions and sharps safety is required at all times.

- Should an exposure incident occur, immediate evaluation for postexposure prophylaxis (PEP) and follow-up care should be sought.

**Rationale: HBV**

The CDC estimated in 2006 that there were 1.25 million individuals in the U.S. chronically infected with HBV. The risk of infection after an exposure varies with viral titer, volume of inoculum and site of exposure. Transmission may occur via percutaneous injury, mucous membrane exposure, or contact with non-intact skin. With a sharps injury, larger quantities of blood are transmitted when the device is visibly contaminated with blood, the needle was previously in the vasculature of the source patient (especially hollow-bore needles), and when a deep injury is sustained. When a sharp injury occurs through a glove, the amount of blood on the external surface of the device may be reduced by 46 to 86 percent. Transmission might also occur through contact with contaminated environmental surfaces, as HBV has been found to remain infective on such surfaces for over seven days.

Body fluids that have titers that may result in transmission are blood, semen, vaginal secretions, and cerebrospinal, synovial, pleural, peritoneal and amniotic fluids. Those that have a titer too low to pose a significant risk of transmission, unless contaminated with blood, are feces, nasal secretions, saliva, sputum,
sweat, tears, urine and vomitus. Blood has a 100- to 1,000-fold higher titer than the aforementioned fluids.

The risk of seroconversion to HBV pursuant to a percutaneous injury with source blood that is HBsAg positive is 22 to 31 percent. For blood that is HBeAg or precore mutant positive, the risk is 37 to 62 percent. The presence of HBeAg and the precore mutant are correlated with active viral replication and infectivity.

The prevalence of HBV infection among health care workers (HCWs) was 10-fold higher prior to the recommendation for vaccination. The seroprevalence among HCWs is now no higher than that of the general population.

Anyone without a documented adequate response to the HBV vaccine series should receive PEP after a significant exposure. PEP includes one to two doses of human immune globulin (HBIG) with or without the HBV vaccine. For current recommendations, you are referred to http://www.nccc.ucsf.edu/hiv_clinical_resources/pep_guidelines/ (please note that this valuable website has PEP recommendations for HBV, HCV and HIV).

Rationale: HCV

In 2006, approximately 3.2 million people in the U.S. had chronic HCV infection. The modes of transmission for HCV are the same as those for HBV (see above). Ex vivo survival of HCV is not well defined, but is shorter than HBV, with infectivity declining within hours on environmental surfaces. The risk of acquiring HCV after a percutaneous injury is 1.8 percent (range 0.3 to 7 percent).

After seroconversion, only 15 to 25 percent will clear the virus spontaneously. Of those who develop chronic hepatitis, 20 percent will develop cirrhosis over the following 20 to 30 years, and 1 to 2 percent of those will be diagnosed with hepatocellular carcinoma!

Although at this time no specific PEP has been documented to be effective for HCV, it is recommended that evaluation be sought after HCV exposures to assess baseline liver function and determine treatment options if seroconversion should occur. Some promising treatment regimens for acute infection have resulted in a sustained virologic response (absence of HCV RNA for six months after completion of the treatment). A combination of interferon and ribavirin is given for 48 months in one of these regimens.

Rationale: HIV

The CDC estimates that in 2003 about 1.1 million people were living with HIV in the U.S., and that 56,300 new infections were occurring each year. Modes of transmission are the same as those for HBV and HBC (see above). The risk of
conversion from a percutaneous HIV exposure is 0.3 percent, while the risk of a mucous membrane exposure is 0.09 percent. HIV titers vary with the stage of the disease and treatment. Viral titers are highest during the viremic period of acute infection and with advanced disease. Rates of seroconversion are directly proportional to the viral load.

The efficacy of PEP for HIV infection is based on viral pathogenesis. In the first 24 hours after exposure, HIV infects the dendritic-like cells, after which the virus migrates to regional lymph nodes where it is detectible after 24 to 48 hours. The virus is detectible in peripheral blood within five days. The decrease in seroconversion after PEP is estimated to be from 50 to 81 percent.

The treatment of HIV includes five classes of drugs: nucleoside reverse transcriptase inhibitors; nucleotide reverse transcriptase inhibitors; non-nucleoside reverse transcriptase inhibitors; protease inhibitors; and single fusion inhibitors. PEP is complex and has evolved over time. A two-drug regimen taken for four weeks is generally recommended for PEP. Evidence suggests that standard PEP may be less effective when the source-patient viral strain shows antimicrobial resistance. However, because it takes one to two weeks to carry out resistance testing, it generally does not influence initial PEP. For the latest recommendations, refer to http://www.cdc.gov/hiv/resources/guidelines/index.htm and http://www.nccc.ucsf.edu/hiv_clinical_resources/pep_guidelines/ (please note that this valuable website has PEP recommendations for HBV, HCV and HIV).

**Prevention of HAI in Patients**

**Recommendations**

Hand washing with soap, whether or not antimicrobial, should be performed whenever there is visible contamination with blood or body fluids. Alcohol-based hand rubs are recommended for hand hygiene when there is no visible contamination. Spore-forming organisms such as *Clostridium difficile* and *Bacillus anthracis* are poorly inactivated by waterless hand hygiene products and require the physical action of washing and rinsing for removal.

The wearing of artificial nails during direct patient care is discouraged in ORs or ICUs. Nail polish may be worn if it is not chipping or peeling. Rings should be removed prior to performing a surgical hand scrub.

Indications for hand hygiene include:

- Before and after direct contact with patients
- Before donning sterile gloves
Infection Control (cont’d)

- After contact with body fluids, non-intact skin, mucous membranes, wound dressings
- When hands that have contacted a contaminated body area will subsequently contact a clean site
- After contact with high-touch environmental surfaces in the vicinity of the patient
- After removal of gloves (hands are considered contaminated after glove removal because of the potential for glove failure and self-contamination)
- Before eating
- After using the restroom

Gloves should be worn whenever any contact with blood, body fluids, mucous membranes, non-intact skin, or other potentially infectious material is anticipated. Gloves are not intended for reuse as removal of microorganisms and integrity cannot be ensured.

Rationale

Hand washing is one of the most effective infection-control practices to protect both patients and health care workers from colonization and/or infection. Hands carry a relatively high count (3.9 x 10⁴ to 4.6 x 10⁶ colony-forming units) of resident and transient bacteria. Dermatitis increases bacterial counts and decreases compliance with hand hygiene. Many products do include compounds to reduce dermal irritation. Subungual areas have the highest bacterial concentrations and are frequently colonized with coagulase-negative Staphylococcus, gram-negative rods, Corrynebacteria, and yeasts. For effective hand hygiene, the use of alcohol-based hand products is faster than hand washing with soap and water.

There is a direct correlation between contamination of environmental surfaces in the OR and positive cultures on the internal surface of intravenous stopcocks. Patients with positive stopcock cultures have a higher incidence of postoperative infections and mortality. Positive cultures in anesthetizing locations were most common on the adjustable-pressure limiting valve and anesthetic dial.

The OR has unique infection-control issues compared with other clinical care areas. OR personnel care for a single patient for prolonged periods of time. Consequently, microorganisms may be transmitted via two mechanisms: contamination of normally sterile sites with a patient’s own bacteria; and transmission of bacteria to subsequent patients by microbes that have contaminated environmental surfaces during a previous case. Although equipment is cleaned between cases, not all bacteria will be eliminated,
necessitating efforts to minimize environmental contamination. Thus, gloves that have been used during patient care should be removed prior to touching equipment. However, this may be in conflict with the requirement to perform hand hygiene upon removal of gloves. There are, indeed, times when gloves should be removed before touching environmental surfaces and when there is inadequate time to perform hand hygiene—as, for example, immediately after intubation when anesthetic gases and ventilator need adjustment. In these circumstances, hand hygiene should be performed as soon as patient safety allows. Alternatively, double gloves can be worn and the outer glove removed prior to touching environmental surfaces.

The wearing of gloves, however, is not a substitute for hand hygiene as there are both a measurable level of glove leakage (from manufacturing defects or damage during use) and self-contamination during removal. The pre-use glove leakage rate ranges from 1 to 4 percent, while the post-use rate ranges from 1.2 to 53 percent with surgical gloves performing better than examination gloves. The incidence of positive hand cultures after glove use and removal ranges from 2.2 to 34 percent, thus emphasizing the essential role of hand hygiene in infection control.
One positive aspect of a Presidential election year is that there are many opportunities to address misconceptions and false statements that arise during the campaign season. Rick Santorum’s recent assertions regarding euthanasia (EU) in the Netherlands provide another welcome chance to address common urban legends regarding physician-assisted suicide (PAS) and EU in the United States and abroad.

Currently, PAS is legal in several European countries (Belgium, the Netherlands and Luxembourg) and in three of the United States (Oregon, Washington and Montana). Assisted suicide (with or without a physician) is legal in Switzerland. EU is legal in Belgium, the Netherlands, and Luxembourg, with the proviso that it be voluntary and requested by a competent patient.

A large majority of the American public favors PAS (70 percent), and a significant majority support EU, yet the public and physicians have deep and legitimate concerns about the ethics of these activities. Concerns regarding PAS and EU include the following: 1) that patients who seek suicide are incompetent by virtue of being depressed and hopeless; 2) that PAS and EU are unnecessary: better pain management practices will eliminate requests for PAS and EU; 3) that vulnerable populations—i.e., the poor, elderly, isolated, less educated, and those less able or likely to access the health care system—will be more likely to commit suicide; 4) that physicians or others will abuse the legality of PAS or EU to take the lives of persons who would not choose to die; and 5) that participating in PAS or EU will damage the professional ethics of physicians. After a decade in which PAS and/or EU has been legal in several European countries, and up to a decade in the three American states, we now have data to examine these claims.

Are Patients Who Seek PAS or EU Incompetent?

Depression is a significant component of many patients’ perspectives at end-of-life, and it does influence their wish to die in 8.5 to 17 percent of cases. But depression and other mental illness per se are not synonymous with incompetence, and their role in end-of-life decisions remains unclear.
Investigations do not consistently show that depression affects patients' end-of-life treatment decisions. And depression does not appear to be significantly different between patients who request EU and those who do not. Studies do suggest that the diagnosis of clinical depression may be missed by Oregon physicians assisting suicides, but they do not indicate whether depression affected patient decision-making in a significant way. An unanswered question is: should a decision regarding PAS or EU require a higher standard of competence than other end-of-life decisions, and if so, how high should that bar be? Requiring that dying patients not be depressed seems unreasonable, if even achievable, and sets an insurmountable barrier. And what then happens to patients' decisions regarding other care at end-of-life—for example, undergoing terminal chemotherapy, a question requiring the balancing of many complex concepts involving extreme risk, minimal benefit, “futility,” and morbidity?

Is Better Pain Control the Solution for EU and PAS?

Despite a widespread belief that untreated pain is the most worrisome problem for patients at end-of-life, repeated studies show that this is not so. In fact, satisfactory end-of-life pain control is achieved in all but a small minority of patients. One study even suggests that oncology patients who are experiencing pain are actually less likely to find PAS or EU acceptable. The most prominent concerns for patients at end-of-life are loss of autonomy and loss of dignity. PAS and EU are generally rated highly desirable by patient groups because they do answer such fears. Statistics from Oregon and Washington, where PAS has been practiced since 2001 and 2010 respectively, show that many patients who ask for PAS and receive lethal prescriptions never use them. Families have indicated that patients who have the means of a humane death at their disposal gave comfort and confidence to their relatives, thereby enabling them to want to—and actually—live longer. Jerome Sobel and Ludvig Minelli, who direct the Swiss suicide organizations EXIT and DIGNITAS, respectively, both claim that they are in the “suicide prevention business,” because their many experiences parallel those findings.

Are Vulnerable Populations at Risk?

Review of data from Oregon and Washington do not support a contention that vulnerable populations are selectively victimized by legalized PAS, nor that PAS is becoming epidemic. PAS accounted for approximately 22 deaths per 10,000 total deaths in Oregon in 2011. Most patients were white (95.6 percent), well educated (>70 percent with college education), and insured (96.7 percent). The majority (96.7 percent) were enrolled in hospice care. Only 1.4 percent were referred for psychiatric evaluations. Furthermore, Washington and Oregon residents are likely to be well educated with regard to their end-of-life options.
Will Physicians Be Encouraged to Kill Patients Against Their Will?

Santorum asserted that 10 percent of all Dutch elderly are killed by their doctors, half of them against their will, and that the elderly wear bracelets begging doctors not to euthanize them. If this were true, then we would indeed all have reason for alarm. But Santorum’s assertions actually bear little resemblance to reality. In the Netherlands, both PAS and EU are legal but require competent, voluntary and repeated requests by the patient. PAS and EU account for 1.8 percent of all deaths in the Netherlands annually, or fewer than 2,000 deaths in 2007. Of those, only nine did not follow the strict legal procedures, and all nine were shown to be documentation errors, not errors in ascertaining competence, questions of voluntariness, or other substantive issues that might have affected outcomes. Far from being terrorized, the elderly population of the Netherlands strongly favors the option of euthanasia (70 percent in 2008).

Surveys show that EU is actually practiced by a surprising number of physicians globally, without the regulation of law. Thirty-six percent of Australian surgeons report giving drugs to hasten death, 3.7 percent of U.S. oncologists admit to performing EU, and 10.8 percent to assisting suicide prior to its legalization. Up to 38 percent of German physicians admit to performing EU at some time, and in the U.K., 7.4 percent of surveyed physicians reported giving drugs with the intention of hastening death. In none of these countries is EU legal. In the Netherlands, prior to legalization, EU had been practiced and poorly regulated. A 2005 study reported that before legalization, 0.4 percent of EU cases in the Netherlands involved ending a life without explicit request, a rate that was cut in half by legalization and regulation. If anything, studies suggest that legalization provides regulation, oversight and investigation that is otherwise absent, and that episodes of EU and PAS may even decline with legalization.

Is It Ethical for Physicians to Participate in EU or PAS?

Tough questions arise when we look at the issue of physician professionalism and PAS and EU. There is no doubt that the traditional view of physicians has held that our primary goal is to preserve life, regardless of the consequences. The ancient oaths are unequivocal in vowing not to use the privileged position that we as physicians have for the purpose of killing. It is, or at least was, an impenetrable rule necessary to patient trust.

But modern physicians have already breached “the trust” as it probably would have been understood in ancient times. Abortion was specifically prohibited by the Hippocratic oath, but is now considered by many an acceptable and ethical practice bound by the privacy of the doctor-patient relationship.
Withdrawing life-supportive interventions would almost certainly have been seen as a form of killing and not allowed (had our physician forefathers been able to foresee such technology). It seems impossible to reconcile a profession that now embraces facilitating death under certain circumstances with the ancient oaths. Nonetheless, the concept that facilitating death is permissible within the purview of ethical medical care is gaining traction, both in European cultures and with the American public. Increasingly, the role of the physician is seen as one that is intimately involved in issues related to patient dignity and ending suffering, not just preserving life.

The professionalism argument forces us to ask whether our professional mandate is truly unalterable over time. A stance that physicians can only practice in the context of ancient beliefs regarding right and wrong would seem to posit medicine as an ideology and not a profession. The “social contract” physicians have with society implies that there are two sides to the contract: the profession and society. The benefits physicians have demanded of society have changed over the centuries: does society have a right to alter their expectations of physicians as well?

A very real concern is the possibility that participating in activities that facilitate death as directly as PAS and EU do will be morally corrupting to physicians. There is some strong evidence that this might be so. In 2005, Osofsky and colleagues examined the effects of participating in legal executions on several tiers of participants: chaplains and spiritual supporters, prison guards, and death chamber participants. Their findings were both relevant and disturbing. For most people, participating in killing is a powerful emotional and moral event. In order to manage internal conflicts, participants in executions at all levels of involvement employ various degrees of “moral disengagement.” Moral disengagement is the creation of beliefs that allow individuals to rationalize that they are not morally responsible for activities in which they nevertheless play a critical role. In the case of executions, such arguments include distancing themselves from the decision to kill (i.e., the judge and jury condemned the prisoner, not I); dehumanizing the prisoner (he or she is an animal, a monster, different from us, and therefore not subject to moral rules and protections); and rationalizing that execution isn’t terrible (because it is “humane”). The authors found that, no matter how “engaged” morally a participant initially may have been, participation in killings uniformly converted them to moral “disengagers.”

Dehumanization of subjects and denial of moral responsibility are not qualities that would generally be considered desirable in a caring physician. Yet nothing is known at this time about what, if any, moral and psychological defenses
The Ethics of Ending Life (cont’d)

physicians utilize while engaging in the facilitation of death under other circumstances, and how it may affect, for better or worse, the qualities we feel are essential for a physician’s professional life.

Not So Final Thoughts

Here is what we know: our patients are worried about how we will care for them at end-of-life, and while most generally have confidence that their medical needs, including pain control, can be managed, they are doubtful that their spiritual and social needs (e.g., autonomy, dignity) will be adequately addressed. PAS and EU are options that a large majority of the public feels very strongly have a rightful place in their end-of-life care, and they want their physicians to help them with support, information, and even participation. In areas where PAS and EU are practiced legally, there is little evidence at this time to support concerns that the socially vulnerable are being systematically exploited. But physicians must still address the following fundamental questions: 1) does their social contract to relieve suffering extend so far as to include facilitating death at a patient’s request, and if so, 2) whether by doing so, the profession as a whole—or the individuals who participate—will suffer significant moral harms of sufficient gravity as to warrant continued professional sanctions against participation in PAS and EU.

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References


16. Personal communication during in-person interviews with the author, September 2011.


Part 1 of this two-part series by Dr. Van Norman—“The Language of Ending Life”—appeared in Volume 61, Number 1 (Winter 2012), of the CSA Bulletin, pages 78–82.

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**MARK TWAIN’S WIT AND WISDOM**

When in doubt, tell the truth.

Wit, by itself, is of little account. It becomes of moment only when grounded on wisdom.

Any mummery* will cure, if the patient’s faith is strong on it.

*Useless or silly show or ceremony.
Breaking the Ice:
An Anesthesiologist Searches for Medical Clues in the Antarctic

Walk into Warren Zapol’s office at the Massachusetts General Hospital (MGH), and you immediately recognize signs that a polar scientist is in residence. Framed photographs on the wall show research teams bundled up in red parkas; in one photo, Zapol and a flock of emperor penguins cavort on the sea ice. Zapol has led nine expeditions to Antarctica and although his “day jobs” as head of the department of anaesthesia and critical care at MGH, and Reginald Jenney Professor of Anaesthesia at Harvard Medical School, preclude more frequent travels, he has maintained a deep connection to the Antarctic, which he calls “the most beautiful place in the world.”

On his first trip to Antarctica in 1974, Zapol’s research centered on measuring the blood pH of fish. But he quickly shifted his attention to one of the South Pole’s warm-blooded creatures, the Weddell seal (Leptonychotes weddelli), which weighs 770 to 880 pounds and is about 6 feet long. While a human who can swim unaided to a depth of 20 meters and stay submerged with three to four minutes of breath-holding is considered an expert diver, that ability pales in comparison to the behavior of this seal, which has the amazing ability to dive deeper than 500 meters and stay underwater for more than 90 minutes. The animal has developed adaptations that allow it to withstand the intense pressure of deep-sea diving, not to mention the lack of oxygen and the extreme cold.

The challenge facing Zapol was to determine what physiologic and biochemical strategies the Weddell seal has evolved, and whether such information could be deployed in treating human respiratory failure. Zapol points out that one of the greatest dreams in medicine is to find a way to shut down metabolism when the body cannot supply oxygen and eliminate waste products, particularly during acute heart attacks and strokes. “If you knew how to shut down metabolism, much as the seal can, you could preserve the brain and the heart from injury.”

Diving Virtuoso

During a dive, the seal must provide its tissues with oxygen, limit buildup of carbon dioxide in the blood, and avoid various ills of extreme pressure, such as
nitrogen narcosis—what divers call “rapture of the deep.” And if the nitrogen tension in blood and tissues becomes too great as the seal swims to the surface, the result can be “the bends,” a condition that may lead to blocked vessels in the brain and spinal cord, paralysis, and even death.

So, how do Weddell seals overcome these obstacles? Laboratory studies have provided some important clues. Human divers depend on their lungs for oxygen storage, but seals do not. Storing twice as much oxygen per kilogram of body weight as humans, they concentrate it mainly in the blood. Another adaptation is bradycardia. Further, some of the seal’s tissues stop functioning during a dive; others switch to anaerobic metabolism.

Yet to fully understand the adaptations that allow Weddell seals to penetrate to such depths and stay submerged so long, field studies were required. “Forcing a seal confined in a laboratory to put its face underwater does not necessarily evoke the same response as a dive undertaken freely in the sea.” So, on six occasions, Zapol and his team headed to the National Science Foundation’s research station on the shore of Antarctica’s McMurdo Sound to study the behavior of the seals in the wild.

Wild Discoveries

McMurdo is 800 miles from the South Pole on the shores of Ross Island, an active, 12,448-foot-high volcano covered with ice, snow and glaciers. Zapol and his colleagues generally made their trips during the Antarctic spring in October and November. At that time, temperatures average minus 18 degrees Celsius and the sea ice is beginning to break up, yet is still thick enough to allow planes to land directly on it. The researchers lived and worked on the ice itself.

To allow the scientists to understand metabolically what happens when a seal dives, Roger Hill, Ph.D., then a physicist and pulmonary circulation research fellow at Zapol’s MGH laboratory, designed, developed and programmed software and built a battery-operated diving microcomputer that could be glued to the seal’s dorsal fur. It was programmed for predetermined seawater depths and diving times to record heart rate, body temperature, and swimming velocity; it also commanded a pump to draw blood samples.
Young male seals were gathered from colonies near the shore and sledged to the study site about 5 miles offshore. A 3-foot-diameter hole was drilled through the sheet of ice roughly 6 feet thick, in an area that had no nearby cracks through which the seal could surface. The seals were briefly anesthetized with 1 gram of intramuscular ketamine followed by halothane via a to-and-fro system, a 25-liter reservoir bag, and a carbon dioxide absorber. Catheters were inserted and the computer was attached; when the seals recovered from the anesthesia, they entered the hole and swam away.

For shelter against the elements, the research team used a small hut on skis that was towed across the ice to the desired location and positioned so that a hole cut out of the bottom of the hut was over the hole in the ice. The hut also housed a computer to retrieve data from the diving computer when the seals returned to breathe. Another small hut formed the research team’s living quarters.

The researchers soon learned that the seals’ diving responses did not match what they had seen in the laboratory. Ninety-five percent of the seal’s voluntary dives were short feeding dives, lasting less than 20 minutes; the animal would head straight down for its prey, the Antarctic cod, and then resurface. Only 5 percent of the dives lasted longer than 20 or 30 minutes, these longer dives occurring when the seal was exploring new territory or escaping from predators.

Through these free-diving seals in their natural habitat, it was determined that the “diving reflex”—the profound circulatory redistribution brought about by selective systemic vasoconstriction and vagal bradycardia—was a natural phenomenon and not due to the stresses of the laboratory. The longer dives of 200 to 300 meters were characterized by bradycardia, with little variability of heart rate, that remained present until the seal resurfaced. On the shorter trips, the seal’s heart rate would quicken and slow in accordance with its swimming speed. In the laboratory, even short dives had evoked the response typical of a long dive. The reason? “In the laboratory, the seal doesn’t know how long it will be submerged, so it prepares for the worst.” Moreover, the seal’s arterial oxygen tension dropped to 20 to 30 mmHg, concentrations lower than those estimated in exhaled gas from humans summiting Mount Everest. Seals’ muscle is extremely rich in myoglobin, which slowly desaturates as it releases large stores of oxygen into the circulation, thus enabling the long dives.

Zapol also focused on two of the seal’s great secrets: the extension of the diving reflex from its use of the spleen as a storage tank for red blood cells (RBCs), and its ability to collapse its lungs. It was estimated that the Weddell seal stores about 60 percent of its RBC supply in the spleen (humans store less than 10 percent). “The seal’s spleen appears to be something of a contractile scuba tank in its ability to store and release RBCs needed for bouts of diving,” discharging
about 20 liters of packed RBCs into the circulation, thus giving the seal added circulating RBCs to rapidly take up oxygen when it briefly breathes air at the surface during a series of dives.

From their studies, the team also learned that the seals’ lungs collapse at the beginning of each dive. This collapse decreases buoyancy, making it easier for the seal to descend, and limits the amount of nitrogen that can enter the blood during a dive. As they descended, the seals’ blood nitrogen concentrations increased to three to four times higher than those at the surface, equivalent to about 30 meters of seawater pressure. However, the increase of blood nitrogen stopped with further descent and then concentrations actually declined, confirming that the seal’s lung completely collapses with each dive below 25 to 50 meters, thus ceasing the uptake of nitrogen from alveolar gas into the blood. In fact, the seal’s lung becomes airless, resembling a fetal lung. “When people go for a long dive, they breathe in, to fill up their lungs. Seals do the opposite; they breathe out when diving to help collapse their lungs. It’s such a smart technique. We found that out early when we measured the amount of nitrogen in their blood and noted that it didn’t rise to the levels that a human scuba diver’s would rise to.” Thus, the seal is able to remain alert during deep dives, allowing it to find and capture its prey without succumbing to nitrogen narcosis.

The Weddell seal studies provided major insights into mammalian adaptations for diving, but so far have not resulted in breakthroughs in treating human respiratory failure. In contrast, Zapol’s pioneering landmark work with inhaled nitric oxide would change the therapy for newborns with persistent pulmonary hypertension as well as other causes of hypoxic respiratory failure, as well as for children undergoing cardiac surgery and adults having left ventricular assist devices implanted. However, as a result of the seal studies, Dr. Zapol and his team of skillful scientists were honored by the U.S. Board on Geographic Names, which named a glacier in Antarctica after him! The Zapol Glacier can be found at 78 degrees south, 85 degrees west.
Routine Preoperative Laboratory and Diagnostic Screening

By Thelma Z. Korpman, M.D., MBA

The only policy that has been revised as often as the nil per os orders (see pages 40–45) for our institution is the guidelines for ordering routine preoperative laboratory and diagnostic screening. Once upon a time there were standard batteries of preoperative tests to provide baselines, comfort or knowledge. The cost of such testing and questions about immediate utility have, over the years, resulted in the current recommendation: only those tests that are clinically indicated should be ordered. Sounds simple enough; however, if it were that simple this article would not be of interest!

In 2003 the American Society of Anesthesiologists (ASA) House of Delegates approved the Statement on Routine Preoperative Laboratory and Diagnostic Screening, which originated from the Standards and Practice Parameters Committee. This statement reads:

Preoperative tests, as a component of the preanesthesia evaluation, may be indicated for various purposes, including but not limited to: 1) discovery or identification of a disease or disorder which may affect perioperative anesthetic care, 2) verification or assessment of an already known disease, disorder, medical or alternative therapy which may affect perioperative anesthetic care, and 3) formulation of specific plans and alternatives for perioperative anesthetic care. No routine* laboratory or diagnostic screening† test is necessary for the preanesthetic evaluation of patients. Appropriate indications for ordering tests include the identification of specific clinical indicators or risk factors (e.g., age, pre-existing disease, magnitude of the surgical procedure). This statement will be integrated into an update of the ASA Practice Advisory for Preanesthesia Evaluation at a future date. It will not appear independently after that time.

Anesthesiologists, anesthesiology departments or health care facilities should develop appropriate guidelines for preanesthetic screening tests in selected populations after considering the probable contribution of each test to patient outcome. Individual anesthesiologists should order test(s) when, in their judgment, the results may influence decisions regarding risks and management of the anesthesia and surgery. Legal requirements for laboratory testing where they exist should be observed. The results of tests relevant to anesthetic management should be reviewed prior to initiation of the anesthetic. Relevant abnormalities should be noted and action taken, if appropriate.

* “Routine” refers to a policy of performing a test or tests without regard to clinical indications in an individual patient.
† “Screening” means efforts to detect disease in unselected populations of asymptomatic patients.
What is most important in the ASA’s statement is that any tests should be ordered only if they are likely to discover something that may affect perioperative anesthetic care and that may lead to formulation of specific and alternative plans for management of the anesthesia and surgery. Under this rubric, no routine tests (tests without regard to clinical indications) are necessary. As an obvious corollary, if a test were to be ordered, then the results relevant to anesthetic management should be reviewed and appropriate action should be taken prior to anesthesia; otherwise the test does not meet the guideline criterion of affecting anesthetic care. This seems simple, yet the fact is that time and money are wasted on “routine testing” that fails to make a meaningful contribution to the perioperative assessment.

Both anesthesiologists and surgeons are equally guilty when it comes to the ordering of “routine testing.” With regard to reviewing test results, anesthesiologists often, but not inevitably, will check the results of the tests that they order; however it is the experience of many that surgeons rarely check the results or respond to abnormal results of the tests that they order. Surgeons will state that they order the tests because “anesthesia” wants them to do so, and some anesthesiologists say that they order tests to protect themselves legally. Neither explanation is scientifically rigorous, nor do they demonstrably improve care. Preoperative testing should be individualized for each patient. The preoperative history and physical examination should be the determinants of any testing applicable to each particular patient. Indeed, the ordering of non-demonstrably-necessary tests as a routine is not appropriate.

Using this framework, in the ambulatory surgery center it would be very rare to “need” a test. Preoperative guidelines consistent with the ASA statement would be:

<table>
<thead>
<tr>
<th>TEST</th>
<th>TO ORDER OR NOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine hemoglobin/hematocrit or complete blood count</td>
<td>NO — unless history or signs of anemia</td>
</tr>
<tr>
<td>Routine pregnancy</td>
<td>NO — unless patient requests test or states she may be pregnant and the patient’s management would be altered. Patient’s permission/request for pregnancy testing should be documented. Pregnancy test results should be meticulously confidential and only revealed to the patient herself.</td>
</tr>
<tr>
<td>Routine potassium</td>
<td>YES — if end-state renal disease</td>
</tr>
<tr>
<td>Glucose</td>
<td>YES — if diabetic</td>
</tr>
<tr>
<td>Electrocardiogram</td>
<td>YES — if active abnormal cardiac condition determined by history and/or physical (decompensated congestive heart failure, chest pain, arrhythmia, murmur)</td>
</tr>
<tr>
<td>Other tests</td>
<td>Based on history and physical</td>
</tr>
</tbody>
</table>
Preoperative Laboratory and Diagnostic Screening (cont’d)

In-hospital preoperative testing guidelines are similar; however, due to the higher-risk kinds of surgeries performed in the hospital compared to the ambulatory surgery center, more indications for testing may exist. Some examples include:

1. Creatinine level if intravenous contrast dye will be injected
2. Hemoglobin/hematocrit if there is potential for significant blood loss
3. Type and screen if transfusion requirement likely
4. Pregnancy test if possibility of pregnancy. Patient’s permission/request for pregnancy testing should be documented. Pregnancy test results should be meticulously confidential and only revealed to the patient herself.
5. Potassium if end-stage renal disease
6. INR if on Coumadin
7. Blood glucose and HgA1C if diabetic
8. Chest X ray in the morbidly obese patient (BMI > 40) with at least one risk factor for coronary heart disease, poor exercise tolerance or both to look for undiagnosed heart failure, cardiac chamber enlargement or abnormal pulmonary vascularity
9. Chest X ray for thoracic surgery
10. Coagulation and liver function tests if hepatic disease
11. Electrocardiogram based on American College of Cardiology (ACC)/American Heart Association (AHA) standards

A short summary of the ACC/AHA standards for preoperative 12-lead electrocardiogram includes:

1. Vascular surgery patients with at least one clinical risk factor (coronary artery disease, congestive heart failure, diabetes, unstable coronary syndromes such as unstable angina or recent myocardial infarction, murmur, creatinine > 2) should have electrocardiogram.
2. Patients with known coronary, peripheral or cerebrovascular disease undergoing intermediate-risk surgery (orthopedic, head and neck, prostate surgery) should have an electrocardiogram.
3. Morbidly obese (BMI >40) with at least one risk factor for coronary heart disease (same as in #1) or with poor exercise tolerance should have an electrocardiogram.
4. Vascular or thoracic surgery patients or any other patients with clinical indications (as long as the results of the preoperative electrocardiogram will affect clinical management) should have an electrocardiogram.
5. Patients scheduled for intermediate-risk surgery with at least one of the above clinical risk factors (same as in #1) may have an electrocardiogram.

6. Patients with low functional capacity undergoing intermediate-risk procedure should have an electrocardiogram.

7. An electrocardiogram is not indicated for asymptomatic persons for low-risk surgeries. Low-risk surgeries include superficial or endoscopic surgery, cataract surgery, breast surgery and ambulatory surgery.

8. Electrocardiograms should not be ordered because the patient is above a certain age; rather the basis for ordering them should be history and physical and ACC/AHA standards.

**Summary**

Regarding the ordering of routine preoperative laboratory and diagnostic screening:

1. Order only tests that in the judgment of the provider will influence decisions regarding risks and management of the surgery and anesthesia.

2. Results of tests should be reviewed prior to coming to the operating room.

3. Action should be taken if results are abnormal.

4. The benefit must outweigh the risk; *prima facie*, there will be no benefits if the ordering provider does not care about the results. If there are results, the most significant indication that the test was appropriate is action on the results *before* the patient comes to surgery.

5. If caring for a vulnerable population of people that never sees a physician unless desperately ill, preoperative screening tests may be indicated. The results of these tests may influence decisions regarding the management of the surgery and anesthesia and thus fit the criteria and should be ordered.

6. In any individualized case, deviation from the recommendations in this article may be reasonable if likely to benefit the patient. The goal is to deliver quality care following a cost-conscious, evidence-based approach.

**Reference**

ACOs: The Last Best Hope to Retain Pluralism

I recently dined with a friend and esteemed colleague, George Lundberg, M.D., distinguished Editor-in-Chief of the Journal of the American Medical Association for 17 years and a member of the Institute of Medicine. Knowing him to be a “controversial” but thoughtful medical commentator, I asked him if he might read the trio of articles on the Patient Protection and Affordable Care Act (PPACA) that appeared in our last CSA Bulletin (Volume 61, Number 1) and then comment on them. His response was that he has not published a personal assessment of PPACA as he deems it too long and complex a project, and also knowing that many others had done and were doing so, as in our Bulletin. However, he offered the following “letter” taken from a spoken commentary on the website MedPage Today (www.medpagetoday.com), about what he considers to be a critical portion of PPACA, the accountable care organizations (ACOs). —Stephen Jackson, M.D.

By George Lundberg, M.D., Editor-in-Chief, The Medscape Journal of Medicine; Editor-at-Large, MedPage Today; president and chair of the board of directors of The Lundberg Institute; consulting professor of pathology and health research policy at Stanford University School of Medicine

The cost curve of American medicine continues to bend up. That is unsustainable. It must begin to bend downward. Two news reports from last year focus the problem:


And CNN Money, May 11, 2011, reports “Your family’s healthcare costs $19,393.” That is for a family of four, which has a median income of $75,700—before taxes.

Opportunity knocks, loudly. We can change our medical world now. American medicine has been very successful. American medicine has been a dismal failure. Both statements are correct, depending on how one looks at it.

It is now our opportunity, indeed I say our professional responsibility, to preserve the best, and to scuttle the worst. We can build a new medical world based less upon process, quantity, volume, and lucre, and more on quality, safety, speed, outcomes, and patient-centered efficiency.

In this new era of accountable care organizations (ACOs), keep your eyes on the prize. And the prize is positive outcomes for the health of the mind, body, and spirit of the patient. Keep healthy people healthy, vigorous, and confident;
ACOs: The Last Best Hope to Retain Pluralism (cont’d)

recognize and treat acute illness quickly and effectively; manage chronic illness efficiently; do not promote disease mongering, cyberchondriasis, medical bankruptcy, or what Nortin Hadler and Clifton Meador call “the worried well.”

ACOs may take many forms. I believe that physician leadership will be the key.

The three goals of an ACO are to increase perceived value of care, improve actual clinical outcomes, and lower health care costs. If it saves money, the ACO gets to keep some of the savings. This truly is an exciting opportunity to do well by doing good. With ACOs, the American health care non-system actually can and should be reinvented. Now.

I recommend engaging and empowering communities to work with the health care sector in building ACOs for their common good.

The credo of The Lundberg Institute is: one patient; one physician; one moment; one decision; let it be a shared decision, informed by the best evidence, and considering cost. Might ACOs make health-community informed, shared decision-making of the same sort possible, facilitated by participatory technologies and social media as recently suggested by Springgate and Brook in JAMA (http://jama.ama-assn.org/content/305/17/1800.full?etoc)?

Exciting time. Be creative. Seize the moment. Save American pluralistic health care. It may be our last best chance.

MARK TWAIN’S WIT AND WISDOM

Clothes make the man.
Naked people have little or no influence in society.

No man’s life, liberty or property is safe
while the legislature is in session.

If you don’t read the newspaper you are uninformed.
If you do read the newspaper, you are misinformed.

Suppose you were an idiot. And, suppose you were
a member of Congress ... But then I repeat myself.
As the speed of change seems to be increasing exponentially, we are often faced with information overload. One area that we cannot become lax about is the ever-increasing Practice Guidelines and Committee Opinions that affect the multidisciplinary area of obstetric anesthesiology. This article will review what national societies have urged upon their members, discussing new topics, as a continuation of a prior CME article in the Bulletin.¹ The American College of Obstetricians and Gynecologists (ACOG) has released other documents that are very informative and pertinent to obstetric anesthesiology practice. This article will also review documents by the American Society of Anesthesiologists (ASA). Both societies have important guidelines that affect your daily practice. This review is intended to help you understand changes in clinical practice and to improve patient outcomes.

Anesthesia When the Parturient Is on Antidepressants

In February 2010, ACOG released a committee opinion stating that depression is very common before, during and after pregnancy. Indeed, one in seven pre- and postpartum women is treated for depression. Practitioners should be alert to signs of depression.² Some women may be reluctant to mention a history of depression/mood disorder, especially in the presence of friends or family. Be sure to check the prenatal records or ask about this on the preanesthesia assessment. Moreover, antidepressant medications may interact with anesthetics. Commonly prescribed antidepressants in pregnancy include selective serotonin reuptake inhibitors (SSRIs), bupropion, and even tricyclic antidepressants.

Communication Counts—Medical Errors

In July 2010, ACOG reaffirmed that communication gaps and patient handoffs are very important causes of medical errors and omissions.³ It also suggested instituting a labor-hospitalist model (in-house, dedicated obstetrician for labor) of obstetric management, but such an approach may not be popular or feasible. However, expect more hospitals to employ a hospitalist model in obstetrics. Be sure to
get a complete report from the nurse or obstetrician prior to administering an anesthetic for labor analgesia or cesarean delivery, and to give an appropriate handoff of patients when being relieved or transferring care.

**Timing of Antibiotics for Cesarean Delivery**

In September 2010, ACOG changed the standard of care to giving antibiotics before skin incision for cesarean deliveries. Historically, pediatricians wanted to evaluate newborns for sepsis based on the infant’s own blood/cerebral spinal fluid culture and sensitivity, and for decades antibiotics were given immediately after umbilical cord clamping. Changing antibiotic administration to within 60 minutes prior to skin incision reduced wound infections from 1.4 percent to 0.6 percent. The unintended effect of preincisional antibiotics is that if a newborn shows signs of suspected sepsis, then it may be treated empirically with antibiotics, as its blood cultures can be negative due to antibiotic transfer from the mother.

**Laboring After Cesarean—What’s Really Required?**

In August 2010, ACOG again updated its practice bulletin regarding vaginal birth after cesarean (VBAC). Current terminology changed again! The term VBAC had historically been used whether successful or not. The new terminology is trial of labor after cesarean (TOLAC), which becomes VBAC if the delivery is vaginal. If a hospital will be performing TOLAC/VBAC, then resources for cesarean should be “immediately available” (see next paragraph). Some hospitals stopped offering TOLAC because they do not maintain 24/7 staffing for performing a cesarean section in-hospital. However, a woman cannot be “forced” into a cesarean if she does not want one. The risk of uterine rupture (with potentially bad outcome for mother and/or baby) is increased with use of oxytocin and prostaglandin. A valuable discussion of the risks of uterine rupture appeared in the Winter 2012 issue of the CSA Bulletin. Use of predictive indicators for successful VBAC may help choose or triage potential candidates.

In May 2009, ACOG updated its Optimal Goals for Anesthesia Care in Obstetrics. This opinion states that “immediately available” is a local decision. A qualified anesthesiologist is to be responsible for all anesthetics administered and should be readily available to assume that responsibility (either in person by phone). Notably, the “30-minute rule” still is promulgated in this 2009 opinion—that is, anesthesia services and surgical personnel must be available to permit the start of a cesarean within 30 minutes of the decision. However, the newer ACOG Practice Bulletin #116 (November 2010) significantly changed fetal heart rate terminology (to Category I, II, and III) and seems to have discarded a universal “30-minute rule”; this is discussed in depth in a previous Bulletin article.
Neuroprotection of the Fetus

In March 2010, ACOG set guidelines for neuroprotection of preterm babies. The delay of delivery for preterm birth now includes the administration of magnesium sulfate, not as a tocolytic, but to benefit the neonate. Recent literature has shown that maternal magnesium sulfate administration may reduce the risk of cerebral palsy in infants who have preterm birth. Note that the dose of magnesium is an initial 6-gram load (not the typical 4 grams for seizure prophylaxis), then infused at 2 grams/hour for 12 hours. This will produce a somewhat higher blood level than the anti-seizure dose given for preeclampsia. Thus, one should expect more cardiovascular interactions (e.g., hypotension) and muscle weakness with the administration of anesthetics and muscle relaxants.

Cesarean Under Local Anesthetic Infiltration

The Practice Bulletin for Obstetric Analgesia and Anesthesia, released in 2002, is an older but still important ACOG reference for obstetric anesthesiologists to know. ACOG notes that maternal request is sufficient reason to provide pain relief. Perhaps more noteworthy for extremely challenging clinical situations is that ACOG clearly states that infiltration of local anesthesia can be used for cesarean delivery when adequate general or regional anesthesia is unavailable. Just as an anesthesiologist must be willing to establish a surgical airway (e.g., cricothirotomy) when necessary, obstetricians also must be willing to perform a cesarean section under local anesthesia infiltration when necessary. This has important medicolegal ramifications if you, the anesthesiologist, are not ready to proceed with the anesthesia, yet the obstetrician declares the need to proceed immediately with surgical delivery. For example, when you encounter a truly difficult airway, you may choose to perform an awake intubation using difficult-airway equipment (e.g., fiberoptic intubation, video laryngoscopy) rather than immediately induce general anesthesia and risk being unable to ventilate the patient. However, while the obstetrician does have the option to proceed under local infiltration if the fetus’ life is deemed to be at risk, the anesthesiologist is neither expected nor required to put the mother’s life in danger by attempting to administer an anesthetic he/she deems to be unsafe and life-threatening.

Blood Loss During Cesarean

ACOG notes that even today, hemorrhage is still one of the top three causes of maternal mortality. Estimates of blood loss before, during and after delivery are notoriously inaccurate and usually underestimate the blood loss. Postpartum hemorrhage is fairly common, occurring in 4 to 6 percent of parturients. For any postpartum patient with a heart rate greater than 120, consideration should be given to checking her hemoglobin. A great resource for tools regarding
obstetric hemorrhage is the California Maternal Quality Care Collaborative, www.CMQCC.org.

Parturients Having Surgery Other Than Cesarean Delivery—Fetal Heart Rate Monitoring

In February 2011, ACOG provided some reassuring guidance for anesthesiologists concerned with providing anesthesia during pregnancy. ACOG reaffirms that no anesthetic agents have been shown to have any teratogenic effects in humans at typical concentration and common duration. Monitoring the fetal heart rate (FHR) may help in maternal management of physiologic parameters, may be useful as a check on fetal status (e.g., fluids, blood pressure, carbon dioxide), and may show the need for fetal delivery. Elective surgery should be delayed if possible until after delivery. Non-urgent surgery preferably should occur in the second trimester, as the incidence of spontaneous abortion and preterm contractions is lower than in the first or third trimesters.

My personal bias is to monitor the fetus at any gestational age, if possible, so that you can evaluate its condition and maximize the intrauterine resuscitation of the fetus should it be deemed necessary. Some obstetricians may be uncomfortable with what actions (e.g., cesarean), if any, should be performed with a very preterm fetus with abnormal FHR patterns. However, FHR monitoring is a useful tool, like the pulse oximeter, in the armamentarium of the clinician. In the majority of circumstances, the FHR readings will be normal. Monitoring FHR will draw attention to potential problems and impending calamity, and will improve the chances of instituting remedial measures without delay.

Acute-onset Hypertension in Preeclampsia

While treatment of severe hypertension in preeclampsia has always been encouraged for systolic blood pressure >160 mmHg, most clinicians did not treat until >180 mmHg or diastolic blood pressure >110 mmHg. With ACOG Committee Opinion #514, new aggressive guidelines for emergent therapy of hypertensive crises have been established. Citing the risk of intracranial hemorrhage, treatment protocols beginning soon after the detection of hypertension with hydralazine and/or labetalol have been established. The degree of systolic hypertension may be the better predictor of cerebral injury. The new recommendation is for treatment of elevated blood pressures greater than or equal to either systolic blood pressure >160 mmHg or diastolic blood pressure >110 mmHg that persists for only 15 minutes. Thus, anesthesiologists should expect more aggressive and earlier pharmacologic treatment of severe hypertension, which, in turn, may interact with both regional and general anesthesia, especially for imminent cesarean delivery.
Related Recommendations from the ASA

The American Society of Anesthesiologists also has guidelines that may help to improve patient outcomes.

Preventing Neuraxial Infections

Neuraxial infections due to regional anesthesia are rare, especially in obstetrical patients. The 2010 ASA Practice Advisory on Prevention of Infection prescribes wearing masks, changing masks after every case (or epidural), washing hands before and after each procedure, and removal of jewelry, including not only watches, but also rings.\textsuperscript{14} The use of sterile drapes is recommended as well as a sterile occlusive dressing at the site of epidural catheter insertion, although there is no requirement for the size of the occlusive dressing.

The use of alcohol with chlorhexidine is the preferred prep solution, providing the best antibacterial effect for the longest period of time. However, the Food and Drug Administration has not approved chlorhexidine for neuraxial anesthesia due to studies that showed intrathecal chlorhexidine produced neurotoxicity in animal models. Nonetheless, a recent retrospective study showed no difference in neurologic complications of spinal anesthesia using a chlorhexidine prep when compared to the literature (0.04 percent rate, five cases), with symptoms resolving within 30 days.\textsuperscript{15}

Oral Intake During Labor and Postpartum Tubal Ligation

Guidelines covering these two situations are described on page 45, in the trio of articles on \textit{nil per os} (NPO).

Summary

The anesthesiologist taking care of obstetrical patients should be familiar with the guidelines of not only the ASA but also ACOG. In the future, more organizations will be establishing guidelines that will change physician and nursing practices. As part of any team, knowing the ever-changing rules that the other players are following will serve to avoid surprises, decrease communication errors, and lead to improved patient care and outcomes.

References


Informed Refusal

By James W. West, M.D.

The Case

A 41-year-old female with hepatitis C cirrhosis complicated by hepato-pulmonary syndrome is listed for liver transplant. She has high priority status due to the severity of her pulmonary disease, which is usually reversible with liver transplant. Pertinent lab results are: hemoglobin 12, INR 1.1, bilirubin 1.0, creatinine 1.0, and platelet count 75,000. Her situation is further complicated by the fact that she is a Jehovah’s Witness and will not accept blood transfusions.

Should this patient be a candidate for liver transplant, given the relatively common need for blood transfusion during the operation? What are the anesthesiologists’ obligations to the patient, to themselves, and even to other patients on the transplant recipient list? Is the decision to follow through with this case different from any other major surgeries, such as coronary artery bypass surgery or liver resection?

Jehovah’s Witnesses

Jehovah’s Witnesses (JWs) began as a Bible study group formed in 1870 by C.T. Russell in Allegheny, Pa. Members of this group believe that God’s name is Jehovah, which is an English translation of the name that appears in Hebrew texts. They also believe in the literal interpretation of the Bible, except in cases in which it is obvious that it is allegorical. JWs believe that only one government is owed allegiance—God’s Kingdom. They do not salute flags, serve in the military, or vote in political elections. They also believe we are living in the “last days” of the present system.¹

As with many religions, JW beliefs and teachings have evolved as society has evolved. In 1945 there was a ban placed on blood transfusions based on three quotes from scripture:²

Genesis 9:3–4—Every moving animal that is alive may serve as food for YOU. As in the case of green vegetation, I do give it all to YOU. Only flesh with its soul—its blood—YOU must not eat.

Leviticus 17:10–16—As for any man of the house of Israel or some alien resident who is residing as an alien in YOUR midst who eats any sort of blood, I shall certainly set my face against the soul that is eating the blood, and I shall indeed cut him off from among his

people. For the soul of the flesh is in the blood, and I myself have put it upon the altar for YOU to make atonement for YOUR souls, because it is the blood that makes atonement by the soul [in it]. That is why I have said to the sons of Israel: “No soul of YOU must eat blood and no alien resident who is residing as an alien in YOUR midst should eat blood.” As for any man of the sons of Israel or some alien resident who is residing as an alien in YOUR midst who in hunting catches a wild beast or a fowl that may be eaten, he must in that case pour its blood out and cover it with dust. For the soul of every sort of flesh is its blood by the soul in it. Consequently I said to the sons of Israel: “YOU must not eat the blood of any sort of flesh, because the soul of every sort of flesh is its blood. Anyone eating it will be cut off.” As for any soul that eats a body [already] dead or something torn by a wild beast, whether a native or an alien resident, he must in that case wash his garments and bathe in water and be unclean until the evening; and he must be clean. But if he will not wash them and will not bathe his flesh, he must then answer for his error.

Acts 15:28–29—For the holy spirit and we ourselves have favored adding no further burden to YOU, except these necessary things, to keep abstaining from things sacrificed to idols and from blood and from things strangled and from fornication. If YOU carefully keep yourselves from these things, YOU will prosper. Good health to YOU!

A 1951 article in The Watchtower, a publication of the JW governing body, explained the ban:

“…when sugar solutions are given intravenously, it is called intravenous feeding. … the transfusion is feeding the patient blood and .. [the patient] is eating it [blood] through his veins.”

Over the years, adaptation has been required to keep up with advances in medicine. Guidelines have been developed to help members deal with renal dialysis, cardiopulmonary bypass, blood harvesting including cell saver, acute normovolemic hemodilution (ANH), and autologous blood donation as well as organ transplantation. See Table 1 for a timeline of significant events in the JW faith.

| TABLE 1: Events in the history of the Jehovah’s Witness church and transfusion |
|-------------------------------|---------------------------------|
| 1870 | study group formed |
| 1879 | first issue of The Watchtower published |
| 1901 | discovery of ABO blood groups |
| 1914 | first blood bank transfusion |
| 1931 | changed name to Jehovah’s Witnesses |
| 1945 | ban placed on transfusions |
| 2008 | 7.1 million members worldwide and 1.1 million members in the United States |
Ethical Principles

Ethical dilemmas can be examined in the context of the four basic principles of medical ethics defined by Beauchamp and Childress: 1) respect for autonomy—a norm of respecting the decision-making capacities of autonomous persons, 2) beneficence—a group of norms for balancing benefits against risks, 3) nonmaleficence—a norm of avoiding harm, and 4) justice—a group of norms for distributing benefits, risks, and costs fairly. In the U.S., the principle of respect for patient autonomy is usually the most heavily weighted of the four, while in many European countries, the principle of beneficence may weigh more heavily than respecting individual autonomy (see CSA Bulletin, Volume 61, Number 1, pages 36–46).

Adults with appropriate decision-making capacity express their autonomy through the informed consent process. Physicians demonstrate respect for the autonomy of competent patients by accepting their informed decisions, whether or not they consent to medical treatment. It seems self-evident that without respect for informed refusal, the concept of informed consent is invalidated: “consent” would then merely be acquiescence of the patient to the physician’s recommendations. Adults are therefore even allowed to make what doctors may sometimes consider unwise or foolish decisions. The physician does not have to agree with the patient, but neither can a physician be compelled to give inappropriate, bizarre, or substandard care.

In order to give informed consent, a patient must have appropriate decision-making capacity; be able to understand the nature of the procedure and the risks, benefits and alternatives including that of doing nothing; and the probable outcomes of both acceptance and refusal of the proposed procedure. In addition, the decision must be made free of coercion. Coercion is present if the patient feels threatened, bullied or subjected to irresistible pressure to make a decision he or she would otherwise not make.

Legal Precedents

Although legal decisions are not always synonymous with “ethical” ones, a review of some legal precedents regarding JWs and how they have changed provides some insights into how medical ethics have shifted in the U.S. from a paternalistic and/or beneficence-based emphasis to one of respect for autonomy.

In 1964, two U.S. courts compelled transfusion for adult patients. In Georgetown College v. Jones the court of appeal ruled that the “patient’s religion merely prevented her from consenting to a transfusion, not from receiving one” and a transfusion was ordered. In Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson, a pregnant JW was not permitted to refuse a necessary transfusion.
Over the last 40 years, U.S. courts have rejected these cases and consistently upheld the rights of adult JWs to refuse blood even when a transfusion would be lifesaving—and even when others, such as dependent children, may be indirectly affected. On the other hand, when the patient is a minor child and hospitals have sought court orders to give blood believed to be absolutely necessary to preserve life, such orders have usually been granted. Exceptions have sometimes been made when an older teenager is committed to his/her religion and seems to fully understand the scope and consequences of his/her decision. Legal precedents in many European countries have paralleled those in the U.S.\(^6\)–\(^9\)

### Specific Issues to Consider in This Case

Key questions arise in most cases involving JWs and others who refuse certain types of treatment on religious or other grounds.

**Does the Patient Have Appropriate Decision-making Capacity?** All patients over the age of majority are assumed to have adequate decision-making capacity unless proven otherwise. Anesthesiologists can usually tell whether patients have decision-making capacity, which is generally present if the patient understands the nature of his/her illness/condition, the nature of the proposed procedure and its inherent risks and benefits and alternatives, and the consequences of refusing treatment. In doubtful cases, evaluation by a psychiatrist may be helpful.

**Have All Appropriate Risks, Benefits and Alternatives Been Explained?** There are other important issues in this case that need to be addressed, aside from the usual explanation of anesthesia and surgical risks. These include assuring that the patient understands that there are some blood cells in solid organs; explaining the specifics of blood conservation techniques; and clarifying the risks of not accepting blood in the face of massive hemorrhage.

In non-emergent cases such as these, there is also often time to plan. Patients should be encouraged to discuss their options not only with the surgical team, but also with the local hospital liaisons from their church (who can be a resource for physicians as well). Preoperative treatments with erythropoietin, iron supplements, or other methods to improve baseline hematocrit should be discussed. Consideration should also be given to intraoperative use of desmopressin and any other measure that will minimize blood loss during the procedure.

**Can a Surrogate Decision-maker Refuse Transfusion for an Incompetent Patient?** All JWs are encouraged to carry a durable power of attorney that explains in detail what their beliefs are concerning blood and blood products.
If this is not available and it cannot be verified that the patient is a practicing JW, then physicians generally err on the side of transfusion. Consultation with hospital legal affairs or an organization’s ethics committee may be helpful if the appropriate action remains unclear.

**Can a Surrogate Decision-maker Change a Plan Made by a Previously Competent Patient?** A surrogate decision-maker’s task is to make decisions for the patient when the patient cannot make them for himself. Ideally, surrogates are not supposed to express their own wishes, but are supposed to make the same decision that a patient would make if he/she were able to do so. Once the patient’s decisions are known, whether physicians agree or not, those decisions should stand unless new information becomes available that brings the previous decision into question. This can be particularly difficult if the patient has refused a treatment that the physician thinks is lifesaving, and the physician knows, believes, or even hopes that the surrogate would capitulate and allow the prohibited treatment. That is when physicians discover if they truly believe in patient autonomy.

**Is the Patient Making a Decision That Is Free of Coercion?** Patients should be free of coercion from health care providers and feel safe that regardless of their personal choices their doctors will not abandon them. Additionally, providers must also strive to ensure that the choices a patient makes are *truly* his/her own. It is not unusual for members of the JW church community, as well as family members, to flock to the bedside of a JW patient, both to support their loved one and also to protect him/her from receiving blood. Sometimes the decisions JW patients express in the presence of family and church members are different from those they later express in private. In the author’s experience, this is extremely rare. However, it is important that at some point prior to surgery and anesthesia, patients have an opportunity to express their transfusion preferences to the anesthesiologist in private. This might be done in a preoperative holding area after the family and/or church members have been sent to the waiting room. The intent should not be to talk the patient into receiving blood, which would be itself coercive, but to insure that his/her true wishes are known and followed. If the patient does recant, it is then important to determine what, if anything, can/should be told to family members about whether blood products were given. Principles of patient confidentiality demand that specifics of treatment such as this only be discussed with the patient unless there is an agreement with them to do otherwise.

**Which Blood Products Will and Will Not Be Acceptable?** It is not a given that a patient professing to be a JW will not accept any blood products. In one study, for example, up to 10 percent of pregnant JW patients indicated that they would accept blood in an emergency. Nevertheless, in general, few if any
baptized JWs will accept whole blood, packed red blood cells, plasma, platelet concentrates, or white blood cell transfusions. Stored autologous blood is also not acceptable because it is out of contact with the body for an extended period. Fractionated products such as albumin, cryoprecipitate, cryo-poor plasma, and individual factors are left to the “discretion of the practicing Christian,” as are organ and bone marrow transplantation.

Other “gray areas” include, but are not limited to, cell saver, ANH, cardiopulmonary bypass (CPB), and renal dialysis. In these situations, The Watchtower has stated that if the blood is kept in continuous circuit with the body and not stored for any length of time, then accepting its transfusion is a personal decision.

CPB and dialysis would almost always involve a continuous circuit. Cell saver and ANH do not necessarily involve a continuous circuit, but one can be created by flushing the cell saver bag and tubing with crystalloid and connecting the circuit to the patient’s IV prior to blood collection. If, after collecting blood for ANH, the line to the collection bags remains connected to the patient then it, too, is considered to be a continuous circuit.

**What Are the Capabilities of the Surgical Team?** When large surgical procedures are planned that may involve significant hemorrhage, it is important to assess whether the surgical and anesthesia team have the skills, experience and resources necessary to perform this procedure on a patient who has limited their ability to care for him/her by refusing blood. The principle of nonmaleficence, doing no harm, might suggest refusing to do the surgery if the team does not have sufficient experience; modifying the surgical plan; or referring the patient to another center with more experience in “bloodless” surgery techniques. There are centers in the U.S., for example, that have created a niche in caring for high-risk JW patients. Accessing the official JW website may be of help. Consultation with, or referral to, such centers may be useful.

**Is It Appropriate to Undertake Liver Transplantation or Other Major Surgery in a JW Patient?** In many routine surgical and anesthesia cases, distributive justice (fair allocation of scarce resources) is not a large consideration in the decision-making process. However, except in the case of a living related donor, solid organ transplantation involves use of a very limited resource. Even centers that specialize in organ transplants in JWs have strict criteria for selecting the proper candidates for organ transplantation. If there is relative certainty that the preoperative status of the patient will mandate the use of blood products during the transplantation, then a JW patient should not be a candidate if they would refuse such transfusions. On the other hand, many potential candidates for liver transplantation are not in severe failure but are at the top
of the recipient list due to other complicating factors such as hepato-pulmonary syndrome, hepatocellular carcinoma, or hepato-renal syndrome. Many of these patients have normal coagulation and hemoglobins and have a reasonable chance of receiving a liver transplantation without transfusion, whether they are JWs or not. Such patients may be appropriate candidates for organ transplantation.

What Are the Anesthesiologist’s Rights and Obligations? Many anesthesia providers feel that refusal of standard care in the operating room, such as blood transfusions, places them in an untenable position in which a seemingly irrational patient choice prevents them from fulfilling their professional obligations to provide lifesaving therapy. The American Society of Anesthesiologists has developed guidelines for the anesthesia care of patients with do-not-resuscitate orders or other directives that limit treatment that specify the following:

When an anesthesiologist finds the patient’s or surgeon’s limitations of intervention decisions to be irreconcilable with one’s own moral views, then the anesthesiologist should withdraw in a nonjudgmental fashion, providing an alternative for care in a timely fashion. … [if such] alternatives are not feasible within the time frame necessary to prevent further morbidity or suffering, then in accordance with the American Medical Association’s Principles of Medical Ethics, care should proceed with reasonable adherence to the patient’s directives, being mindful of the patient’s goals and values.

In non-emergent situations, anesthesiologists have the right to excuse themselves from a patient’s care, as long as they are willing to refer the patient to another provider. This referral could even be to another medical center that has developed expertise in caring for JW patients, and may be desirable in certain situations even if the anesthesiologist would personally be willing to care for the patient.

If the situation is a life-or-death emergency with no time to make a referral, then the anesthesiologist is obligated to care for the patient, trying as much as possible to adhere to the patient’s wishes.

These guidelines are similar to the Guidelines on Clinical Management of JWs published by the National Health Service in Great Britain in 2005. European countries vary somewhat in the depth of obligation a physician has to honor a patient’s wishes to not be transfused. In France, for example, an autonomous patient’s wishes are generally respected, but the law gives leeway to physicians acting in the course of an emergency. In Germany, transfusion even to save a life would be in direct conflict with constitutional guarantees of autonomy—although it is uncertain how this would play out in court if challenged.
Case Resolution

In this case, the patient had been advanced on the recipient list due to her hepato-pulmonary syndrome, the only cure for which was a liver transplant. In addition, her pulmonary status was worsening, and it was felt that she soon would not be a candidate at all. Though the transplant team did not have extensive experience in transplanting JWs, the most experienced surgeon did have a track record of operating on patients such as this with minimal blood loss and minimal use of blood products. The lead anesthesiologist had extensive experience with JWs in other major surgeries such as cardiac surgery. Both of these individuals committed to being involved in this case, whether on call or not, at the time a liver became available for this patient.

The patient agreed to ANH and cell saver as long as a continuous circuit was maintained. She also agreed to albumin and recombinant factor VII if necessary. At the time of surgery three units of blood were drawn off and left in circuit with the patient. The surgery went smoothly, and the patient received the three units of blood and two units of cell saver after the new liver had been revascularized. DDAVP was also administered. She tolerated the surgery and was discharged ten days later, having had a slightly extended postoperative ICU stay due to her pulmonary status.

References


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The CSA Has a New Emblem!

By Karen S. Sibert, M.D., CSA Assistant Secretary, Chair of the Committee on Professional and Public Communications

Many of us in the CSA have great affection for our original 1948 seal (below). It has a classic style with laurel leaves, the California bear, and a traditional monogram that puts the large “A” in the center of the seal.

As we have moved into the 21st century though, the CSA’s Committee on Professional and Public Communications (CPPC) realized that we have important new public relations work to do. We need to improve our outreach to patients, physicians in other specialties, hospital administrators, and legislators—all of them people who need to understand how important anesthesiologists are during the most critical times in a patient’s life.

The CPPC and the Board of Directors agreed that we need to undertake what’s known as “rebranding”: the work of redefining the CSA’s image so we can communicate better with our target audiences. The new brand ideally would be contemporary but honor our traditions, and incorporate medical imagery too.

We worked with a Southern California advertising agency to come up with new designs to present to the Board of Directors. We considered several options: some more traditional, others more abstract. We looked at color palettes and fonts. Last, we considered many choices of taglines to express in just a few words what we want people to remember about anesthesiologists.

Realizing that we would never reach 100 percent consensus, we ultimately decided on an updated version of a traditional circular seal. We also developed a tagline—something the CSA did not have before—which we hope will resonate with anesthesiologists and members of the medical community as well as the public.

Over the coming months, you’ll see the logo and tagline unveiled and rolled out on letterheads, the Bulletin, the website—wherever the CSA name appears. We’ll keep you in the loop at every step as our public relations campaign continues to develop, and look forward to hearing your ideas for future initiatives.
What Can You Do to Help Your Colleagues in the Absence of the Diversion Program?

By Jeffrey Uppington, MBBS, F.R.C.A., Director District 8, Chair CSA Physician Health and Well-Being Committee, and Leinani Aiono-Le Tagaloa, M.D.

Case Presentation

He had been the chief resident, and a good one. An excellent clinician, he was always stepping up to fill in for colleagues, doing extra call, seemingly always in the operating room. So it was natural to offer him a job on the faculty, even though toward the end of his residency he seemed more excited and excitable than usual. Soon after he joined the faculty, his behavior became odder—leaving the operating room frequently, and generally not being “his usual self”—but everyone cut him a lot of slack because, after all, he was a good guy. Finding him unconscious in the bathroom with a syringe of fentanyl in his arm was a shock. Fortunately, he recovered physically from this event, then went on to enter the Physician Diversion Program of the Medical Board of California (MBC), and is practicing to this day.

How Would He Be Managed Today?

Each one of us has heard some variation of this story; it is well known that doctors have an increased tendency to abuse both drugs and alcohol. More importantly, anesthesiologists who are affected by drug and alcohol addiction have four times the prevalence of other specialties—4 percent compared to 1 percent. Our colleagues with these and other problems need our help in treatment, and then effective and safe reentry into the workplace with sufficient steps and monitors in place to assure patient safety. In past years, the MBC’s Physician Diversion Program monitored the well-being of impaired physicians and ensured their continued safety to practice. However, this all fell apart in 2007 when the Diversion Program was closed without any provision for a substitute.

Drs. Lee Snook and Tom Specht, in a previous CSA Bulletin (Volume 60, Number 2—Spring/Summer 2011), described what has happened in California since the state legislature closed the Diversion Program. They also outlined the work of the California Medical Association (CMA) in laying the groundwork for California Public Protection and Physician Health, Inc. (CPPPH), an entity that would assist physicians who have diseases of addiction—or mental health issues—that prevent them from working in an unimpaired condition. Our colleagues with these and other problems need our help in getting treatment,
and then effective and safe reintroduction into the workplace while assuring patient safety. In order for CPPPH to come into being, legislation is needed to secure funding from physician licensing fees. Unfortunately two attempts to establish and fund this substitute entity for the former diversion program have failed, but a third, SB 742 (Lee), sits, for now, as a placeholder. Meanwhile, our colleagues have no generally available resource.

The Well-Being Committee at UCD Medical Center

The remainder of this article describes what one hospital Physician Well-Being Committee, at the University of California, Davis (UCD), Medical Center, has done to fill the existing void. This is not the only such Well-Being Committee (WBC) to have done so, and there likely are other effective programs about which we personally do not know. The purpose of the Davis committee, on which the authors of this article serve, is to lay a framework upon which other committees can build. Anesthesiologists can and should take a lead on these committees, which every hospital must have for accreditation purposes, if only because our specialty is disproportionately affected by addiction.

For the past several years, our WBC has managed a number of impaired physicians' treatment and reentry into the workplace. The committee has based this aspect of its work on the WBC of the University of California, San Diego (UCSD). In this article, we will describe how the UCD committee is composed, how it works, and how it manages impaired physicians. Elements of this committee’s functions could serve as a model for other institutions.

The UCD committee is made up of a broad range of members of the medical staff, many of whom expressed or demonstrated interest in the committee before appointment. They are appointed by the Chief of Staff (COS). The Chair is a psychiatrist and the Vice Chair is a psychologist—a skill set that is extremely important to the functioning of the committee. Psychologists may not be part of the medical staff in other institutions, but as we will show, a Chair or Vice Chair with psychiatric and/or psychological skills is important.

The committee has set itself two main goals. One is to maintain the health of the medical staff, thereby ensuring quality patient care. The other is to monitor the health of the medical staff members who have had a psychiatric or substance-related problem of sufficient severity that patient care has been or could be potentially at risk. During the demise of the Diversion Program, it was stated that 10 percent of physicians are expected to have some kind of psychiatric or substance abuse problem. This supposed statistic was bandied about, allegedly demonstrating a failure of the Diversion Program because there were only some hundreds in diversion, rather than the thousands that
the statistic indicated should be the case. We disagree with this statistic as it does not conform to our experience: it has never been our experience that 10 percent of our colleagues are impaired. However, while the 10 percent is a recognized statistic in psychiatric circles, it is over the person’s lifetime. It has also been stated that only about 1 percent of these physicians would have problems of a severity that could potentially endanger patient care (Peter Yellowlees, Chair UCDMC Well-Being Committee, personal communication). This we do believe is closer to the truth.

Referrals to the WBC come from department chairs and training directors for residents, or result from a report of some acute incident involving a physician. The Chief Medical Officer (CMO) or COS may also request a referral. At our medical center, there can be as many as two or three referrals a day on an unusual day. We have about 1,200 faculty and 700 residents in the health care system. Our referrals have so far always been made by a third person—the chair of the department or another senior member of the department—about physicians who have either been determined to be impaired or suspected of being impaired. They are evaluated by the Chair or Vice-Chair of the committee. The evaluation consists of a broad psychiatric evaluation, but no notes are kept, and the consultation remains confidential. However—and the physician in question is informed of this up front—confidentiality may be breached either for the person’s safety or for the safety of patients. Most of the referred are judged not to be impaired or to pose no safety risk.

If our Chair thinks that the person needs hospitalization, for either chemical dependency or mental illness, then he makes this referral, and also communicates this information to the involved physician’s primary care physician (if one exists) and spouse or other family members. If chemical dependency is at issue, referral is to a hospital that is able to make an inpatient assessment (e.g., Betty Ford Center). Note that this all is voluntary. If the physician refuses, and if there is judged to be a patient safety issue, then the CMO or COS is informed. Outpatient therapy is a possibility for a psychiatric problem. Meanwhile the physician involved is removed from clinical service. The physician in question is made aware that cooperation with the process is his/her best way to ultimately maintain their medical license and career. If they are impaired and do not avail themselves of therapy and monitoring, then there is no choice but to refer to the Medical Staff Executive Committee for possible punitive action, and to refer to the MBC if such action is deemed appropriate.

The determination is also made as to whether monitoring is needed after discharge from inpatient care. Generally, if the case is severe enough to require admission to a facility, then monitoring is obligatory. Monitoring contracts have to be agreed to and signed and follow that which is recommended by the
Federation of State Medical Boards (FSMB), in force since April 2011 (http://www.fsmb.org/pdf/grpol_policy-on-physician-impairment.pdf). This policy does have a number of statements that fly in the face of the unfortunate direction in which California has moved, such as “through a formalized contract, each state medical board should have available to it a Physician Health Program [PHP] that meets the standards set by this document and the FSMB-PHP guidelines” and “it is recommended that boards have a non-disciplinary process for referral to PHP to encourage early detection and intervention.” Hopefully the proposed CPPPH program can one day function in the role of a PHP.

The monitoring program for the chemically dependent physician includes regular psychiatric appointments, a workplace monitor, random urine screens, and regular meetings with Alcoholics Anonymous or Narcotics Anonymous. We use the Pacific Assistance Group for support and monitoring services, but other services are available. There is a regular (at least quarterly) report from either Pacific Assistance Group or the treating psychiatrist to the Chair of the WBC, who makes confidential reports to the committee every six months, or more frequently as the need arises.

A full review for people with substance abuse occurs at three years, but it would be an exceptional person who was not monitored for five years. Physicians with mental health issues are monitored until their psychiatrist feels they are fit to return to work.

At the moment we are monitoring five out of 1,200 medical staff. Four others who have been monitored either have left the institution or have done well and are no longer monitored. We have not reached the expected 1 percent, however, so we have been looking at other pathways for referral to our WBC. We have instituted new medical staff policies that require all physicians who have a “driving under the influence” (DUI) citation to be referred to the committee. Since this policy began, we have seen a few referrals, largely residents driving home from a party. All have been assessed to not have a chemical dependency, but rather, poor judgment. All DUIs as a routine are forwarded to the MBC, which makes its own recommendations.

We are attempting to improve self-referrals. To do so the committee, through its education subcommittee, has developed a well-being website, has an education outreach, and meets with faculty and residents at Grand Rounds, faculty meetings and other venues. The website has links to examples of self-assessments for mental illness, substance abuse and burnout. The committee is discussing implementing a routine voluntary screening of medical staff for these maladies. This has already been implemented at UCSD. It consists of an on-line screening tool and requires a part-time psychiatric social worker or
person with comparable skills. Through the screening tool, a member of the medical staff can confidentially and anonymously e-mail with questions and comments, and hopefully—this is the experience at UCSD—some medical staff will then feel confident enough to self-refer to the committee.

Even if every hospital did achieve success, this would still leave many of our colleagues who do not practice in a hospital setting on their own. Thus the CPPPH is the hope for all physicians in the state in regard to support and monitoring of mental health and substance abuse problems, and we should actively support their efforts.

Our motto as physicians is *Primum Non Nocere*—first do no harm. As we strive to live that ethic for our patients, as is prominent in the ASA Guidelines for the Ethical Practice of Anesthesiology, we also have the ethical responsibility to help each other.

We are available for advice if necessary. We are also aware that each institution has its own medical staff culture and variable support from the hospital’s medical staff office. However, an approach such as we have outlined not only protects the physicians, but equally protects patients from harm. Such improvement in patient safety and the resulting reduction in medicolegal risk should be something every hospital should support.
Book Reviews

C-Section: How to Avoid, Prepare for and Recover from your Cesarean by Mark Zakowski, M.D.

By Stephen Jackson, M.D.

The C-section rate has increased 50 percent this past decade to over 32 percent nationally, becoming one of the most commonly performed surgeries—an estimated 1.2 million annually in the United States. Many women fear having a cesarean, while on the other hand, as many as 6 to 8 percent choose to have a non-medically indicated elective C-section. In his easily readable and engaging book C-Section: How to Avoid, Prepare for and Recover from your Cesarean (Quantum Birthing, 2010; available as printed book or for Kindle on Amazon.com), Mark Zakowski, M.D., provides pregnant women and their partners with an informative, comprehensive, insightful, and patient-friendly resource and guide on the topic of cesarean deliveries. Dr. Zakowski, a longtime associate editor and contributor of educational articles on obstetric anesthesia for this Bulletin, provides patients with information ranging from becoming more knowledgeable about the factors that influence the decision to perform a cesarean, to what a pregnant woman can do in preparation for a cesarean, and on to tips on enhancing the postoperative recovery period. Obstetricians and anesthesiologists might find this book worthy of recommendation to their patients in order for them to become better prepared for the entire cesarean experience.

In this book, women are educated in how to reduce fear and anxiety while awaiting their cesarean; learning the right questions to ask of all their physicians; picking the safest place to deliver; and improving the likelihood of a faster and otherwise uneventful recovery. There is valuable and beneficial material for women who know they want a cesarean as well as for those who plan on having a vaginal delivery. There even is information on how the “labor partner/coach” can help improve the total experience, such as what that individual, as well as the parturient, should expect in the operating room. The book also explains the risks of induced labor, the applicable jargon (e.g., TOLAC—trial of labor after cesarean), and the medical indications for a cesarean. In essence, Dr. Zakowski, the Chief of Obstetric Anesthesiology for two decades at nationally recognized hospitals in New York and California, assists the consumer to make a more informed decision before, while, and after giving birth.
Importantly for anesthesiologists, information here on proper preanesthetic fasting status, the risks and benefits of receiving a regional or general anesthetic, proper positioning for an epidural or spinal, and other practical points regarding anesthesia can make C-sections less stressful, and more enjoyable, for both the obstetric patient and the anesthesiologist.

Your Medical Mind: How to Decide What Is Right for You by Jerome Groopman, M.D., and Pamela Hartzband, M.D.

By Andrew G. Kadar, M.D.

Advised to take statin medication, a 51-year-old woman with a total cholesterol of 240, an HDL of only 37, hesitates. She checks a Department of Health and Human Services website and discovers that her estimated 10-year heart attack risk without treatment is 1 percent. Taking a statin reduces that by one third. Knowing that her father also had high cholesterol and lived a long healthy life and having met someone who suffered debilitating muscle aches after taking statins, the woman decides to refuse treatment.


Because medicine is not an exact science, “the assessment of whether the benefit is great enough to warrant the risk of harm—i.e., the decision for where the threshold for intervention should lie—is necessarily a value judgment.” To arrive at the best course of action for any given patient, the authors argue that we need to consider that individual’s attitudes about health and medicine.

The most appropriate intervention for someone who believes in natural treatments may not be right for a person who prefers high-tech medicine. The authors also classify people as “believers” and “doubters,” those who feel there is a best answer for a given health problem and those who tend to be skeptical about any prescribed solution.
Of course, many people fit somewhere along the continuum between these extremes and can move along the scale over time and changing situations. Groopman uses himself as an example of this. A failed spine surgery turned him from a maximalist to a more risk-averse consumer of health care. When faced with treatment for his own elevated cholesterol, he negotiated with his physician to start with half the recommended statin dose and was gratified to see his total cholesterol drop from around 240 to 160 on the lower amount of medication.

The authors propose that physicians should practice not just “evidence-based” but also “judgment-based” medicine—that is, to give consideration not only to all available scientific data, but also to how it applies to any individual patient. This would incorporate factoring in the patient’s attitudes about medical care.

Groopman, a staff writer for The New Yorker and an oncologist, previously wrote a book called How Doctors Think. This time, Hartzband, his endocrinologist wife, joins him to present the flip side of the story, which could have just as well been entitled How Patients Think and Why That Matters. This easy-to-read, engaging and insightful book can illuminate how we think about our own health as well as that of our patients. As informative as it is for the lay reader, Your Medical Mind is even more valuable for physicians.

MARK TWAIN’S WIT AND WISDOM

Virtue has never been as respected as money.

It’s so hard to find politicians of such high morals that they will stay bought.

When I was a boy of 14, my father was so ignorant I could hardly stand to have the old man around. But when I got to be 21, I was astonished at how much he had learned in seven years.

An honest man in politics shines more than he would elsewhere.

The radical of one century is the conservative of the next. The radical invents the views. When he has has worn them out, the conservative adopts them.
California and National News

Aetna Lawsuit Points to Surgery Center Out-of-Network Gaming and Kickbacks An ambulatory surgery center management company, Bay Area Surgical Management, LLC (BASM), has been sued by Aetna Life Insurance Company for what Aetna alleges is a fraudulent scheme. BASM supposedly attracts referrals by offering illegal kickbacks to its surgeon-owners. BASM recruits owner-surgeons who are “in-network” for insurance plans (such as Aetna) to “self-refer” their insured patients to have surgery performed at one of BASM’s “out-of-network” surgery centers. BASM sets its own surgery center facility fees and bills Aetna (and other insurance companies with generous out-of-network benefits) exceedingly high sums. While patients normally would be deterred from undergoing surgery at a BASM center because their co-pay would be extraordinarily high, BASM allegedly has taken patients’ reactions to having to pay that exceptionally large co-pay out of the equation. How? Aetna alleges BASM’s patients are assured that they do not have to ante up what would be those (huge) co-payments or deductibles related to the inflated billings. BASM’s routine waiver of patient co-payments allegedly is concealed from the insurance carriers. These unfettered billings yield meteorically high profits, of which BASM supposedly keeps 25 percent and distributes the remainder to the surgeon-owners of the surgery center. The self-referring physicians’ return on their apparent well-below-market investment dwarfs the most lucrative arm’s-length return from otherwise seemingly legitimately operated ambulatory surgery centers. In fact, the return from the center that induces the patient referral is typically higher than the separately paid professional fees (which the surgeons collect as well). Aetna posits that the physicians’ annual return on capital, supposedly typically 200 to 1,200 percent, constitutes kickbacks (unlawful self-referral for apparent excessive compensation). Safeguarding patients from kickback-motivated self-referrals prevents the harmful consequences of medical/surgical decisions that primarily are motivated by the financial interests of physicians and other entities. The Medical Board of California and other interested state (and even federal) parties may well decide to investigate such schemes that appear to constitute fraudulent and unethical behavior. Moreover, with the egregious billings, ultimately the affordability of health care is being jeopardized and the ethical principle of social/distributive justice is being violated. What is clear is that the scheme outlined above is a strong inducement to ethical corruption of a community of physicians. On the other hand, the business practices of health insurance carriers, in particular the excessive profits that they extract from health insurance premiums, divert money from the care of patients to the pockets of executives and shareholders, and thus similarly pervert justice.

Marketing Back Surgery and Its Profits  Tri-City Regional Medical Center, a nonprofit hospital in Hawaiian Gardens, Calif., has become a center for back surgery performed on workers’ compensation patients. The center’s spinal fusion business has jumped from $3 million to $65 million in one year. Much of this economic benefit accrued from the hire of a richly rewarded ($3.2 million over three years) non-physician marketer/consultant to recruit surgeons to operate in the hospital. That individual also supplied spinal implants through distributorships he owned, inflating the costs of the spinal hardware two- to 10-fold. He may have used some of these profits for what is alleged by some to constitute kickback monies to referring chiropractors and surgeons who brought their workers’ comp back surgeries to Tri-City.

Across the nation, there has been a remarkable upward trend in the total amount of money spent for back surgery. California employers paid $7 billion in insurance premiums for workers’ comp in 2010, and spinal fusion surgery accounted for 40 percent of inpatient hospital charges. In addition to a previous racketeering conviction for which the marketer had spent 21 months in jail, he also established a business association with another entrepreneur (who, likewise, benefitted through a similar process of hardware distributorships and surgeon/patient recruitment) at Pacific Hospital in Long Beach. In fact, in the first decade of this century there were over 5,000 of these procedures performed at Pacific, the total billings exceeding by threefold those of any other hospital in California! Our state’s Workers’ Compensation Division permits hospitals to bill separately for spinal implants—that is, not including the cost of such in the overall surgery charges, the rule for Medicare and Medicaid. That separate billing policy elicited an additional cost of $55 million in 2008! Incredibly, the division doesn’t limit the amount of markup for distributors, although it does restrict a hospital’s markup.

Adapted from an article in The Wall Street Journal by John Carreyrou, Tom McGinty and Joel Millman, Feb. 9, 2012.

Medicare Scam Tops All Records  Federal agents arrested a Dallas-area physician—with the able assistance of his office manager and Texas home health care agencies—for the largest ever scheme of a single physician in conspiring to defraud Medicare/Medicaid ($375 million). Dr. Jacques Roy and others allegedly billed “asleep-at-the-wheel” Medicare for services that were unnecessary or not even provided! All busy Dr. Roy did was approve 500 times as many patients (5,000 vs. 100) as the average physician for home health care services. This nimble physician, himself, certified more Medicare patients than any other medical U.S. practice!

Jeffrey Young, Huffington Post, April 4, 2012.
Spine Surgeons Take Double Cut by Implanting Their Own Devices  A growing number of spine surgeons now use hardware from medical device companies they own rather than implants from third-party manufacturers. This conflict of interest can constitute an incentive to operate more frequently and even unnecessarily. In 2008, spinal fusions become the 16th most common inpatient operation in the U.S., jumping up from 37th in 1998, and now account for an over $10 billion industry. A federal anti-kickback law prohibits hardware producers from paying surgeons to use their products, but those companies have skirted this by entering into partnerships with the spine surgeons, paying them consulting fees and royalties for help in designing the devices. In some cases, those surgeons would use the company’s device exclusively and then author favorable research. But now there is an avalanche of surgeons establishing their own companies and making and using their own hardware. The FDA has a less stringent approval process for medical devices that approximate those already approved. Surgeons simply have to submit mechanical testing data attesting to their hardware as being “substantially equivalent” to existing devices, and FDA approval usually is obtained within 90 days. But spine surgeons don’t hold a monopoly on this conflict of interest: orthopedic surgeons have their hip and knee replacement hardware, and cardiologists and cardiac surgeons their devices.


Aetna Takes It “in the Ear”—and Doesn’t Like It  In another insurance scam, two Houston physicians self-referred their in-network (participating physician) insured patients to their own out-of-network (non-participating facility) Humble Surgical Hospital in order to charge what might be considered to be humiliating fees, including a bill for almost $100,000 for the removal of ear wax! The patients allegedly were comforted by being informed that they would not suffer from the huge co-pays or deductibles that would result from the vastly inflated out-of-network facility fees. It appears that California and Texas are vying to be top-ranked in medical insurance scams.


Health Insurance Costs Escalate, Wages Unchanged  From 2003 to 2010, the average cost of health coverage for California families and their employers increased 52 percent, to $13,819 annually. During that period, family income rose only 4 percent. Employers wrestle with this burden and continue to pay the major part of those costs, but more frequently they are making employees contribute a larger share in the form of new co-payments, higher deductibles, and cutbacks in health care benefits. In negotiations, unions have tended to forgo wage raises in favor of lowering employees’ share of cost for health coverage. However, the cost to the average working family for its
portion of health premiums increased 68 percent, from $2,282 to $3,845, over those seven years. The public experiences premium increases, but justification is largely not provided, and regulators need more power to restrict rate hikes. This is particularly critical in light of the federal PPACA requirement of proof of health insurance by 2014. The insurers claim that higher premiums reflect higher costs of medical care incurred by new technology, higher drug costs, an enlarging aged population with chronic illnesses, unfettered end-of-life costs, and an unbridled utilization of available services.

Commonwealthfund.com (Nov. 21, 2011) and Sandy Kleffman, San Jose Mercury News.

California Middle Class Declines as Gap Between Poor and Rich Enlarges Less than half of California’s families can be classified as middle class (income $44,000 to $155,000). Thirty years ago over 60 percent of families qualified for the middle income bracket. Until 2006, there actually was a net economic improvement, the number of families moving into the upper class outnumbering those that fell into the lower class. However, while the hard-hit economy reduced the economic standing of most families, the lower classes were most adversely affected: their income decreased by 21 percent while the upper class dropped by only 5 percent. For decades, the nation has witnessed the widening income gap, but California’s income divide continues to surpass that of most other states. Education, rather than race or income, was the largest determinant in how people have been able to cope with the economic downturn. Matt O’Brien, San Jose Mercury News, Dec. 8, 2011.

California Continues to Lack Control Over Insurance Industry Rate Hikes Although on Jan. 1, 2011, California regulators at the Department of Managed Health Care (DMHC) were given expanded authority to scrutinize health insurance rate hikes and to require documentation justifying these raises, they continue to be void of any enforcement powers. The new law (SB 1163) permitted state regulators to determine that a rate hike was excessive, but persuasion, cajoling or public shaming were the only armamentarium available to counter such hikes—and they have proven largely ineffective. The Department of Insurance has been somewhat effective in blunting rate hikes in 17 percent of 300 cases it reviewed in 2011. The DMHC was successful in negotiating several reductions with Health Net and Kaiser, but Anthem Blue Cross flatly refused to budge with its huge premium increases. Further legislative efforts, such as AB 52 (Feuer), have run into stiff lobbying opposition.

Adapted from article by Sandy Kleffman, San Jose Mercury News, Jan. 15, 2012.
CMA Requests Amendments to Medical Liability Reform
The CMA has sent a letter to the U.S. House of Representatives leadership that opposes H.R. 5. This bill does support aspects of medical liability reform, and in addition, it also favors repeal of the Independent Payment Advisory Board (IPAB), which CMA strongly favors. This apparent confusion regarding the CMA’s stance is explained by the fact that the CMA has “serious concerns with two additional medical liability provisions in H.R. 5 that will expose California physicians to even greater liability despite the bill’s stated legislative intent to reduce health care costs and [medical malpractice] insurance premiums.” The two provisions of major concern include 1) the fair share rule; and 2) no punitive damages for medical products and devices that comply with FDA standards. The fair share rule would preempt California’s joint and several liability law and would “dramatically increase the potential for physicians to face enforcement proceedings against their personal assets.” The law would make it necessary for physicians to purchase “increased medical professional liability insurance coverage,” and would increase physician liability premiums in California. The CMA requested two amendments to the law that would recognize state laws already in place, including “any state law that governs the allocation or recovery of damages among tort feasors.” In the second instance, the letter also expressed concerns with granting complete immunity from punitive damages to medical product and device manufacturers, distributors, and suppliers, but not physicians. CMA is seeking to fix the distressing provisions so that it can support the other favorable parts of the bill.

CSA Needs Your Home Address and Your Zip+4!
If you have not given us your home address, please update your information online at www.csahq.org under Membership/Member Profile Update, or call the CSA office at 650-345-3020. The CSA database offers the CSA the ability to give members contact information for their legislators. Since legislative districts are determined by home address, your zip+4 is essential to provide you with this information.

Spring 2012 111
Memories of a Former Patient

By Danielle Reicher, M.D.

I had a mask induction when I was 4 years old. That personal experience is why I was somewhat surprised at the confident reply by one of my anesthesiologist colleagues to a surgeon’s inquiry as to whether a 4-year-old surgical patient would remember a mask induction. My associate seemed fairly convinced that ultimately there would be little or no memory of the event. I smiled to myself as I heard this answer, and it got me thinking about my hospitalization many years ago as a child in 1960.

As was commonplace in those days, I had been admitted to the hospital the night before a diagnostic cystoscopy. I did not enjoy my welcome to the hospital, which began with blood tests. Before my blood was taken, I asked from where they would take the sample because, on a previous traumatic occasion, blood had been drawn from my earlobe. No answer was given to me, but in anticipation that my question meant that I would resist efforts to obtain my blood, a team was summoned to hold me down. They did this with such brute force that I barely felt the needle enter my antecubital vein, which, by the way, I did not fear at all.

I do not recall having received a premedication injection. A feeling of fear and panic overwhelmed me that morning as I was wheeled to the operating area. The next and most vivid memory was my receiving a mask induction for anesthesia, the smothering feeling of a mask held tightly on my face and breathing an unpleasant inhaled anesthetic. I believe that I kicked my anesthesiologist in the face! Then I remember waking up and feeling dizzy, strange and confused.

Later that day, I began to feel so much better. I was able to eat and walk around the ward. The sights that I saw while ambulating about—such as the tiny babies in the nursery—left further permanent memories. Down the hall from me, looking like a fragile porcelain doll, was a 12-year-old whisper of a girl who, I learned, had congenital heart disease and a primitive external pacemaker. She looked so weak, pale and alone. I am certain that these early experiences ultimately played an influence in my choosing to enter the medical profession and, perhaps, even to choose anesthesiology. Indeed, the powerlessness that I felt changed me forever.

All these years later, I am still not a fan of the mask induction yet I know children fear needles as well. Hopefully, anesthetic experiences nowadays are less traumatic with the use of oral premedications to allay anxiety, provide some element of amnesia, and facilitate a smooth inhalation induction (or even the insertion of an intravenous access). Although that mask induction may, in part, have led me to medicine as a career, one thing is certain: The experience was unforgettable.