Georgia Society of Anesthesiologists, Inc. Newsletter

scope

Spring 2009

100% Participation Possible!

Matthew Klopman, M.D., Chief Resident, Dept. of Anesthesiology, Emory University School of Medicine

After attending the 2008 ASA Legislative Conference and witnessing the fruits of our labor in the form of sweeping Medicare reform that included a fix to the onerous Anesthesiology Teaching Rule, I returned to Emory determined to educate my fellow residents about the excellent work that the ASAPAC does on our behalf every day. After an information session and e-mail detailing ASAPAC's work, we began fundraising in November (just after the start of the new ASAPAC fiscal year) with the goal of 100% resident participation. Five weeks later we mailed our last batch of ASAPAC donations and achieved our goal: All 47 of our residents contributed at least $20 and many donated more.

Many of you may ask how we were able to convince all 47 residents to contribute without employing the threat of medieval torture. By investing a small amount of time and a little effort it turned out to be surprisingly simple.

While at the ASA Legislative Conference, I learned that lobbying by the ASAPAC means educating the legislators about the medical practice of anesthesiologists. Without ASAPAC's lobbying efforts over many years, likely none of the 2008 Medicare reforms would have been enacted. Instead of a small increase in payment to anesthesiologists, there would have been a significant decrease. The fix to the Anesthesiology Teaching Rule means more resources available for academic departments to train future colleagues.

These issues impact all anesthesiologists, including current residents who are the future of the specialty. Providing this pertinent information helped the residents understand the value of making a contribution. The only hurdle was making it convenient for residents. At four successive weekly grand rounds meetings application forms were available and residents who had not yet contributed were reminded about our commitment. We were able to

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PM Conference Applauded

Thomas Gallen, M.D., Resident PGY-2, Dept. of Anesthesiology, Medical College of Georgia

As I progress through residency at Medical College of Georgia I have learned that Anesthesiology is not as simple as it seems. In broad terms I have concluded that the field of Anesthesiology rests on four basic pillars: Clinical practice, Research, Politics and Business. As a resident the majority of my training focuses primarily on clinical practice and research. We are exposed to the politics related to our field since it pervades our lives given the present political climate and the successful activism of the ASA and the ASAPAC. Sadly the business aspect of the practice of medicine is learned largely after residency through trial, error and guidance by our peers. Despite its influence on our lives it is not covered in the systematic and rigorous way that clinical practice is.

It is for this reason that I opted to participate in and learn from the most recent Conference on Practice Management in warm and beautiful Phoenix, Arizona.

For the first time this well-attended conference also included a resident track which focused on topics ranging from evaluating a prospective practice to negotiating with your hospital or group to evaluating a billing company. These talks were invaluable to me in gaining an appreciation for some of the basics of the business of anesthesia including how anesthesia is billed and why proper documentation and precise coding are so critical.

I applaud the ASA and the conference organizers for including residents and the Foundation for Anesthesia Education and Research (FAER) for funding 20 (and 50 next year!) residents to attend. By my count there were 40 or more residents in attendance, which speaks to the insight and curiosity we have regarding this pillar of our practice.

The main conference was also well attended by practicing anesthesiologists both in registration and attendance even with the ample availability of golf courses. I attended

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Spring 2009

From the President

Bruce Hines, M.D., President

Under the leadership of Immediate Past President Dr. Howard Odom we embraced the concept of "continuum of leadership" for the administration of our Society. It was his vision to formalize many of the traditions and customs that have allowed this great organization to thrive. He reduced to writing many of the policies, procedures and processes of our Society and guided the members of the Executive Committee and Board of Directors through the formal process of adopting these governance documents. The "continuum of leadership" championed by Dr. Odom will serve our Society for many years. Accordingly, as President this year, I will work to continue to enhance the benefits of membership in our Society through successful implementation of our new policies and procedures.

As your President, I will work with President-Elect Dr. Rickard Hawkins and other officers to continue to build on Howard's hard work for the further benefit of our organization, its members and our patients. During the course of the year, you will note some communication upgrades which are designed to make relevant information more readily available to members.

Certainly, by now you have noted a stark change in the Newsletter, with not only visual enhancement but content amplification as well. Congratulations to Dr. Kathy Stack and all who have contributed to the building of this communication resource.

I look forward to serving you this year and would appreciate your feedback.

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Inside this Issue

Kathryn Stack, M.D.

I hope you are all well as spring has settled in. The 2009 annual Winter Meeting, "From OR to ICU: Critical Issues in Anesthesiology", was held at Stone Mountain's Legacy Lodge and Conference Center on January 31, 2009. Activity Director Dr. Cinnamon Sullivan assembled an impressive selection of speakers. Attendees were treated to an outstanding array of presentations highlighting resident and fellow research in Georgia's two anesthesiology training programs, as well as lectures discussing many aspects of caring for the critically ill. The speakers' topics included echocardiography, transfusion practices and blood management, ethical decision-making in the OR and ICU, and advances in organ transplantation. An update on medico-legal issues to be debated on the state and federal level raised more than a few eyebrows in the audience. Up to 8 CME credits were available for this one day meeting.

Plan to attend the summer meeting, "Emerging Roads in Anesthesia: Reaching Beyond the OR", July 31 – August 2, 2009 on St. Simons Island at The King & Prince Beach and Golf Resort. Activity Director, Dr. Mary Arthur, has a great selection of speakers lined up, including ASA President-elect, Dr. Alex Hannenburg, who will present an ASA update.

Congratulations to Dr. Steve Sween on his election to the position of Vice Speaker of the ASA House of Delegates. We know Dr. Sween will continue to be an effective leader within the ASA; and the GSA is fortunate to have another great advocate on the national level. Dr. Peggy Duke has assumed the responsibilities of the ASA Director for the GSA. Look for her Director's report, as there are many issues on the table.

Resident interest in the GSA and resident activity within the society has grown at a fantastic rate. Dozens of anesthesiology residents at Emory University and Medical College of Georgia are represented by the Resident Component of the GSA. With the support of Committee of Academic Anesthesia co-chairs, Dr. Tom Philpot (Emory) and Dr. Audrey Alleyne (MCG), the Resident Component of the GSA continues to grow in terms of membership, support, and activity within the society. In response to this growth and interest, each edition of the GSA *Newsletter* will include an article (see front page) authored by a resident member. I hope these articles keep our general membership informed of the activities and perspectives of our resident members.

While the spring brings warmer air, longer and sunnier days, and imminent family vacations, there remains a gray cloud of uncertainty over the pace of our nation's economic rebound and impending debate over healthcare reform. All of us have, in some way, been affected by the economic down-turn, and we wait pensively to hear details from the Administration and Legislature about healthcare reform. This summer and fall promise to be a very interesting time as national healthcare reform may be in the forefront of issues to be addressed and debated. Stay tuned, stay informed, and stay involved.

I encourage GSA members to submit thoughts, opinions, and feedback on current issues to the Newsletter. The "Letter to the Editor" section provides an effective forum for GSA members to engage in ongoing discussions regarding issues that are important and relevant to you. Submit LTEs to kstack@emory.edu. LTEs will be published in subsequent editions, space permitting.

Letters to the Editor

Editor Kathy Stack seeks input from GSA members and spouses on a broad range of topics. Comment may be submitted to kstack@emory.edu. Please limit submissions to 200 words and include your name, email address and city of your practice or residence.

Examples of comment/response may cover topics as diverse as the following:

- Current newsletter articles
- Contemporary issues impacting patient safety
- Cutting edge public policy questions
- Practice management challenges
- Trends in medical practice
- Suggestions for future articles/themes
- Recommendations for annual meeting locations
- Topics for future CME conferences

Patient DUI: New Hazard for Docs

Palak Turakhia, M.D., Resident, Emory University School of Medicine - Department of Anesthesiology
Michael Byas-Smith, M.D., Associate Professor, Emory University School of Medicine - Department of Anesthesiology

Patient's legal access to drugs that can adversely affect their performance while driving an automobile has reached unprecedented levels in the state of Georgia and the nation. Data that accurately describe the impact of this phenomenon on public safety is difficult to unearth but the physician liability index in this matter is palpable. This brief article evaluates two sobering state Supreme Court decisions that ruled in favor of plaintiffs litigating suits against well-intentioned practitioners. Take note that the plaintiff was a third party, not the doctor's patient. The injury or death of persons involved in these cases was the result of a motor vehicle incident that was presumed to be caused by a patient's DUI.

GSA member Dr. Byas-Smith testifies at a 2007 State House study committee on pain management.

Case #1. Coombes v. Florio, (Massachusetts 2007),

Supreme Judicial Court of Massachusetts gave an answer to the question of whether physicians have a responsibility to individuals put at risk by their patients in the course of treatment. Lyn-Ann Coombes sued Dr. Roland Florio for negligence when her son Kevin was killed by Dr. Florio's patient in an automobile accident.

Ruling: A Massachusetts trial court granted summary judgment in favor of Dr. Florio finding that he "owed no duty of care to anyone other than his own patient." Ms. Coombes appealed, and the case was heard by the Supreme Judicial Court of Massachusetts. In a 4-2 decision, the court reversed and remanded the trial court decision for summary judgment for further proceedings.

Majority Opinion: Dr. Florio owed a duty of reasonable care to Kevin Coombes under ordinary negligence principles instead of malpractice. In support, they referred to several nonmedical and medical cases in which parties were held liable for foreseeable consequences caused by the conduct of an intermediary. For example, a liquor store was found negligent for selling alcohol to a minor who later injured a bicyclist. A doctor was held liable for a person's death in an automobile accident caused by his patient who was prescribed an eye patch for the treatment of an eye abrasion. In this case, the court ruled that "the general requirement [is] that when a doctor knows, or reasonably should know that his patient's ability to drive has been affected, he has a duty to the driving public as well as to the patient to warn his patient of that fact."

Dissenting Position: By extending a duty of reasonable care to third parties such as Kevin Coombes, physicians would no longer be able to use professional judgment because they would be bogged down by discussing every possible adverse side effect of treatment. Instead of being concerned about patients, they would be forced to deal with "an amorphous, but widespread, group of third parties whom a jury might one day determine to be 'foreseeable' plaintiffs". Furthermore, one cannot compare a physician's professional judgment with the unreasonably dangerous situations of a bar selling alcohol to a minor or a homeowner's failure to store a weapon properly. The justices also argued that by extending this duty, confidentiality would be threatened by third parties demanding to know what is discussed between doctors and their patients. Finally, they feared that it would dramatically increase already high health care costs by inviting a flood of litigation.

Case #2. Carole McKenzie, vs. Hawaii Permanente Medical Group, Inc. (Hawaii, 2002)

The supreme court of Hawaii gave opinion on whether [Dr.]Robert Washecka was negligent in regards to an incident in which plaintiff Kathryn McKenzie, a pedestrian, was seriously injured when she was struck by an automobile driven by patient Wilson. The McKenzies and Wilson (Dr. Washeka's patient) claim that the accident was caused by a fainting episode precipitated by the negligent prescription of medication to Wilson by Robert Washecka, M.D., an employee of Kaiser. The district court certified the following question to this court pursuant to Hawaii Rules of Appellate Procedure (HRAP) Rule 13 (2000)2:

Does a physician owe a legal duty which would create a cause of action legally recognizable in the courts of Hawaii for personal injury of a third party who was injured in an

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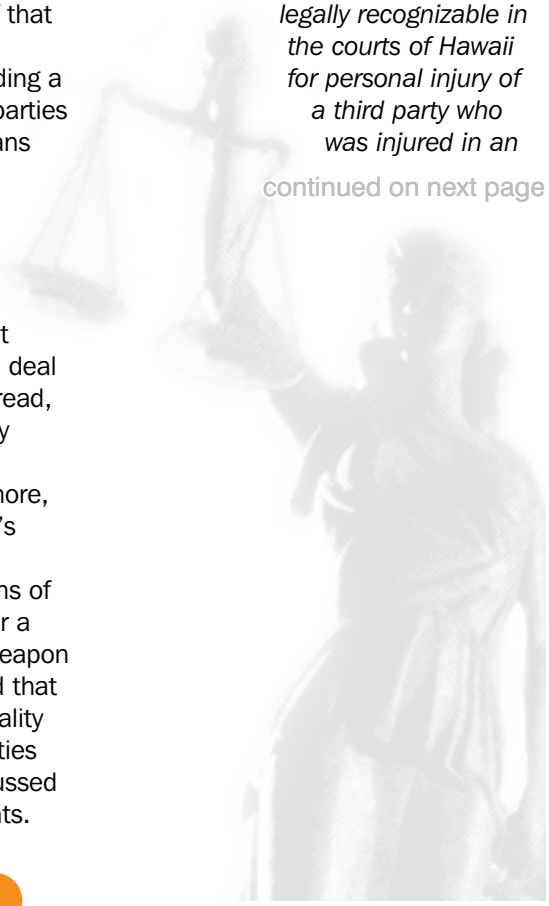

accident caused by his or her patient's adverse reaction to a medication that the physician negligently prescribed?

Kaiser essentially argued that it owes no duty to the McKenzies because they are not patients of Dr. Washecka and that physicians do not owe a duty to non-patient third-parties. Dr. Washecka does not have a "special relationship" with Wilson mandating that Dr. Washecka control Wilson's behavior for the McKenzies' benefit. According to Kaiser, the social utility of medication usage far outweighs the risk of harm to unrelated non-patients. Kaiser maintains that exposing physicians to liability for harm to such persons would discourage beneficial medication prescriptions and would create "divided loyalties" between physicians and their patients, requiring physicians to choose between the interests of their patients and those of unknown non-patients.

The McKenzies argue that: (1) where -- as here -- the defendant's conduct in negligently prescribing prazosin creates the injury, foreseeability, rather than the existence of a "special relationship" between the physician and patient, is the major criterion determining whether a duty is owed them by Dr. Washecka; (2) even if a "special relationship" is necessary to create a duty entitling them to protection, a physician-patient relationship is such a relationship; and (3) policy considerations, including deterrence of negligent conduct, the fair allocation of the costs of harm, and fair compensation for victims, mandate that Kaiser owes a duty to them. The McKenzies further contend that Kaiser's policy concerns are exaggerated and that imposition of a duty in this case would impose no more of a duty upon physicians than they presently owe to their own patients. Wilson agrees with the McKenzies and also generally asserts that it is sound public policy to hold physicians accountable to the general public for negligent prescribing practices when it is foreseeable that a member of the public will be harmed by such practices.

Court's Ruling: In favor of the Mckenzies.

Space limitations prevent a complete evaluation of the details of these and other cases in the record. The records suggest to the authors that the physicians involved in these cases were not negligent in the conduct of their duties. We could end this discussion quickly by telling all doctors to instruct all their patients to abstain from driving while taking medications, when one or more of their drugs could cause impairment. Indeed, some physicians in Georgia have taken this approach. The law does not advocate this approach, but neither does it provide any special provision for a more prudent one.

The authors are convinced that many patients are capable of driving safely while using potent opioid medications for pain control,

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About this article...

You may wonder why the pages of this GSA Newsletter would include an article of tribute to an anesthesiologist who never practiced in Georgia and visited the state perhaps only a few times. It is my pleasure to explain.

The idea began when I got notice of the passing of Dr. Nik Gravenstein, a pioneer of the specialty of anesthesiology. Among his many contributions is a 1970 landmark article in *Anesthesiology* dealing with a workforce analysis of tasks and levels of anesthesia care duties. He along with Georgia anesthesiologists, Drs. John Steinhaus and Perry Volpitto, acknowledged the differences between physicians and nurse anesthetists in requisite education, responsibility and skill level. At the same time they extended the list of providers by defining what today is known as the Anesthesiologist Assistant (AA). In that one watershed article, the physician was clearly established as the leader of a resulting team of anesthesia providers. Georgia is the ninth most populous state in the nation and holds the distinction of employing the largest number of AAs of any state. Now you can see how all anesthesiology practices who provide care via the physician-led ACT (whether with AAs or NAs) have benefited from the collective vision of Drs. Gravenstein, Steinhaus and Volpitto.

My next thought was of Dr. Wes Frazier who was the AA Program Director at Emory for more than 25 years. I was fortunate to work in the Emory AA Program before starting medical school. There I heard Wes speak often and with great respect for Dr. Gravenstein. So, I suggested that Dr. Kathy Stack invite Dr. Frazier to share details of just a few of his contacts with Dr. Gravenstein as an opportunity for all Georgia anesthesiologists to learn something of the people and pathway that produced the ACT many of us now take for granted.

The article by Dr. Frazier in this issue is both a personal and professional tribute to one of the visionaries of anesthesiology. Dr. Gravenstein's clear view into the future continues to pay dividends across our state and nation in every ACT-provided anesthetic. I think you will join in my appreciation of these personal insights that reveal a dynamic innovator, skillful physician and insightful teacher. ***-Howard Odom***

In Memoriam

Recollections

Meeting and working with Dr. Nik Gravenstein

Wesley T. Frazier, M.D.

Dr. Nik Gravenstein
1925-2009

My first encounters with Nik were at several ASA Annual meetings in Reference Committee sessions considering the possible ASA recognition of Anesthesiologist Assistants (AAs). This was just a few years after he and John Steinhaus had joined forces to found the first AA educational programs at Case Western Reserve and Emory.

These efforts had some roots in their joint concern about quantitative Manpower issues, but perhaps many people do not realize that there were two even more important concerns expressed in their "leap of faith." First, they were deeply concerned about the quality of education of Anesthetists. Then, the supply was only Nurse Anesthetist graduates from predominantly two year Nursing programs, followed by a mainly "OJT" anesthesia education.

In expressing this "quality of education" concern, they chose two different paths – Nik starting the program at Case Western Reserve (CWR) as a combined pre-med/anesthesia 4 year curriculum. John chose a different model – at the Masters level, admitting only students who already had premedical backgrounds. The second additional concern which John and Nik shared was to be able to augment Anesthetist education by emphasizing the potential role of modern technology in the support of patient care in the OR. At the time there was almost no advanced monitoring in routine use. More of this thread of Nik's interest later.

In about 1976, the ASA House of Delegates gave "tentative" approval to the ASA support of AA education. Resolving the differences in the two educational models became the charge of a committee chaired by Dr. Jim Arens which after due deliberation chose the Emory model.

The celebration at Emory and CWR over the initial supportive ASA action was cut short the next year when the Arens Committee report (including a model curriculum representing a fusion of the two existing programs) was "accepted for information only" by the House of Delegates, with the added words (to the effect of) "the ASA does not wish to be involved in AA education." Thus ended the embryonic work of ASA with the AMA to create a national accreditation process for AA educational programs. The choice then was to halt the development of the AA profession or to find an alternative channel of physician sponsorship.

Together, John, Nik, and I chose to take another "leap of faith" and form a new organization – the Association for Anesthesiologist Assistants Education (AAAE), the governing Board of which included several academic Chairpersons and ex-ASA Presidents.

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"... I remember Nik with a debt of personal gratitude for his inspiration ..."

Most of the early membership consisted of GSA and the Ohio Society members.

Ultimately, with Nik's support, the AAAE was able to go back to the AMA and set up mechanisms for the national accreditation of AA programs. In more recent years, I am sure that Nik joined many who took great satisfaction in the action of the ASA to resume the educational sponsorship of AAs.

This swirl of educational/political events described above was taking place at a time when Nik was transitioning from his position as Chairman at CWR back to the University of Florida. Even though his model of AA education had been rejected and he was no longer involved directly in AA education, he remained a steadfast supporter of AA education and continued his participation in the AAAE. More recently, even though he remained in the background, I am sure that Nik's support was with the Florida Society as they successfully fostered the passage of a law in Florida allowing AA practice there and leading to the founding of an AA program in Fort Lauderdale.

Now, back to Nik's interest in technology as applied to patient monitoring in the OR. The first step which he and John Steinhaus took as they planned to start AA programs was to obtain a joint federal grant for the development of monitoring instrumentation (which then was only available in a rudimentary form commercially).

As for the Nik's technology work at CWR, there were early efforts to develop a computerized anesthetic record as well as a very novel remote surveillance system. In the early '70s, Nik invited me to come up to CWR to become familiar with their AA program. My main memory of that visit is being taken to a satellite hospital where an AA student was involved with a case and monitoring information was being transmitted back to the University Hospital via a laser link. This monitoring information was then reviewed by an Anesthesiologist and directions given in regard to case management.

After Nik's move from CWR to FL, he took advantage of the engineering expertise there to continue his passion for technology in patient care. One of the main areas of emphasis was in the development of Anesthesia simulators. Along with the Harvard and Stanford groups, Nik's group at Florida led the way for development and commercialization of these most valuable devices. This leads to my next-to-the-last encounter with Nik.

About 1997, a pharmaceutical firm arranged to have the University of Florida simulator group bring a couple of their units to Atlanta for training sessions for Emory Residents. When I heard of this wonderful opportunity, I requested that I be allowed to bring several of our senior AA students as well. At the orientations session, the lead person apologized that one of their main teachers had not been able to make it and they had to arrange a substitute. When we arrived in the room to start a session, who would be at the "head of the table" but Nik Gravenstein, himself. We (and he) had a delightful day – the students learning from the Master, and I just stood aside and marveled at his skills and kind manner as the consummate teacher.

I will always remember this day as the culmination of my many fortunate encounters with this most creative and inspiring person. I also think that it is likely that Nik did want to get familiar with the performance of our AA students – who in many ways owed their profession to the early "leap of faith" that he and John Steinhaus took in raising the level and increasing the depth of Anesthetist education by the founding of the two original AA programs. As will many of us, I remember Nik with a debt of personal gratitude for his inspiration and the opportunities which I likely would not have had except for his and John's pioneering efforts.

SAVE THE DATE

Georgia Society of Anesthesiologists

Summer Meeting 2009

Emerging Roads in Anesthesia: Reaching Beyond the OR





Activity Director

Mary Arthur, MD
Medical College of Georgia
Augusta, Georgia
MARTHUR@mail.mcg.edu

July 31 - August 2

King & Prince Beach & Golf Resort
St. Simons Island, GA

Objective:

The demand for anesthesia services is increasing due to more complex procedures being performed outside the operating room. Non-operating room anesthesia claims are reported to have had a higher severity of injury and more substandard care than operating room claims. The theme of the 2009 summer GSA meeting, Emerging roads in Anesthesia: Reaching beyond the OR will equip the learner to focus on preventing adverse outcomes. In addition, registrants will receive instruction in cutting edge approaches in critical care, pain management and chemical terrorism where anesthesiologists are beginning to play an ever increasing role.

Faculty:

1. **Fredric I. Weitz, M.D.**
   Emory University School of Medicine, Atlanta, GA
2. **Ted Weatherred, M.D.**
   Medical College of Georgia, Augusta, GA
3. **Adam E. Berman, M.D.**
   Medical College of Georgia, Augusta, GA
4. **Allen N. Gustin, Jr., M.D., F.C.C.P.**
   University of Washington School of Medicine, Seattle, WA
5. **William Hammonds, M.D., M.P.H.**
   Medical College of Georgia, Augusta, GA
6. **Mark Dershwitz, M.D.**
   University of Massachusetts Medical School, Worcester, MA
7. **Manuel R. Castresana, M.D., F.C.C.M.**
   Medical College of Georgia, Augusta, GA
8. **Alexander A. Hannenberg, M.D.**
   American Society of Anesthesiologists, Newton, MA

The Rundown:

1. **Off-site anesthesia: The Emory experience**
   Fredric I Weitz, M.D.
   Emory University School of Medicine
   Atlanta, GA 30322
   Learn the general requirements for providing anesthesia outside the operating room.
   Learn the unique considerations for each area:
   - Radiology suite: Neurovascular procedures, Interventional uro-radiology, CT/MRI
   - Gastrointestinal endoscopy suite
   - Psychiatric unit

2. **Off-site pediatric anesthesia: The MCG experience**
   Ted Weatherred M.D.
   Medical College of Georgia
   Augusta, GA
   Learn the general requirements for providing anesthesia for the pediatric patient outside the OR.
   Learn the unique considerations for each area:
   - Radiation therapy
   - MRI/CT

3. **Introduction to Electrophysiology Studies and Catheter Ablation**
   Adam E. Berman, M.D.
   Medical College of Georgia
   Augusta, GA
   Anesthetic Considerations
   Learn the interaction between anesthetic agents and the normal conduction system of the heart.
   Learn the various "phases" to any catheter ablation procedure.
   Learn isoproterenol infusion or other maneuvers that modulate autonomic tone to induce arrhythmias in the EP laboratory.

4. **Cardiac Rhythm Device Management for the Anesthesiologist**
   Adam E. Berman, M.D.
   Learn the preoperative management and preparation of the patient with a cardiac rhythm management device (CRMD)
   Intraoperative management of the patient with CRMD
   Post operative management of the patient with CRMD

5. **New Trends in Mechanical Ventilation**
   Allen N. Gustin, Jr., M.D., F.C.C.P.
   University of Washington School of Medicine
   Seattle, Washington
   Learn the new trends in mechanical ventilation
   Learn criteria for new modes of ventilation compared to conventional ventilation

6. **Heparin Induced thrombocytopenia**
   Allen N. Gustin, Jr., M.D., F.C.C.P.
   Learn the anesthetic considerations of the patient with HIT
   Learn preoperative optimization of the patient with HIT

7. **"A Life in Pain"**
   William Hammonds, M.D., MPH
   Medical College of Georgia
   Augusta, Georgia
   Discuss considerations for a career in anesthesiology outside the operating room
   Gain summary points in the development of pain medicine over the last 35 years
   Receive an overview of what a full time "pain doctor" does in daily practice
   Learn the different types of practices in pain medicine available to residents finishing anesthesiology today

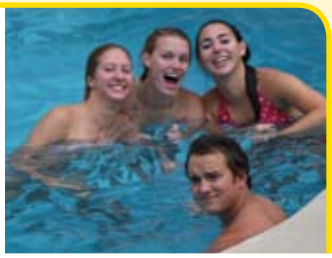
8. **Total Intravenous Anesthesia (TIVA) Pearls**
   Mark Dershwitz M.D., Ph.D.
   University of Massachusetts Medical School
   Worcester, Massachusetts
   Learn the advantages of TIVA and drug selection

9. **Managing chemical weapons exposure**
   Mark Dershwitz M.D., Ph.D.
   Learn what the anesthesiologist needs to know

10. **Off-site Hearts**
    Brian Thomas M.D.
    Georgia Perioperative Consultants, LLC
    Atlanta, GA
    Review anesthetic considerations for patients presenting for cardiac procedures in the cath-lab

11. **ASA Issues Update**
    Alexander A. Hannenberg, M.D.
    President-Elect, ASA
    Newton-Wellesley Hospital
    Newton, MA
    Receive a national Anesthesia issues primer
    Understand how federal issues can impact patient care and outcomes



Director's Report

Peggy Duke, M.D.

Advocacy by physicians is the key to educating legislators at state and national levels about issues that are important to physicians. Advocacy by the GSA, frequently in conjunction with MAG, has been successful in the past improving medical liability policy for Georgia physicians.

The practice of medicine by physicians as opposed to non-physicians has, thus far, been maintained. This is in large part because physicians have helped legislators understand the difference in the educational levels and expertise of physicians versus other non-physician healthcare providers. Non-physician providers should be extenders for physicians, with full oversight by a physician. Non-physician healthcare providers should not practice medicine and should never be a substitute for a physician. All patients deserve to have their healthcare managed by a physician led team.

At The State Level:

Be a part of patient advocacy by contacting your legislators and voicing your support for those measures important to all patients in Georgia—physician led medicine is the best medicine for patients.

Some important bills to watch:

SB 62—Prompt Pay Statute: This bill would extend Georgia's prompt pay stature to all health insurance coverage in the state. (Passed Senate; pending House)

Four Trauma Care Funding bills

HB 160 "Super Speeder" legislation—introduced by Rep Jim Cole (R-Forsyth) (Passed)

HB 148 $10 fee on automobile tags—introduced by Rep. Austin Scott (R-Tifton) (Pending)

HB 183 Fee on telephone services and wireless device sales—introduced by Rep. Harry Geisinger (R-Roswell) (Pending)

HB 192 Support to Georgia trauma care system from the ad valorem taxes—introduced by Reps Fran Millar (R-Dunwoody), Ben Harbin (R-Evans), Ron Stephens (R-Savannah), Jay Roberts (R-Ocilla), Penny Houston (R-Nashville) (Pending)

Passage of these four bills would fully fund Georgia's trauma care system. Georgia has only four Level 1 Trauma centers. According to MAG President Dr. M. Todd Williamson, trauma -related death rate for Georgians is 20% higher than the national average, and is due to inadequate trauma care system. This is legislation that all physicians, regardless of specialty, need to be involved in promoting.

ASA Board of Directors March 7 and 8, 2009 Celebration of Advocacy

The Board of Directors approved the concept of an opening session at the 2009 ASA Annual Meeting on Saturday October 17, 2009 that stresses the importance of advocacy particularly during these very vexing, anxious, changing times in health care. Look for this event in the 2009 ASA Annual Meeting Registration package. Make plans to attend.

Fospropofol/propofol DEA classification

The Board of Directors approved the ASA President sending a letter to the Drug Enforcement Administration (DEA) and the Federal Drug Administration (FDA) suggesting that fospropofol be classified as a Schedule III drug. The rationale for doing this is that the FDA had suggested to the DEA that they designate fospropofol as a scheduled drug due to its potential for abuse. Proactively requesting that fospropofol be a Schedule III drug might prevent its being given a Schedule II designation. Were fospropofol to be given a Schedule II classification, propofol would highly likely also be given a Schedule II classification.

In addition, the Board of Directors approved a revised Statement on the Safe Use of Propofol that suggests continuous capnographic monitoring when possible.

Wellness Booth at the 2009 ASA Annual Meeting

A Wellness Booth will be set up at the annual meeting where, for a fee, an ASA member can have blood work and other tests performed as preventive medicine screening. Members are urged to use their own primary care physicians. However, because many physicians ignore their own health, a Wellness Booth at the ASA Annual Meeting provides an opportunity for basic screening to be done.

ASA Branding Campaign

The ASA's new logo and tag line.

American Society of Anesthesiologists

Anesthesiologists: Physicians providing the lifeline of modern medicine

Go to www.asahq.org to read about the rationale for making this change. Even today, not everyone knows that anesthesiologists are physicians. It is imperative that all anesthesiologists promote their role as the physician who provides the lifeline of modern medicine. Anesthesiology has been recognized as a leader in patient safety initiatives beginning many years before the IOM report was published. We seldom provide this information to our patients and the public. If we do not provide this essential information to our patients, the public, legislators and others, no one will. Anesthesiologists have always been the patient's advocate—we should let our patients know this.

Healthcare Changes are Coming/Federal Issues

Provided below is a link to a document titled, "Call to Action Health

continued on next page

"If we do not provide this essential information to our patients, the public, legislators and others, no one will."

Reform 2009." This document was prepared by Sen. Max Baucus (D-MT), the Senate Finance Committee Chairman.

http://www.asahq.org/news/Baucusfinalwhitepaper.pdf

Two recently introduced bills that deal with ensuring coverage and care to all Americans are below. Little is known, much will change, but these bills plus the Baucus paper provide a glimpse of what lies ahead. The ASA will have information as soon as possible at: www.asahq.org

- S. 391, Healthy Americans Act: Introduced by Sen. Ron Wyden (D-OR)
- H.R. 193, The AmeriCare Health Care Act of 2009: Introduced by Rep. Fortney "Pete" Stark (D-CA).

The ASA's position on Healthcare Reform, as outlined by ASA President Dr. Roger Moore, is to support policy that:

- Establishes a pluralistic system building on the best features of public and private coverage, administration and financing, ensuring access to health insurance for all;
- Recognizes and values the leadership role of physicians as champions of high quality, cost efficient patient care based on their advanced education, skills and experience; and
- Promotes and further supports efforts to improve quality, specifically research that improves patient safety and clinical outcomes.

Knowledge is Power. Stay informed. Visit the ASA (www.asahq.org) and the GSA (www.gsahq.org) web sites frequently to learn the latest pertaining to Healthcare Reform and other issues, at the state and national level which impact anesthesiologists and the patients that we serve.

Now is the time for all physicians to unite advocating for physician-led care as the best, highest quality and safest care for our patients. Now is the time for all anesthesiologists to contribute to the ASAPAC and the GSAPAC.

Updated ASA Statement on the Anesthesia Care Team

Howard Odom, M.D., Chair, Anesthesia Care Team Committee

Just two years ago in the winter 2007 issue of the *Newsletter*, I reported on a major revision of the *ASA Statement on the Anesthesia Care Team*. It was the first significant modification of the *Statement* since 1992. The revised *Statement* adopted at the 2006 ASA Annual Meeting included significant additions & refinements. (See the previous article in the 2007 Winter *Newsletter* - pg 4.)

However, the general consensus was that more work remained to bring the *Statement* in line with other published ASA Standards & Statements and current practice. The Committee on the Anesthesia Care Team has been working since then to address the remaining issues. As in previous years, the proposed Statement sparked spirited debate.

The updated *Statement* adopted by the 2008 ASA House of Delegates maintains the philosophy that the ACT is directed by an anesthesiologist without changing the wording of the previously adopted *Statement*. However, the new *Statement* contains an added definition of "Qualified Anesthesia Personnel / Practitioner." The issue arises from the "Standards for Basic Anesthetic Monitoring" where "a qualified anesthesia practitioner" uses the basic monitors during the entirety of anesthesia care provided. Both the monitors and the practitioner are specified. Though the ACT mode of practice is not specifically referenced, the definitions in the ACT Statement must be consistent with other ASA Standards in any instance of anesthesiologist-directed care.

You may be asking, "Why spend time on a point of internal consistency in ASA policy when there are so many other bigger external issues on our plate?" The changes in the Statement address points that are relevant to both current and anticipated pressures on anesthesiology practice. The *Statement* takes a broader view of anesthetists to include aspects of senior student clinical education.

Within the world of Nurse Anesthetist (NA) training programs, the opinion is held that student anesthetists can be allowed to serve as the sole anesthesia practitioner in the OR during their senior (second) year of training. This solo, but "supervised" experience while in the "safety" of the training environment is considered valuable for developing the autonomous decision-making skills which graduates will use in practice. ORs are routinely staffed with senior NA students. The supervising practitioner may be an anesthesiologist or graduate nurse anesthetist. The NA educational model seems to presume production of a "completed" anesthetist able to individually provide care. It is open to question whether getting the feel of the pressure involved in solo care is necessary or helps to complete an individual's preparation for practice.

By comparison, Anesthesiologist Assistant (AA) training programs have always maintained the requirement (both at the academic and community rotation sites) that AA students may not be left alone, always having a fully-trained & licensed anesthetist present as the provider of record. A consequence of this policy is that students cannot be the tool of scheduling more cases than can be supported by employee anesthetists. The AA educational model has the goal of producing "entry level" anesthetists capable of practicing within the ongoing structure of an anesthesiologist-led team approach to care. I see this pathway and educational outcome as a more realistic one that acknowledges the responsibility for life-long learning by every practitioner.

So where do these two training models fit within the current ASA Statement on the ACT? The added language in the Statement takes patient safety as its prime motivation for addressing the issue of training non-physician anesthetist students. In other words, first consideration is due to the patient's care rather than to any potential educational benefit of the student. To deal appropriately with this issue – within the realm of interest of training future members of the ACT – the *Statement* suggests the process and mechanical details which must be considered. The added sections of the *Statement* on non-physician anesthetist students include:

1. **Deemed capability** of the student to perform delegated duties and student willingness to be alone.
2. **Privileging** students to be supervised 1:2 by an immediately physically available qualified anesthesia practitioner.
3. **Case Assignment and Supervision** – selection of appropriate cases and either 1:1 or 1:2 supervision at a more frequent, higher level than graduate anesthetists in the interests of both education and patient safety
4. **Backup Support** – contingency planning to have secondary anesthesiologist support should the primary be involved in another case when help is needed.
5. **Informed Consent** for only a

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Dr. Neeld Announces Candidacy for AMA Board

From Staff Reports

John B. Neeld, Jr., M.D., long an active member of the GSA and Past President of the American Society of Anesthesiologists, has announced his candidacy for the Board of Directors of the American Medical Association. The AMA Board is responsible for guiding the activities and policies of the Association, and its members are nationally recognized as leaders of American medicine.

The Board election will take place at the AMA's upcoming annual meeting, June 13-17 in Chicago. The ASA has endorsed Dr. Neeld's nomination, and its delegation, as well as those of other national specialty societies and state medical associations, is working for his election.

Dr. Neeld is Chairman Emeritus of Northside Anesthesiology Consultants in Atlanta having served as Chair for 22 years. A graduate of Vanderbilt University and Vanderbilt University School of Medicine, he conducted his residency in anesthesiology at Emory and is a Fellow, American College of Anesthesiologists, and Diplomat, American Board of Anesthesiology. John served as President of the ASA during 1998-99. He has also served on the Board of Directors of MAG Mutual Insurance Company since April 1998.

In May 2007, the American Society of Anesthesiologists presented John with its Excellence in Government Award, recognizing his longtime support of the Society's legislative activity, his involvement in AMPAC, and strong interest in national politics.

Dr. John and Gail Neeld, ASA's Excellence in Government Award, 2007, Washington, D.C.

Hospital/Provider Payment Bundling on Horizon

Jason Williams, M.D., Chair, Practice Management Committee

There seem to be more questions than answers when it comes to our economy and just how to fix it. It doesn't take long to be overwhelmed with all of the media's hype and opinions from "drive-by" bloggers. The government's input can be just as confusing. From the practice management standpoint it is interesting to see just what President Obama is promoting for his budget proposal for health care. According to Sen. Jay Rockefeller, D-W.Va., who chairs the Senate Finance Health Subcommittee, health care reform is the President's number one priority this year. This is one thing on which we as physicians should keep a careful eye to see where it will take our patients and us.

In his request for $634 billion for health care reform, President Obama has proposed that $176 billion can be saved over the next 10 years from "competitive bidding" for Medicare advantage plans. It is thought that this cut will rein in on one of the cash cows of the insurance industry. (We'll see plenty of input from the insurance industry's lobbyist on this I'm sure.) Linking hospital quality to hospital payment measures has been proposed to save another $12 billion. As we all well know the latter measure has already been implemented…how many of us have been asked to assist on the measure with the prophylactic antibiotic timing in the OR?

These changes, along with about a dozen more, are not going to fix the problem according to the "Report to Congress, Reforming the Delivery System, 2008." This report was from the Medicare Payment Advisory Commission led by Mark Miller, Ph.D. He and the Commission point out that a more fundamental change is required to "fix" our health care system.

According to Miller, there are two things that fundamentally flaw the current system. The first is the inherent incentive to increase revenue by increasing volume in a fee-for-service structure. The other is the lack of rewarding of coordination of

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GSA PAC report

Catherine Meredith, M,D., Chair, GSA-PAC

At the GSA Committee for Responsible Healthcare Policy (GSA-PAC) we are grateful for the donations we receive from our members. These funds are pooled and distributed to officials who have demonstrated support for pro-patient, physician-led healthcare, and it is through the relationships that we build with these lawmakers that we are able to enjoy an active and successful political agenda.

We have determined that the most effective means of distribution is to hand deliver many of our contribution checks, spending as much time with the recipient legislators/candidates as we are able. Thanks again to GSA lobbyist Jet Toney and the members of our Governmental Affairs Committee for continuing to successfully deliver our message.

Though this year is not an election year, continuing to enjoy good standing in the state political arena is of utmost importance. With the onset of our nation's economic difficulties, the natural reaction of many is to delay political and other contributions until the economic climate is improving. But more than ever, NOW IS THE TIME to be active! Legislation is being drafted now. Legislators have time to talk with us now. Our careers and futures are being affected now. Maintaining our place at the table while healthcare policy is crafted will be much easier than trying to promote change after the fact. Your PAC contributions are more important than ever.

Each year we face new and different issues that affect the way we practice medicine, and the GSA PAC will continue to be important throughout our careers. To join the GSA's critical grassroots advocacy effort, go online to the Members section of www.gsahq.org. Or mail your contribution to GSA-PAC, 1231 Collier Road Suite J, and Atlanta, GA 30318.

GSA Executive Secretary and Lead Lobbyist Jet Toney with Georgia House Speaker Glenn Richardson and Majority Jerry Keen.

Please feel free to contact me if you wish to discuss participation in GSA-PAC or to propose a political contribution for a state level candidate in next year's elections. For more information email me at katiemeredith@yahoo.com or visit the GSA website.

ASA Statement (continued from page 12)

non-physician student being physically present while under the direction of the responsible anesthesiologist.

6. Disclosure to Professional Liability Carrier of the utilization of non-physician student anesthetists as the only provider present at times during care.

Dr. Jeff Plagenhoef and the ASA Committee on the Anesthesia Care Team spent an immense amount of time and energy to provide our profession with an informative, workable and much needed update. Our medical responsibility to patients and professional interests have been well considered. I would encourage every GSA member to read the revised *Statement*. Whether you presently work with anesthetists in the Care Team mode or not, this updated ASA *Statement* is important to Georgia and will very likely influence your practice in the future.

ASA Statement on the ACT

Continued Themes

1. Anesthesiologist-led team
2. Accurate identification of Care Team personnel
3. Supervision of Nurse Anesthetists by Surgeons
4. Billing Terminology distinguished from the definitions of the ACT
5. Identifies other personnel involved in perianesthetic care

New Items Added

1. Reference to ASA Standards for Basic Anesthetic Monitoring
2. Definition of "Qualified anesthesia personnel"
3. Supervision of senior anesthetist students

2009 GSA-PAC Patrons

The following GSA members have contributed to the Committee for Responsible Healthcare Policy in 2009. The Committeee, also know as GSA-PAC, supports state level candidates and elected officials who fight for patient safety and physician-led medicine. To contribute, go to the members only section of www.gsahq.org or mail your contribution to GSA-PAC, 1231-J Collier Rd. NW, Atlanta, GA 30318.

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Hospital/Provider Payment (continued from page 13)

care or cost savings. The commission also favors the use of bundling of hospital and physician payments, which should be of great concern to us as anesthesiologists. And faster than you would expect coming from our government, CMS has started five test sites to participate in a three-year bundled payment demonstration.

According to the announcement on January 6 of this year, the Department of Health & Human Services says that this program will "better align the incentives for both hospitals and physicians." The hospitals are Baptist Health System in San Antonio; Hillcrest Medical Center in Tulsa, OK; Lovelace Health System in Albuquerque, NM; Oklahoma Heart Hospital in Oklahoma City; and Exempla Saint Joseph Hospital in Denver. How the hospital and providers "share" a given amount of reimbursement will prove to be interesting to say the least!

Just look up on the internet the afore-mentioned Report to Congress… it's actually an easy read for a government document and is full of "interesting" proposals that we need to

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2009 Georgia General Assembly - *Session Final Report*

Steve Walsh, M.D., Chair, Government Affairs Committee

The 2009 Session of the Georgia General Assembly adjourned near midnight on Friday, April 3. Influenced by the economic-induced "pall" which hung over the session, lawmakers introduced fewer bills than normal and, accordingly, passed fewer bills than in a traditional 40-day session. This dynamic impacted medical and health care issues as well.

The Georgia Society of Anesthesiologists did not take the lead on legislation in 2009. The Society expended its political capitol working alongside other specialty societies to support the advocacy efforts of the Medical Association of Georgia on several important issues of interest to Anesthesiologists including the following:

Third Party 'Prompt Pay' Bill - HB 342

The legislation would extend current state "prompt pay" requirements to health plan third-party administrators. The state Senate passed the legislation, but the bill hit a snag with the leadership of the House of Representatives. During the legislative interim, GSA will work to break the logjam on this important payment bill. Georgia already requires prompt payment of health claims but the law does not currently impact ERISA health benefit plans.

Go to www.legis.state.ga.us to read HB 342 and other legislation of interest.

Rental Networks - SB 50

Legislation that would crack down on contract abuses regarding use of insurance rental networks was briefly considered by the Senate Insurance Committee. SB 50 is likely to birth an interim study committee on health care contracting. Action on the legislation will be renewed in the 2010 session.

Prescription Drug Monitoring - HB 614

The legislation arises out of the 2007 House Pain Management Study Committee report calling for a mechanism to track prescribing for the purpose of determining and stopping fraud and abuse. GSA substantially participated in the work of the study commission.

HB 614 passed the state House with only 5 "no" votes. However, libertarians in the state Senate managed to sabotage the legislation on the Senate floor by claiming that the work of the Georgia Drug and Narcotics Agency would be akin to a "big brother" invasion into the privacy and civil liberties of Georgia citizens. An attempt to add the bill as an amendment to a related bill on the House floor late in the session fell short when libertarians in that chamber charged the bill would lead to "big brother" invasions of personal privacy regarding prescription drug prescribing and use.

Medical Practice Act - HB 509

Legislation proposed by the Georgia State Medical Board made dozens of changes in the current Medical Practice Act. As passed by the House and Senate, the legislation makes routine updates, modernizations and corrections in the practice act. The Medical Association of Georgia was heavily involved in re-writing portions of the action which could have, had changes not been made, become the foundation for scope of practice expansion attempts by physician assistants. During early meetings on the initial draft of the legislation, GSA lobbyist James E. "Jet" Toney expressed concerns about the sections of the bill which addressed PA scope of practice. Those concerns were addressed in the final version of the bill. (HB 509 not signed by governor as of publication.)

Trauma Care

Several bills were introduced for the purpose of creating funding sources for a bona fide statewide trauma network. None of the sources, in themselves, would adequately fund the network nor would they be sustainable at initial levels of revenue generation. As an observation, it appears that last year's enthusiasm for developing and funding statewide trauma resources has been diminished by the pervasive $3 Billion shortfall in state revenue.

SB 156 passed the Senate but did not receive action on the floor of the House. The stated purpose of this bill is to strengthen Georgia's trauma care system. It seeks to revise the duties of the Georgia Trauma Care Network Commission and the State Office of EMS/Trauma, change definitions regarding trauma care, specify trauma funding priorities and abolish the Georgia Trauma Trust Fund.

HB 160 has been signed by Gov. Sonny Perdue and will generate money to upgrade the state's trauma care facilities by imposing higher fines on drivers who are caught speeding. Supporters state the fines will raise $23 million a year for trauma care, an amount far short of the $100 million price tag that has been calculated for an adequate network.

"This is a simple, straightforward attempt to slow high-speed drivers and reduce high-speed crashes and trauma injuries," Perdue said. "I believe we can not only help fund trauma care through increased fines, but we can also reduce the heavy burden on our state's emergency rooms."

The bill imposes an additional $200 fine for driving over 85 mph anywhere in the state and for driving 75 mph or more on a two-lane road. Speeders will also have to pay higher driver's license reinstatement fees for drivers committing a second and third offense for violations that result in a suspended license and for other negligent behaviors.

In Memoriam

Jack Elbert Raybourne M.D.

Macon anesthesiologist Jack Raybourne, M.D. died September 25, 2008 after a brief illness. Dr. Raybourne practiced anesthesiology in Bibb County from 1959 through 1987. Following retirement, he and his wife spent 11 years cruising aboard their boat. He was a member and former lay reader and senior warden of St. Paul's Episcopal Church. Dr. Raybourne was born in Charleston, SC and was the son of the late Mr. and Mrs. Ernest M. Raybourne.

"Jack was a real sport, loved the sea and loved people," GSA Past-President Bob Lane, M.D. recalled. "Everyone thought the world of "Happy Jack" Raybourne. When he retired he and his wife spent years on the boat, coming in for Jack's annual physical and to turn in his taxes! He and Rinky sailed all over and had a ball. His truly was a life well lived."

Dr. Raybourne served in the Merchant Marines 1944-46 and was a 1st Lieutenant in the U.S. Army 1953-1955. He was a graduate of the College of Charleston and the Medical University of South Carolina where he was charter member of the MUSC chapter of the Alpha Omega Alpha Honor Medical Society.

He is survived by his wife of 59 years, Mary Clare "Rinky" Raybourne; his daughter, Susan R. Raybourne, MD of Columbia, SC; son and daughter-in-law, Steven and Donna Raybourne of Georgetown, TN; and one granddaughter, Ashley Walker.

"Everyone thought the world of 'Happy Jack' Raybourne."

100% Participation (continued from page 1)

obtain 43 of 47 contributions this way. After these four grand rounds, the final four residents were sent individual e-mails reminding them to bring their contributions the next day and were visited individually in the OR to make it easy for them.

The take-home message is that when you educate your peers/colleagues about the importance of the ASAPAC *and* make it easy for them to contribute, achieving 100% participation is *not* an unreasonable goal!

For those of you skimming this newsletter, here are 5 steps to ASAPAC fundraising success:

1. Nominate a *motivated* member of your group/department/residency to act as your fundraising coordinator. Consider sending them to the ASA Legislative Conference held every May for training.
2. At your next group meeting/grand rounds/etc, allow your fundraising coordinator 5-10 minutes on the agenda to make a presentation about the ASAPAC (contact the ASAPAC if you need slides, talking points, etc). Have copies of the donation form available.
3. The fundraising coordinator should be present at the next several group meetings/grand rounds/etc. with forms available and reminders for those who have not yet contributed. The fundraising coordinator may offer to collect the forms and donations on behalf of everyone and mail them in to make it more convenient (this is what we did).
4. Contact the ASASPAC office in Park Ridge periodically to follow your progress.
5. Remember that every contribution, no matter how much, makes a difference!

The following Emory residents contributed to ASAPAC:

Taufiq Ahmed
Sona Arora
David Bailey
Nathan Baldwin
Aundie Bishop
Virlyn Bishop
Jennifer Brandenberger
Brandon Bowman
Amy Alvarez Cabbabe
Greyson Chappelle
Laura Chesoni
Ryan Corley
Laura Ermenc
Douglas Freiberger
Paul Garcia
Charles Garrett
Alison Hanowell
Kirk Hickey
Margaret Hess Holtz
Wykena Jackson
Saba Khan
Matthew Klopman
David Knowles
Scott Kolesky
Andrew Kroh
Mark Lofye
Shalene Magee
Gary Margolias
Jonathan Mauldin
Thanh Nguyen
Marissa Omurtag
Armin Oskouei
Matthew Patterson
Ashley Ryan
Brady Rumph
Joanna Schindler
Julie Schuman
Patrick Segeleon
Aaron Sieradzan
Jigar Tataria
Ben Trapp
Palak Turakhia
Ratna Vadlamudi
Margaret Van De Water
Dana Williams
Jason Williams
Lily Young

I learned that for every $1 the government spends on fraud investigation they get back a return of $15.

PM Conference (continued from page 1)

myriad talks and was disappointed only that I couldn't attend them all.

One of the most interesting to me was Dr. Krishna Kumar's talk on the preliminary results of the RAND survey commissioned by the ASA whose final results are to be peer reviewed and published in the near future. The gist of what he said is that nationally, under a demand-based analysis using counts of anesthesia professionals and procedure times, there will be shortages in the market for Anesthesiologists. As part of the research a parallel and complementary economic analysis suggests there will continue to be an under abundance of both Anesthesiologists and CRNAs. This projection varies widely among states but from Georgia's standpoint the DBA suggests a shortage of Anesthesiologists and an oversupply of CRNAs while the economic analysis suggests a shortage of both anesthesiologists and CRNAs. As someone going into practice in the next few years these data are quite interesting but also tentative in so far as they are preliminary results and should be considered as such.

Several of the other talks discussed various aspects of compliance, documentation, billing and coding. These are topics that seem to be rarely, if ever, covered in residency yet are of the utmost importance in our ability to collect revenue to reimburse our work and in some cases avoid criminal and civil litigation. Some of the most interesting discussions revolved around the new "Recovery Audit Contractor" (RAC) teams established by the Centers for Medicare and Medicaid Services (CMS). The RAC teams are outside entities employed to recover overpayments.

I learned that for every $1 the government spends on fraud investigation they get back a return of $15. The RAC teams are third parties paid for by the revenue that they collect-incentivizing them to find incomplete or incorrect documentation and coding. Though initially just a trial program in six states through the Tax Relief and Health Care Act of 2006 Congress has required a national RAC program by Jan 1, 2010.

Given this wealth of interesting, insightful and important information I would highly encourage both anesthesiologists in training and those already practicing to attend the next Conference on Practice Management meeting, particularly since in 2010 it will be held in Atlanta. I'll be there.

Patient DUI: (continued from page 5)

as many patients are maintained on performance altering drugs for extended periods of time. We do not support the position of driving abstinence for all patients on risky regimens. As it stands, Georgia law does not require it. How then should the good physician approach this dilemma?

The authors offer these perspectives and recommendations to consider that should improve the public safety and reduce physician liability.

1. Have a specific conversation with the patient about driving at the initiation of therapy and document the discussion in the patient's record. The author instructs his patients not to drive for at least 7-10 days after the initiation of therapy or after a significant increase in dosing. This recommendation is supported by the literature and gives the patient an opportunity for self-evaluation. Obviously, patients who display signs of impairment at examination should be instructed not to drive, but remember to document that the instruction was given.

2. Make it clear to the patient that it is their responsibility to assess their abilities. Say explicitly that he or she should not drive if they sense the "least" amount of impairment.

3. Instruct them to give particular caution and consideration to special driving conditions such as long distance monotonous driving and situations that require optimal reaction time and concentration. Then document the discussion.

4. Tell the patient to contact their doctor if there is any question about impairment before driving. When the patient is unsure and impairment is not obvious to you, consider using the help of occupational therapy to provide an assessment. Some centers have facilities that specifically assess driving ability and most can assess general functional abilities required for safe driving.

In the two court cases, the 'day' might have been saved if the physicians had been able to present

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Hospital/Provider Payment (continued from page 16)

become familiar with when we talk to the administrators and our legislative representatives. It would also serve as a reminder to us all to be prepared to work together with our hospital's administration to help sustain quality health care in our communities.

I'm not trying to write an exhaustive report on what is coming out of Washington right now and how it will impact our practices, but what is listed above is just a few of the many proposals being sent to the public and our representatives in government. While we physicians disagree on ways to improve health care and combat its cost, we should agree that our involvement as physicians is paramount to our patient's care. And if our anesthesia practices suffer from these changes, then our patient's health care access will suffer along with it.

Other news:

- Abstracts from the 2009 Conference on Practice Management are now available—go to www.asahq.org to order.
- New Resident Practice Management section on ASA's website. This was created to educate residents on the financial factors that affect an anesthesiologist's practice.
- MGMA 2009 *Cost Survey for Anesthesia* and *Cost Survey for Pain Management Practices* are out! For more information, go to www6.mgma.com.

Patient DUI: (continued from page 19)

more documentation to the court about the instructions and warnings to their patients. We should be advised that once is not enough.

This brief exploration of the liability risks associated with patient DUI in the context of prescription medications deserves expanded discussion. The recommendations we offer here are simply reminders of what we all know to be good clinical practice. This issue is most relevant to the pain management specialist but don't forget about our patients in the outpatient surgery centers whom we assist with pain control. The surgeon is primary, but the secondary physician could be considered culpable as well when blame is being distributed. It may be prudent to find out what instructions patients are given at discharge concerning this issue. Unfortunately, there is no risk-free scenario short of retirement or other forms of failure to practice. Court records suggest that the best protection is proactive, documented discussions with patients. Since we are already doing this, don't forget to write it down.

Suggested Reading:

- *Brandman, JF. Cancer Patients, Opioids, and Driving J Support Oncol 2005;3:317–320*
- *Byas-Smith MG, Chapman SL, Reed B and Cotsonis G. Clinical Journal of Pain*
- *2005 Jul-Aug;21(4):345-52.*
- *Chapman S. The effects of opioids on driving ability in patients with chronic pain. Am Pain Society Bull 2001;11:1–3.*

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