

## FEATURES

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Anesthesiologists have been instrumental in alleviating pain, but they are also altering many misguided attitudes about pain. This NEWSLET-TER explores the complex ethical, legal and regulatory issues that surround the anesthesiologist who practices pain medicine.

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#### SUBSTANCE ABUSE HOTLINE

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## VENTILATIONS

## Service Is for Now... and Research Is Forever

have lived by this maxim as an academic physician by participating in and facilitating the advancement of scientific knowledge through resident education, continuing medical education, clinical trials and editorial reviews. The benefit is obvious — knowledge and innovations improve medical care, which makes clinical practice safer for the patient and less stressful to the physician. Parenthetically, for those who feel stressed because of the current fast pace in completing the daily operating room schedule, imagine the anxiety of your forbearers when the anesthetic mortality rate was 1:10,000 cases!

With anesthesia being so safe, anesthesiologists are in danger of having research in our specialty become inconsequential. Moreover, the financial assault on academic medical centers (AMCs) has forced many programs to severely curtail or eliminate research efforts in favor of clinical care. Finally, anesthesiology groups continue to actively recruit anesthesiology faculty into private practice, further worsening the AMCs' ability to advance knowledge and practice in anesthesiology. This is a serious problem if one is even cursorily concerned about the future of anesthesiology.

A number of factors allow me to suggest that anesthesiology could become a second-rate specialty. First, a recent survey performed by the Society of Academic Anesthesiology Chairs (SAAC) revealed that more than 490 academic positions are currently unfilled. This faculty shortage was corroborated in the *Journal of the American Medical Association*, which reported a 271-physician deficit in anesthesiology for the 2000-01 academic year.<sup>1</sup>

Second, as the discrepancy in salaries between academic and private practices widen, many young faculty are using traditional academic time to engage in clinical service or moonlight to close the dollar gap. Thus, scholarly activity and research projects diminish, including grant submissions. Currently, in this era of additional grant monies being assigned to the National Institutes of Health by Congress for awarding, our specialty hovers at the bottom of the most-funded medical specialties list.

Third, the reluctance of health maintenance organizations to subsidize the extra cost of resident training, Centers for Medicare & Medicaid Services policies designed to reduce resident reimbursement, the attorney general's appointment of lawyer "hit squads" designed to flush out rampant "fraud" in AMCs and a general lack of a strategic plan among ASA, SAAC/Association of Anesthesiology Program Directors (AAPD), the Association of University Anesthesiologists (AUA) and the private sector indicate that a turn-around in faculty staffing is not probable in the near future.

The "good" news is that these downward trends in academic anesthesiology advancement are unlikely to affect you significantly if you plan to retire in the next five years. For the rest, professional life as you know it may change significantly, with negative repercussions. The most obvious consequence is the emergence of poorly trained anesthesiologists or even another dip in resident applications. We cannot assume that the current influx of bright, Americantrained medical students will continue to prioritize our specialty if those in



Mark J. Lema, M.D., Ph.D. Editor

## ADMINISTRATIVE UPDATE

## We Say That We Matter – Let's Make Sure We Keep It That Way

Peter L. Hendricks, M.D. Assistant Secretary

It is difficult to sit down and write an arti-Lcle to be published in two months concerning something that may or may not happen by the time the article is printed. Taking this into consideration, it is my intention to speak to our responsibility as anesthesiologists to practice in such a professional and ethical manner that leaves no doubt to our patients or to scientific study that we do matter. My greatest fear is that if the Bush administration's rule — which would keep nurse anesthetists from independent practice — is adopted (and I predict it will be), too many members will be tempted to say, "Egad! I'm glad that's over. Let's relax, we deserve it!" On the other hand, if the Clinton administration's "midnight massacre" rule is adopted, too many may say, "To #\*%%!\* with it, let them get

what they deserve." We, as anesthesiologists, cannot let either of these unacceptable situations happen.

In the March 2001 ASA NEWSLETTER, ASA President-Elect Barry M. Glazer, M.D., wrote an article titled "Our Patient Safety Record Is in Grave Danger." This article soberly reflected on the negative changes in patient safety that would take place if the Clinton rule were allowed to take effect. Dr. Glazer pointed out the irony of how HCFA (now the Centers for Medicare & Medicaid Services, or CMS) cited a scientific outcomes study that involved an anesthesiologist in every case. It emphasized how safe anesthesia care is today and then used this safety record to justify its decision to no longer require that nurse anesthetists be supervised. In addition, Dr. Glazer's article pointed out recent studies showing patient outcomes are better if a physician is involved in the medical decisionmaking of the anesthetic care; and the outcome is even better if the physician is an anesthesiologist.

#### It does matter if we are there!

In a more recent event during the comment period on the Bush rule, a senior citizen sent a letter to ASA to be forwarded to CMS Administrator Thomas Scully. She wanted to support the ASA position by relating her recent anesthetic experience. During her first knee operation, she was given a general anesthetic. She indicated that it literally took weeks for her to recover her faculties. There was



Peter L. Hendricks, M.D.

no indication that an anesthesiologist was involved in her care (not good). For her second knee operation, she was seen preoperatively by an anesthesiologist and was set up for a regional anesthetic with sedation. On the day of the surgery, the nurse anesthetist berated her in the holding area for her decision to go with regional over general anesthesia. The anesthesiologist intervened, and a regional anesthetic was performed. She indicated her recovery was quicker, uncomplicated and much more pleasant. The patient stated that she most certainly wanted an anesthesiologist involved in her future care.

#### It continues to matter if we are there!

This article is not, however, intended to be a series of anecdotes or studies to show

that we matter: If we do our job right, that is a given. The overriding question is about what we must do to make sure we continue to matter. As noted previously, I believe the Bush rule will be enacted. This will keep the nurse anesthetist supervision rule in its current form unless state governors opt-out. In addition, it will call for a prospective outcomes study. So, yahoo! Things are essentially back to normal, and all is right with the world.

Do not count on it!

Times change, administrations change and the American Association of Nurse Anesthetists has not surrendered! As a matter of fact, the American Hospital Association (AHA) has entered into the fray and indicates that it will not only *NOT* support the proposed anesthesia outcomes study but will continue to advocate the elimination of the nurse anesthetist supervision rule both at the federal and state levels. ASA President, Neil Swissman, M.D., wrote a strongly worded reply to the AHA executive director questioning their motives and their lack of concern for patient safety.

Make no mistake, this battle will be fought in the trenches, state by state and hospital by hospital, and the foot soldiers will be us. It is now more important than ever to act like the physicians we say we are and to continue proving a hundred times over — to our patients, to our colleagues and to the hospitals and clinics where we practice — that we do matter and make a difference in

patient safety. We must be sure that we make ourselves available to all patients to determine their type of anesthesia and to either personally provide or medically direct their perioperative care. This includes after 3 p.m., nights, weekends and holidays. Our strongest defense is to provide great care to our patients, to go out of our way to help our surgical colleagues get their cases done in a timely manner and to participate in every aspect of hospital or clinic life. AHA may claim to make its decisions based on the best interest and safety of the patients, but I would not count on it.

Over the last three years of intensive crisis, we have seen a significant increase in participation by anesthesiologists at the national and state levels. But as Dr. Swissman has noted on many occasions, it is not as much as we can do, and it is anemic when compared with the percentage participation of the nurse anesthetists. Even worse, it appears that as things are cooling off while we wait for the final decision, we are having a corresponding drop in our participation, especially in ASA's Political Action Committee (ASAPAC). This comes at a time when we still need to be continuously engaged. As we found out in Alabama and Louisiana, only a large amount of PAC support coupled with inordinate amounts of time and effort won the day for patient safety. If we are to continue to ensure that, whenever possible, every patient has the benefit of the involvement of an anesthesiologist in his or her care, we must step up to the plate and offer even more of our time, talent and treasure.

Last but not least, we must stand united. As the Assistant Secretary, I read all the reasons people give for leaving ASA. The two primary reasons given are: 1) the required membership in the component society and 2) the perception that benefits from a specialty society are the same or better than those received from ASA. I have spoken with a number of these ex-members, and I am saddened and angered by the comment, "Anyway, I'll get the benefit whether or not I belong to ASA." Membership is our lifeblood, and the more members we have, the more effective we can be at the national and state levels. Our Society continually strives to balance the needs and considerations of all the members of the ASA family. Our state components are our lifeblood as well and are important to our overall well-being. From our experience in Alabama, I can tell you it was only a unified Alabama State Society of Anesthesiologists, with help from ASA and the state medical society, that enabled us to get legislation passed which prevented the independent practice of nurse anesthetists and the opening of nurse anesthetist pain clinics. No individual subgroup could have accomplished this alone, but together we prevailed. It saddens me to hear that an anesthesiologist does not feel he or she needs the ASA family. I think they are wrong, but I continue to hope they change their minds and rejoin.

Our togetherness in the advancement of anesthesiology is paramount to the safety and well-being of the patients for whom we are honored to care. A saying attributed to Ben Franklin so many years ago is just as true today: "We must indeed all hang together, or, most assuredly, we shall all hang separately."

WE ARE ASA — WE ARE FAMILY

P.S. I wrote this article two days before the terrorist attacks in New York, Washington and Pennsylvania. What else will happen prior to publication is unknown, and this article certainly pales in magnitude to these horrendous deeds. But the message of our responsibility to work together to do everything in our power to see that all patients receive the best and safest anesthesia care is still valid and also in the best interest of our country, so I sign off by saying:

GOD BLESS AMERICA.

## WASHINGTON REPORT

## Deadline Approaches for Finalization of Nurse Anesthetist Supervision Rule

Michael Scott, J.D., Director Governmental and Legal Affairs

by the time this column is published, the Centers for Medicare & Medicaid Services (CMS) will most likely have acted on its July 5 proposed rule maintaining the long-standing Medicare requirement that nurse anesthetists be supervised by a physician, while permitting individual governors to opt institutions out of the rule to an extent consistent with state law. Unless such action occurs by November 14, the January 18 final rule of the Clinton administration — eliminating the supervision requirement — will automatically go into effect.

Current indications are that CMS is moving expeditiously to consider public comments on the July 5 proposed rule and to decide whether to finalize the proposed rule in its original or an amended form. Possible amendments could include ASA-proposed refinements to the opt-out process, including the requirement that governors considering an opt-out give the public notice and an opportunity to comment on the proposal — a requirement that makes considerable sense in light of the fact that a governor is required under the proposed rule to determine that an opt-out is "in the best interest of the citizens of the state."

In its comments on the proposed rule, the American Association of Nurse Anesthetists (AANA) vigorously objected to the opt-out requirement that the governor consult with the state boards of medicine and nursing. The AANA claimed that this requirement would allow physicians to "veto" any opt-out. ASA has responded by pointing out that the

proposed rule requires only that these boards be *consulted* and that the governor is thus free to accept or reject the advice they provide. AANA also proposed that an automatic opt-out be granted to all states that currently do not require physician supervision as a matter of state law; ASA has responded that this step would simply represent placing the Clinton rule in effect in a different form.

In their comments on the proposed rule, both ASA and AANA supported the concept of CMS commissioning a prospective anesthesia outcomes study.

There have been limited indications of an attempt by AANA to affect the terms of the final rule by seeking congressional action that would override whatever action CMS decides to take. ASA has been vigorous in responding to these efforts by pointing out that the July 5 rule represents an intelligent compromise between the positions advocated by AANA and ASA over the past four years and effectively responds to those in Congress who believed that the supervision issue should ultimately be decided at the state level.

ASA also has acted vigorously over the past few months in familiarizing gubernatorial staffs across the country with the terms of the July 5 proposed rule and has alerted component society legislative representatives to the possibility of opt-out proposals in their states if the July 5 rule is finalized. An education session for component representatives was held on October 16 in New Orleans, Louisiana, in connection with the ASA Annual Meeting.

As soon as the CMS final action becomes known, ASA members will be advised by e-mail when possible and by an all-member mailing of a *President's Update*.

## House Panels Considering Regulatory Relief Proposals

ctivated by wide support within the House for the principles of the Medicare Education and Regulatory Fairness Act (MERFA) (H.R. 858), subcommittees of both the Ways and Means and Energy and Commerce Committees are currently engaged in developing legislation (H.R. 2768 and H.R. 3046) incorporating several MERFA concepts related to regulatory relief for physicians providing care to Medicare patients.

At the time of this writing, representatives of organized medicine are engaged in an intensive lobbying effort to insure inclusion in any final House bill of appropriate provisions restraining current Medicare contractor audit abuses, assuring physicians due process in connection with appeals from overpayment determinations and requiring that physicians be provided by contractors with information on which they can legally rely.

Action in the Senate on MERFAlike legislation lags in the House substantially, but current hope is that an agreed bill can be developed in the House before the year-end recess with Senate action projected for next year.

Continued on page 18

## **Outcomes Measures in Pain Medicine**

David P. Martin, M.D., Ph.D. Committee on Pain Medicine

ow well do we help our patients who have chronic pain? Are our treatment interventions effective? Answers to these questions are not always straightforward, but if we do not measure outcomes, we cannot improve them. Increasingly, regulatory pressures will require a more formal approach for assessing pain and measuring outcomes. For example, the Joint Commission on Accreditation of Healthcare Organizations will require assessment of pain as the "fifth vital sign" for all patients admitted to the hospital. In the future, pain physicians may need to show objective evidence of the efficacy of their interventions to justify reimbursement by third-party payers. Additionally, the ability to document good outcomes and patient satisfaction will enhance the marketability of pain services.

#### **Determine What to Measure and How**

Before choosing an outcomes measurement tool, it is essential to specify exactly what is to be measured. For example, one can measure subjective symptoms of pain, objective behavioral consequences or both. Determinations can be made by the clinician, the patient's self-report or both. Special attention needs to be given to patient satisfaction surveys. Patient satisfaction depends a great deal on the patient's expectations and mindset upon referral to the pain clinic. Since a patient's expectation is generally not within the control of the pain physician, it can be problematic to find a consistent measure of satisfaction.

One can measure pain intensity by using visual analog or numerical rating scales. These rate pain between 0, "no pain," and 10, "unbearable or excruciating pain." The McGill Pain Questionnaire adds sensory, affective and evaluative dimensions to the measurement of pain intensity. Scales showing pictures of faces representing different degrees of distress can be used to assess pain intensity in children.

Because pain is inherently a complex, subjective experience, pain intensity may not be adequate as the sole outcomes measure. Physicians often turn to objective measures of functional impact such as quality-of-life or economic indicators. Also, it is important to recognize both the physical and psychological dimensions of pain. Physical dimensions include participation in such activities as hobbies or working. Psychological impact includes affective components of mood such as depression.

Third-party payers often value health care utilization as an outcome. Good outcomes are associated with decreased utilization of resources as measured by number of office visits, emergency room and hospital admissions or prescription drug utilization. It can be difficult, however, to make accurate cost and expense estimates in today's health care environment, especially in capitated systems.

The ideal outcomes tool should be easy to use and brief enough to allow for high patient compliance. By minimizing the time needed to complete the survey, patients are more likely to provide their full attention to the task. The ideal outcomes tool also should be reliable and validated for the population to be measured. This is particularly important to consider when assessing outcomes in children or patients who do not speak English.

#### Select the Right Survey Tools

One can collect outcomes data through telephone polling, written questionnaires or direct computer entry. Telephone follow-up often provides a higher degree of compliance but requires increased personnel effort. Telephone calls must be repeated frequently if the patient is unavailable and take more time to conduct and score. Written questionnaires can be used with less expense, although the compliance rate is often less than telephone surveys. Written surveys may provide more accurate assessments because more questions can be asked, and there is less likelihood that the patient will be influenced to answer one way or another to meet perceived expectations of the interviewer. Direct computer entry is a promising option for patients who have the requisite skills. Patients may enter their responses directly on a computer in the office, over the Internet through e-mail or by using portable, handheld electronic devices.

A variety of outcomes survey tools are available. The

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## **Table 1: ASA Nine Outcomes Measures**

#### To be answered by pain patient:

- All things considered, the results of my pain treatment were worth the cost.
  - 1. Strongly disagree
  - 2. Moderately disagree
  - 3. Agree
  - 4. Moderately agree
  - 5. Strongly agree
- 2. How satisfied are you with your pain treatment?
  - 1. Completely satisfied
  - 2. Somewhat satisfied
  - 3. Neither satisfied nor dissatisfied
  - 4. Somewhat dissatisfied
  - 5. Completely dissatisfied
- 3. How much pain have you (on average) had recently?
  - 1. None
  - 2. Mild
  - 3. Moderate
  - 4. Severe
  - 5. Excruciating
- 4. What effect on your overall health has your pain treatment had?
  - 1. Made it much worse
  - 2. Slightly worse
  - 3. No change
  - 4. Slightly better
  - 5. A great deal better
- 5. Recently, how often has your pain interfered with your activities (like visiting friends, doing hobbies and working)?
  - 1. All of the time
  - 2. Most of the time
  - 3. Some of the time
  - 4. A little of the time
  - 5. None of the time

- 6. What effect has your pain treatment had on your ability to perform daily activities?
  - 1. Made it much worse
  - 2. Slightly worse
  - 3. No change
  - 4. Slightly better
  - 5. A great deal better
- 7. Recently, how much of the time have you felt "down in the dumps"?
  - 1. All of the time
  - 2. Most of the time
  - 3. Some of the time
  - 4. A little of the time
  - 5. None of the time
- 8. Since your pain treatment, has there been a reduction in the need for medicines, appointments to your physician or other consultants, unplanned emergency room visits or unplanned hospital admissions?
  - 1. There has been a significant reduction
  - 2. There has been some reduction
  - 3. There has been no change
  - 4. There has been some increased usage
  - 5. There has been a significant increased usage

#### To be answered by treating physician:

- 9. In your professional assessment (e.g., physical findings, diagnostic and/or laboratory testing), how has pain treatment improved the health of your patient?
  - 1. No improvement
  - 2. Very mild improvement
  - 3. Moderate improvement
  - 4. Significant improvement
  - 5. Restored to normal health

ASA Committee on Pain Management in 1997 developed the ASA-Nine outcomes measures questionnaire [Table 1]. These questions assess key dimensions of pain and outcomes. Eight of the questions are answered by the patient (or in the case of pediatric patients, their parents), and one is answered by the treating physician. Two other tools that are well-validated include the health status surveys SF-12\* and SF-36\*, which contain 12 and 36 questions, respectively.

#### Decide When to Measure and Who

When should outcomes be measured? It is necessary to obtain a baseline assessment prior to the initial patient visit to establish a point of reference for subsequent measurements. If the survey is given shortly after the patient's appointment, it may be too soon for the treatment to have its full effect. Measurement at some later time such as three or six months may provide a more accurate assessment of the durability of treatment effect. However, assessing outcomes at later times can raise several problems. Inquiring about patients' symptoms at later times may inappropriately focus a patient on past issues (e.g., pending litigation, disability). It is common for patients to write back and request further assessment of chronic problems when prompted by an outcomes survey.

Measuring outcomes at later times also increases the chance that intervening events may confound the outcome. For example, the patient may be involved in an accident between his or her visit to a pain clinic and an outcomes survey at six months. It would be inappropriate to attribute a poor outcome to an ineffective pain treatment when that outcome may be due to the intervening accident. One way around this is to ask patients if they would recommend similar treatment to a friend or relative who found themselves in similar circumstances. This approach asks the patient to distinguish between the treatment given during the visit and any intervening confounding events.

Which patients should be surveyed? Ideally, all patients seen in a practice should be asked to complete an outcomes survey. If resources do not allow this, it would be possible to survey a smaller number of patients randomly selected from the practice. Alternatively, it might also be reasonable to survey only a selected portion of the practice that has a given diagnosis or treatment. In any case, it is important to recognize that the outcomes one observes cannot necessarily be causally attributed to the care rendered. That is to say, the outcomes will be associated with the care

"Ideally all patients seen in a practice should be asked to complete an outcomes survey. If resources do not allow this, it would be possible to survey a smaller number of patients randomly selected from the practice."

provided, but without a control group, it is impossible to prove that the outcomes are attributable to the treatments given.

At the Mayo Pain Clinic, we use a written survey that includes 19 questions. The questionnaire is given at the initial patient visit and mailed at three and six months following the visit. It is therefore possible to observe the change of physical and psychological function over time. The forms are scanned and scored by machine. This information is then correlated with patient demographic data, diagnoses and treatment. We follow outcomes trends continuously so that we can recognize either improvements or problems associated with the treatments we give.

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## Medicare Coverage and Compliance in Pain Management

Allan R. Escher, Jr., D.O. Lawrence S. Gorfine, M.D. Committee on Pain Medicine

n June 14, 2001, Health and Human Services Secretary Tommy Thompson announced a series of measures to reform the operations of the Centers for Medicare & Medicaid Services (CMS), known then as HCFA, and to improve service for the nearly 40 million Medicare and 37 million Medicaid beneficiaries and their physicians. The administrator of CMS, Thomas A. Scully, announced three new initiatives to make CMS "responsive, efficient and accessible." First, Mr. Scully proposed the creation of Open Door Policy Committees chaired by himself and other senior-level staff who will hear from providers and beneficiary groups in the formulation of policy input. Second, Regional Forums open to the public would gauge the effects of CMS policies. Lastly, Mr. Scully proposed the creation of in-house expert teams to think "out of the box" on ways to simplify regulations and decrease administrative burdens. Indeed, such proposals are certainly positive and hopefully will be of benefit to all physicians.

Pain management patients can present challenges in both diagnosis and treatment plans. Many patients may have several pain conditions requiring the involvement of a multidisciplinary approach.

Frequently, the greatest challenge is formulating a treatment plan that will benefit the patient and also stand up to the scrutiny of Medicare and other third-party payers. To help meet this goal, a new Medicare Web site can be reached at <www.hcf.gov/medicare/mr>. This Web site is an educational tool to help physicians, other providers and the public better understand the coverage decision process and to answer common questions. An area of recent heightened media attention is Medicare fraud.

Many physicians are afraid of fines or even jail for innocent mistakes. The site provides a brief overview of the government's main enforcement tool, the False Claims Act. This act covers offenses "committed with actual knowledge of the falsity of the claim, reckless disregard of the truth or falsity of the claim or deliberate ignorance of the truth or falsity of the claim." The other remedy of the federal government is the Civil Monetary Penalties Law, which has the same standard of proof. In summary, CMS attempts to distinguish between innocent errors and negligence (erroneous claims) as opposed to reckless or intentional conduct (fraudulent claims).

To reduce the incidence of errors, CMS established the Medicare Integrity Program (MIP). An overview of the MIP is provided in the form of a 12-chapter manual that gives examples of fraudulent activities, program memoranda and guidelines. Medical Review, Benefit Integrity and Medicare Integrity Program Provider Education and Training (MIP-PET) are discussed in chapter one; also of benefit are separate exhibits and archives to illustrate the policies regarding Medicare integrity.

CMS established new contracting entities called the Program Safeguard Contractors (PSCs). A PSC can perform with CMS authority any or all of the following: medical review, cost-report audits, data analysis, provider education and fraud protection. A common fallacy is the belief that PSCs get bonuses (bounties) for dollars recovered from providers. CMS is quick to point out that MIP funding is stable and that all monies recovered are returned to the Medicare Trust Fund. Physicians may proactively conduct self-audits to identify coverage and coding errors using the Office of the Inspector General Compliance Program Guidelines, which can be found at <www.os.dhhs.gov/oig/modcomp/index.htm>.

The coverage of pain procedures by Medicare is a



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perennial source of consternation among pain medicine physicians. There are two types of coverage decisions: National Coverage Decisions (NCD) and Local Medical Review Policy (LMRP). NCDs are established by CMS to describe the circumstances for coverage of a specific medical service procedure or device. Once an NCD is published, the decision is binding on all carriers, program contractors, peer-review organizations and Medicare Plus Choice organizations. Of particular importance, the NCD is binding on an administrative law judge during the claims review process. The review process in approving an NCD is rigorous and includes a National Coverage Request Application, Coverage Decision Memorandum and an expert panel review.

CMS contracts with private insurance groups, variously called carriers, intermediaries or PSCs, to process Medicare claims. These "Medicare contractors" then review and render decisions to ensure that the service is covered under Medicare Part A or B. However, "in the absence of a specific national coverage decision, local contractors may make coverage decisions at their own discretion." Treatment plans can be constrained by LMRPs. This is due to the fact that Medicare carriers establish LMRPs to give guidance to physicians in terms of delivery of care and payment of care within a specific geographic area. Contractor medical directors develop these with input from physicians on advisory committees so that they are "consistent with scientific evidence and clinical practice." Contractors' LMRPs may be accessed on a monthly basis on the Web site <www.lrmp.net>.

In Florida, policy number E0782 governs the coverage of implantable infusion pumps. This provides detailed information on such topics as coding guidelines, LMRP description and indications of medical necessity for the system. Approved indications are "Chemotherapy for Liver Cancer," "Anti-Spasmodic Drugs for Severe Spasticity," "Opioid Drugs for Treatment of Chronic Intractable Pain" and "Other Uses" approved by the "contractor's medical staff." Under the "Other Comments" section, definitions are given ranging from the obvious "chronic: persisting over a long period of time" to the esoteric such as "torsion dystonia." Under "Advisory Committee Notes," one learns that this LMRP was developed with input from "representatives of the Florida Society of Anesthesiologists and pain medicine specialists." This is the ideal way for LMRPs to be formulated, with the active involvement of the relevant specialists.

An example of a denied procedure is percutaneous lysis of epidural adhesions on the basis that it is "not considered medically reasonable or necessary," or that the procedure is "investigational." Subjective evidence of clinical benefit to the patient in one's practice does not translate to Medicare coverage of the service or procedure. Objective outcomes data provide the best tool to shape LMRPs in the advisory committee setting. Physicians must be proactive in the draft process of these LMRPs! One can get involved by contacting the contractor medical director in one's geographic area and offering one's expertise in the development of future relevant LMRPs. Also, effective January 1, 2001, contractors began listing draft LMRPs on their Web site, allowing physicians to comment electronically. CMS' new Web site <www.draftlmrp.net> offers browsing, title searches and expeditious links.

Physicians also can provide input through the Carrier Advisory Committee (CAC) structure. One should become familiar with the physicians on the local CAC. If pain management is not represented on the CAC, one could advocate for its presence. There is definitely a push under Secretary Thompson to empower physicians to give input into coverage decisions by Medicare; recent policy revisions reflect this.

Effective October 1, 2001, there will be annual mandated reviews of all LMRPs. Carriers must revise within 90 days those that contradict NCDs, coverage provisions in interpretive manuals or national payment policies. Changes in transmittal #14 (9/26/01) of the Medicare Program Integrity Manual mandates the following disclaimer be included in all LMRPs: "...Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from [fill in appropriate specialty name]." It is up to physicians to fill in this most appropriate blank.

## What's the Fuss Over OxyContin and Other Long-Acting Opioids?

Lynn Broadman, M.D. James P. Rathmell, M.D., Chair Committee on Pain Medicine

hat is all the fuss over OxyContin®? The fact is, in recent times, a great deal of criminal activity has been associated with OxyContin (controlled-release oxycodone), the likes of which has not been seen since the release of Quaalude® (methaqualone) three decades ago. Forty pharmacies in Massachusetts alone have been held up, mostly at gunpoint and mostly in the Boston area, just to obtain OxyContin. The problem is so acute that a task force has been convened in Massachusetts to study the problem. One of the preliminary suggestions of this task force is that OxyContin should only be dispensed from hospital pharmacies where a security force is present to provide protection for pharmacy personnel and customers.

OxyContin was introduced in 1995. The Food and Drug Administration's approved indication for OxyContin is for treatment of patients with moderate to severe pain who are expected to need continuous opioids for an extended time. In 1996, only 300,000 prescriptions were filled for this drug. That number soared to nearly 6 million in 2000. OxyContin is now the most widely prescribed opioid for the control of moderate to severe pain. This has led to an increased opportunity for misuse and diversion of the drug, which in turn has resulted in an epidemic of oxycodone overdoses in the Appalachian regions of Maine, Pennsylvania, Virginia and West Virginia, where heroin and other illicit drugs are difficult to obtain. The death rate due to oxycodone overdose has more than doubled in the United States in the past year, from about 100 per year to more than 200. We should, however, view this statistic in context — during the same time period, nearly 16,000 people died from complications related to use of nonsteroidal anti-inflammatory drugs.

Treatment with OxyContin has become so popular

"Preventing drug abuse is an important societal goal, but... it should not hinder patients' ability to receive the care they need and deserve."

because it provides effective pain relief and does not have the stigma associated with morphine. It fills a niche not filled by any other opioid analgesic. We believe that MS-Contin® never gained popularity outside of pain and oncology clinics because of the stigma associated with morphine. Most physicians knew that morphine was a potent opioid analgesic and that it was potentially addicting. On the other hand, many physicians were familiar with the short-term use of oxycodone. While they knew that, like morphine, oxycodone was a Schedule II agent in the Controlled Substances Act, their experience led them to believe that it was seldom addicting and not troublesome. Physicians outside the pain and oncology clinic environment immediately felt comfortable in prescribing OxyContin. Many still feel comfortable in prescribing OxyContin and other potent long-acting opioid analgesics, but concerns are rising, so much so that physician groups are now meeting with government agencies to formulate a plan to combat the problem.

On July 11, 2001, members of ASA, the American Academy of Pain Medicine, the American Pain Society, the American Society of Regional Anesthesia and Pain Medicine and other concerned medical personnel met with rep-



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resentatives of the Drug Enforcement Administration (DEA) to discuss the problem and draft a consensus statement. A joint statement was drafted [see box].

Two further meetings between government agencies and the medical community were scheduled. The first was set for September 13-14, 2001, in Rockville, Maryland. Here, the Food and Drug Administration's Anesthetic and Life Support Drugs Advisory Committee intended to discuss use of OxyContin and other opioids. The DEA called a meeting of the Practitioners Working Committee for September 25, 2001, in Arlington, Virginia to discuss "...a dramatic increase in the illicit availability and abuse of several prescription drugs." Both meetings were canceled in the aftermath of the terrorist attacks on September 11 but are being rescheduled.

Members of the ASA Committee on Pain Medicine will attend each of these proceedings. Our efforts will be to maintain access to all opioids for our patients who need them while assisting federal agencies in developing effective strategies for combating abuse and diversion.

Due to the rise in OxyContin abuse in the United States, the DEA and the health organizations mentioned in this article held a press conference on October 23, 2001, in Washington, D.C. The organizations involved in this unprecedented meeting discussed the problems associated with recent diversion and abuse of opioid pain relievers. For more information on the conference, visit <www.lastacts.com>.

## **Joint Statement on Prescription Pain Medications**

As representatives of the health care community and law enforcement, we are working together to prevent abuse of prescription pain medications while ensuring that they remain available for patients in need.

Both health care professionals and law enforcement and regulatory personnel share a common responsibility for ensuring that prescription pain medications are available to the patients who need them and for preventing these drugs from becoming a source of harm and abuse. We all must ensure that accurate information about both the legitimate use and abuse of prescription pain medications is made available. The roles of both the medical professionals and law enforcement personnel in maintaining this essential balance between patient care and diversion prevention are critical.

Preventing drug abuse is an important societal goal, but there is consensus, by law enforcement agencies, health care providers and patient advocates alike, that it should not hinder patients' ability to receive the care they need and deserve.

This consensus statement is necessary based on the following facts:

Under-treatment of pain is a serious problem in the United States, including pain among patients with chronic conditions and those who are critically ill or near death. Effective pain management is an integral and important aspect of quality medical care, and pain should be treated aggressively.

For many patients, opioid analgesics — when used as

recommended by established pain management guidelines — are the most effective way to treat severe pain and often the only treatment option that provides significant relief.

Because opioids are one of several types of controlled substances that have potential for abuse, they are carefully regulated by the Drug Enforcement Administration and other state agencies. For example, a physician must be licensed by state medical authorities and registered with the DEA before prescribing a controlled substance.

In spite of regulatory controls, drug abusers obtain these and other prescription medications by diverting them from legitimate channels in several ways, including fraud, theft, forged prescriptions and via unscrupulous health professionals.

Drug abuse is a serious problem. Those who legally manufacture, distribute, prescribe and dispense controlled substances must be mindful of and have respect for their inherent abuse potential. Focusing only on the abuse potential of a drug, however, could erroneously lead to the conclusion that these should be avoided when medically indicated — generating a sense of fear rather than respect for their legitimate properties.

Helping doctors, pharmacists, health care providers, law enforcement and the general public become more aware of both the use and abuse of pain medications will enable all of us to make proper and wise decisions regarding the treatment of pain. (More information about the consensus statement and actions surrounding it can be found at <www.lastacts.org>.)

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## Alphabet Soup: ASIPP, ASRA and ASA

### Do We Need Them All? Who Best Takes Care of the Pain Management Anesthesiologist?

Ann C. Still, M.D. Committee on Pain Medicine

With the continued barrage of controversial issues in the area of pain medicine, many pain physicians question what organization they should look to regarding state-of-the-art techniques, new medicines, research outcomes, ever-changing billing and coding issues and the latest legislative policies. State and national agencies hear varying testimony as to what pain medicine is, who should practice it, what procedures are appropriate for safe and cost-effective patient care and how physicians should be reimbursed. To whom should these agencies listen as the organization that speaks for the pain physician? Two such organizations, in addition to ASA, have taken the lead in pain medicine educational and legislative issues.

#### **ASIPP**

The American Society of Interventional Pain Physicians (ASIPP) was begun in November 1998 as the Association of Pain Management Anesthesiologists to represent interventional pain physicians dedicated to improving the delivery of interventional pain management services across the country. It was their contention that ASA was not looking out for pain physicians who spent little or no time practicing operating room anesthesia. Due to the diverse backgrounds of pain physicians, their name was changed to the American Society of Interventional Pain Physicians so not to exclude other specialists who practiced interventional pain management. The mission of this organization is "to promote the development and practice of safe, high-quality, cost-effective interventional pain medicine techniques for the diagnosis and treatment of pain and related disorders and to ensure patient access to these interventions."

Having grown to more than 1,000 members in just three years, ASIPP has become very visible on both state and



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national levels in the promotion of the practice of interventional pain medicine. A few of their achievements include:

- 1. Passage of the Med PAC Study Bill, which examines barriers to coverage and payments for outpatient interventional pain procedures, including ambulatory surgical centers (ASCs), hospital outpatient and physician offices;
- 2. Inclusion of nine new or replacement codes in the ASC-approved list;
- 3. Level III Current Procedural Terminology  $^{\text{\tiny TM}}$  code for spinal endoscopy; and
- 4. Approval of a new classification for interventional techniques, with higher reimbursement in hospital outpatient settings, including intrathecal pumps.

Through the formation of the ASIPP-Political Action Committee, its presence in Washington has been heard. Tireless lobbying efforts for interventional pain medicine and support of congressional leaders have not gone unnoticed. It is through this means that the Centers for Medicare & Medicaid Services now recognizes pain management as a separate specialty designation.

In addition to its legislative activities, a goal of this organization is the pursuit of excellence in interventional pain education. ASIPP held its Third Annual Meeting, a combined educational and legislative meeting, in Washington, D.C., on September 15-17, 2001. This year's reception honored Congressmen Edward Whitfield (R-KY) and Ernest Lee Fletcher (R-KY) along with invited guest Tommy Thompson, Secretary of Health and Human Services.

#### **ASRA**

The American Society of Regional Anesthesia and Pain Medicine (ASRA) has long been recognized as the premier leader in promoting the education and research of regional anesthesia and pain. Its mission is "to associate and affiliate into one organization all anesthesiologists and other physicians and scientists who are engaged in or interested in the techniques of regional anesthesia for surgery, obstetrics and pain control; to encourage specialization and research in these areas; to promote and sponsor courses and workshops to disseminate information on regional anesthetic procedures; to encourage the teaching of regional anesthetic procedure in all anesthesiology training programs; to edit and publish articles in these and related subjects; and in all ways to develop and further the knowledge of safe techniques for providing surgical and obstetrical

anesthesia with local anesthetic agents and for producing diagnostic and therapeutical blocks with local and lytic agents for the management of pain."<sup>2</sup>

ASRA has recently undergone a total realignment in order to more closely meet the educational needs of its pain medicine physicians. The Society's annual meeting previously contained equal offerings of regional anesthesia and pain medicine. Beginning in April 2002, the Chicago meeting will contain a modicum of pain medicine. The major emphasis of this meeting will be on regional anesthesia for obstetrics, pediatrics and the operating room. A new pain meeting will be held at The Pointe Hilton Squaw Peak, Phoenix, Arizona, on November 7-10, 2002. This three-and-one-half-day meeting will be devoted entirely to pain medicine. Abstracts will be accepted for this meeting, and poster presentations and poster discussions will be held. The John J. Bonica Lecture, an endowed lecture by an expert in the field of pain medicine, will be moved from the annual spring meeting to the fall pain meeting. Lectures on interventional techniques and outcomes will be held. It is anticipated that this new format will strengthen the Society by having two strong components: pain medicine and regional anesthesia.

Five of the 11 active members of the Board of Directors of ASRA are pain medicine specialists, and the journal *Regional Anesthesia and Pain Medicine* is accepting more pain articles for publication than ever before. All of these moves are meant to show our pain medicine physicians that this educational society is totally in support of this new and evolving field of medicine.

As there are now three specialties recognized by the American Board of Medical Specialties with recognized subspecialty certification in pain, should there be more than one organization involved in issues of pain medicine practice? Is the field advancing and changing at such a rapid pace that it necessitates having more than one watchdog keeping an eye on the ranch? Clearly, ASRA has demonstrated its excellence as the leader for the educational and scientific advancement of regional anesthesia and pain medicine. We look forward to the changes they have instituted with a concentrated focus on pain medicine. ASIPP, during its short existence, has excelled at educating our congressional leaders and influencing changes in coding and reimbursement issues and legislative policy. It appears as if both organizations are helping pain physicians in all specialties.

#### ASA

Where does ASA fit into the equation, with its eye having been so focused on the operating room practice of anesthesiology? First and foremost, we must not forget we are anesthesiologists by training. ASA is the national organization that represents all anesthesiologists and deserves our support.

The ASA Committee on Pain Medicine has published three practice parameters dealing with pain medicine: "Practice Guidelines for Acute Pain Management in the Perioperative Setting," "Practice Guidelines for Cancer Pain Management" and "Practice Guidelines for Chronic Pain Management." 3-5

For those critical of what ASA has or has not done for pain physicians, I challenge you to come and join us in the trenches and help anesthesiology be the leader advancing the specialty of pain medicine.

So who will win the title of "leader and voice" for pain medicine anesthesiologists? Whether you pick ASA, ASIPP or ASRA as your leader, one thing is for sure: All pain physicians need to work and support one another in the quest for quality, safety and the delivery of cost-effective pain care. We will all lose, including our patients who desperately need us, if we cannot come together and work for the benefit of *all* pain physicians, no matter what form of pain medicine we practice.

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## **Continuing Medical Education on the Internet:**

ASA/ASRA Electronic Regional Anesthesia and Pain Medicine Techniques Workshop

James P. Rathmell, M.D., Chair Committee on Pain Medicine

There is the future of continuing medical education (CME)? How will physicians choose to keep their knowledge and skills up to date? Will the traditional practice of attending structured meetings with formal lectures and workshops remain the most common educational forum? ASA has ventured into some exciting new means for providing CME using the Web and electronic media. The first program, a joint program between ASA and the American Society of Regional Anesthesia and Pain Medicine (ASRA), was filmed in March 2001 and is available now on the Internet. This article will explain how the Electronic Regional Anesthesia and Pain Medicine Techniques Workshop program was conceived and assembled, what the final product looks like and some of what we have learned about the promise of producing useful electronic CME programs.

The ASA Committee on Pain Medicine and the ASRA Board of Directors first proposed hosting a joint educational program in 1999. At the same

time, the ASA Committee on Outreach Education was planning its annual Regional Refresher Courses and at the request of ASA members, the committee was hoping to assemble a meeting about pain medicine. ASA also was looking for an experimental project to replace the traditional weekend meeting with a program distributed electronically. Our original proposal called for five speakers, filmed presentations and distribution over the Internet or via CD-ROM. Our goal was to maximize the advantages of electronic media by incorporating extensive graphics and video. A techniques workshop in pain medicine would allow us to film procedural details and include informative



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Figure 1: Sunil J. Panchal, M.D., and the crew from SeminarSource.com filming fluoroscopic sequences for sympathetic blocks.

video sequences such as fluoroscopic techniques. During the course of the year 2000, the ASA Board of Directors approved the program in a scaled-down version to include three speakers.

The lecturers included Joseph M. Neal, M.D., from Virginia Mason Medical Center (thoracic epidural analgesia), Sunil J. Panchal, M.D., from Cornell University (sympathetic blocks) and James P. Rathmell, M.D. (neurolytic blocks for cancer pain). Prior to the filming, each speaker assembled a 45-minute PowerPoint® presentation along with extensive graphics. The staff at ASA headquarters obtained copyright releases on all graphics (an enormous task for the hundred or more images used).

The lecturers and the San Diego-based film crew (SeminarSource.com) gathered at the University of Vermont for a one-day filming session in March 2001. In the morning, we filmed the procedural sequences, including thoracic epidural placement, sympathetic blocks and neurolytic blocks [Figure 1]. Anatomic spine models, a live model and a cadaver were used for demonstrating the procedures; fluoroscopy sequences were filmed for the blocks that generally are performed with X-ray guidance (e.g., neurolytic celiac plexus block). On the afternoon of filming, each speaker presented his PowerPoint lecture [Figure 2]. With guidance from the speakers, the SeminarSource crew then



Figure 2: Joseph M. Neal, M.D., filming the presentation on thoracic epidural analgesia.

edited and assembled programs, inserted the procedural video and placed the program on the Internet.

The final product is available to all ASA and ASRA members and can be accessed through either the ASA or ASRA Web sites or by going directly to <www. seminarsource.com/asa>. An introductory video is available free of charge; each one-hour workshop is offered for CME credit at \$35 per workshop. The program uses video-streaming technology (RealPlayer<sup>®</sup>) allowing participants to view the speakers and their procedural videos adjacent to the slide presentation via the Internet [Figure 3]. This works best with high-speed Internet access (DSL, cable or satellite) but is quite reasonable (although somewhat choppy) with a 56K dial-up connection. The lectures are indexed so users can jump from topic to topic within the lectures, reviewing sections at their own pace. Following each lecture, there is a brief multiple-choice test for CME credit.

So, what have we learned about electronic CME? These new electronic media work. They are effective teaching tools. Membership response has been positive — the Web site has received thousands of hits, and many have registered for the programs. The feedback has been excellent. The participant consensus is that electronic media offers an effective way to learn, and all have called for

future programs covering other anesthesia topics. But producing a program like this is labor-intensive, time-consuming and expensive. The requirements put on the speakers are burdensome. Their presentations had to include extensive graphics and be completed months in advance to allow time to obtain copyright releases. And our mistakes — the "ums" and "ers," the pauses, typos — were all captured on film (although there were surprisingly few).

Electronic media is here to stay in the world of CME. Sure, traditional meetings will continue, as 45 minutes in front of a computer terminal cannot rival the fine dining and other diversions available during a week in New Orleans. Future physicians, however, will have more choices. Many technical skills such as the X-ray-guided needle placement techniques filmed for this program lend themselves well to electronic presentations and allow the student to review the technical details whenever they wish, perhaps just before performing the technique

themselves. You cannot get that from of a textbook! The ASA/ASRA Electronic Regional Anesthesia and Pain Medicine Techniques Workshop will be available through mid-2002.

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Figure 3: The final appearance of the Electronic Regional Anesthesia and Pain Medicine Techniques Workshop as it appears online.

## **Epidural PCA During Labor**

Robert D'Angelo, M.D.

The use of epidural patient-controlled analgesia, more commonly referred to as patient-controlled epidural analgesia (PCEA), is becoming increasingly popular in treating labor pain because the technique offers theoretical advantages over intermittent bolus and continuous infusion techniques. These advantages include the potential to reduce local anesthetic use and side effects, increase patient satisfaction and reduce clinician workload.

PCEA theoretically reduces local anesthetic drug use by allowing patients to self-administer only the amount of local anesthetic they require to produce labor analgesia. In contrast, infusion rates with continuous techniques are typically set to produce analgesia in the majority of patients rather than titrated to individual patient requirements. Reducing local anesthetic use with PCEA should lessen the incidence of side effects such as motor block and hypotension and increase satisfaction since these patients experience fewer side effects. In addition, the "feeling of self control" that patients experience with PCEA also contributes to increased satisfaction.

For the anesthesia care provider, however, the most appealing aspect of PCEA may be the potential to reduce workforce requirements. In contrast to continuous infusion techniques that require the anesthesia care provider to physically increase or decrease the infusion rate or administer additional local anesthetic boluses as needed, patients with PCEA simply self-administer additional local anesthetic as needed. The anesthesia care provider is only called if multiple self-administered boluses fail to enhance analgesia. With projections indicating that the number of deliveries and utilization of epidural analgesia will increase in the future while the number of anesthesia care providers will decrease, it is easy to see why the PCEA technique is so appealing.<sup>1</sup>



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"[A]dvantages [of PCEA] include the potential to reduce local anesthetic use and side effects, increase patient satisfaction and reduce clinician workload."

Despite the clear theoretical advantages of PCEA, it is unclear from the literature how best to utilize PCEA in obstetrics. PCEA devices can be programmed to vary the basal infusion rate, the on-demand dose, the lockout interval and the hourly dose limit. However, studies that examine PCEA use during labor vary so significantly in study design<sup>2</sup> (they measure different endpoints, utilize a wide range of PCEA settings and usually enroll small numbers of patients) that using an evidence-based approach to guide clinical practice is nearly impossible [Table 1]. These studies do, however, collectively suggest that PCEA offers advantages over both the intermittent bolus and continuous infusion techniques [Table 2]. The use of a basal infusion in obstetrics, on the other hand, remains controversial. The few studies that control for basal infusions generally find that they increase total drug use without significantly enhancing analgesia.3-5 Other important variables such as patient satisfaction and assessments of manpower requirements, however, are generally not adequately evaluated in these studies.

Potential disadvantages of PCEA include the risk of the patient receiving excessive amounts of local anesthetic, leading to a high block, seizure or cardiac arrest and increased operational costs. A local anesthetic overdose could theoretically occur from excessive self-administration in the presence of a "patchy block" in patients without the mental capacity or language skills required to understand the technique or from overly helpful family members pressing the on-demand button. Although toxicity should always be a concern when administering local anesthetics, the dilute local anesthetic solutions administered in contemporary obstetric anesthesia practices reduce the risk of a life-threatening overdose. In fact, there has not been a reported case of a local anesthetic-induced cardiac arrest in a laboring patient within the United States since 1984.

# Table 1: Studies Examining PCEA During Labor <sup>2</sup>

Number of Studies	18
Patients Administered PCEA/Total Patients	938/1698
Techniques Compared (# of Studies)*	
IB + PCEA	3
CI + PCEA	8
CI + IB + PCEA	3
PCEA Alone	4
Used a Basal Rate (# of Studies)	7
Basal Rate (Range)	0-6 ml/hr
Bolus Dose (Range)	3-12 ml
Lockout (Range)	10-24 min
Hourly Limit (Range)	12-24 ml

\*IB = Intermittent Bolus, CI = Continuous Infusion, PCEA = Patient-Controlled Epidural Analgesia

Although relatively few parturients over this time period were administered labor analgesia by PCEA, our clinical experience with PCEA at Wake Forest University suggests that the technique is safe in obstetrics. We have utilized PCEA in approximately 30,000 patients since 1995 and have experienced no problems with excessively high blocks or local anesthetic overdoses.

Utilizing PCEA is, however, generally more expensive than continuous infusion techniques. A PCEA device costs approximately \$300-500 more per unit to purchase than a comparable continuous infusion device. PCEA devices administer drugs by using either syringes or plastic collapsible containers (intravenous [I.V.] bags) as reservoirs. The devices that use I.V. bags generally require expensive PCEA tubing in order to operate properly, while those that use syringes save money by operating with standard I.V. extension tubing. The primary drawback of the PCEA devices that use syringes is that they are limited to a 60 ml syringe that must be changed more frequently than the 100-250 ml I.V. bags typically used with the alternative PCEA devices. Variables such as the location where the PCEA devices will be utilized (average infusion durations are

longer in the intensive care unit than on a labor suite), number of cases per year, patient population (pediatrics versus obstetric), individual staffing constraints as well as cost all should be considered before purchasing PCEA devices. We utilize PCEA devices at Wake Forest University with 130 ml reservoirs that require special tubing to operate. For our practice, we believe that the benefits of PCEA far outweigh any risks and the increased cost.

Since no clear recommendations can be made from the literature on how best to utilize PCEA in obstetrics, two significantly different clinical regimens will be described that both reportedly produce excellent labor analgesia and high patient satisfaction while achieving different clinical endpoints. In Australia, Michael Paech, M.D., administers 0.0625 percent bupivacaine with fentanyl 2 mg/ml and clonidine 4.5 mg/ml using the following PCEA settings: no basal infusion, 4 ml on-demand bolus, 15 minute lockout, 16 ml hourly dose limit (from a personal communication). This regimen primarily uses PCEA to reduce local anesthetic use and side effects. In contrast, we primarily utilize PCEA at Wake Forest University to reduce worker requirements. We view PCEA as an advanced continuous infusion technique that allows the patient to administer additional local anesthetic boluses when needed. We routinely administer 0.11 percent bupivacaine with fentanyl 2 mg/ml using the following PCEA settings: 10 ml/hr basal infusion, 5 ml on-demand bolus, 10 minute lockout, 30 ml

Table 2: Summary of Findings From 18 Labor PCEA Studies <sup>2</sup>

Outcome Associated with PCEA	Number of Studies*
Reduced Drug Use	6
Reduced Motor Block	4
Lower Pain Scores	2
Increased Maternal Satisfaction	5
Reduced Workload	5
No Differences Found	4

<sup>\*</sup> Some studies report multiple benefits with PCEA.

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hourly dose limit. Even with these higher PCEA settings, it is our clinical opinion that PCEA produces excellent labor analgesia with minimal side effects, increases patient satisfaction and significantly reduces workload. It was previously estimated that PCEA reduces our workload by at least six hours per day, a considerable savings in time on a busy labor unit.<sup>6</sup>

Although both regimens outlined reportedly produce excellent labor analgesia, the Australian regimen is not likely to satisfy our primary goal of reducing workload. Although different PCEA regimens may very well produce equivalent labor analgesia, other factors such as variations in the drugs administered, patient populations and patient and physician expectations may also contribute toward producing labor analgesia. Although these examples illustrate that "ideal" PCEA settings for laboring patients do not currently exist, the literature does suggest that the PCEA technique offers advantages over intermittent and continuous infusion techniques. Until more definitive PCEA studies are conducted, clinicians should tailor PCEA settings to suit their own individual practice needs.

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## **Washington Report**

Continued from page 4

## **Conversion Factor Concerns Increase**

In the past month, concerns have increased among the various medical specialties about the impact for 2002 of the current Medicare Fee Schedule update formula, which is tied in part to changes in the gross domestic product. Specialties are cooperating in an effort to gain relief from a negative update either from CMS or Congress. Given the fact

that Congress is expected to adjourn some time between November 1 and the Thanksgiving holidays, efforts to develop legislation — absent adequate CMS action — will be a significant undertaking.

ASA is fully involved in this effort, while at the same time attempting to persuade CMS in its final fee schedule rule for 2002 to significantly increase the value attributed to physician work performed by anesthesiologists. ASA spent several months

dealing with various subgroups of the AMA-Specialty Society Relative Value Update Committee (RUC), which advises CMS on fee schedule matters, but was never able to obtain a firm recommendation to CMS from the RUC itself.

# Residency Composition and Numbers Graduating from Residencies and Nurse Anesthesia Schools

Alan W. Grogono, M.D.

nesthesiologists and nurse anesthetists have been interested in and concerned about workforce issues since the threat of a relative surplus emerged in the early 1990s. This threat appears to have affected both groups and caused a reduction in the numbers entering the workforce. This article provides updated information provided

increase [Table 1 and Figure 1]. This is still 49 percent less than the peak of 1,796 graduating only six years ago in 1995. The numbers in training (CA-1=1,466; CA-2=1,374; CA-3=1,253) indicate that the number graduating should continue to increase, at least for the next three years. However, even if no attrition occurs from the residencies, these

Table 1

		PG-1			CA-1		CA-2		CA-3		Grad
Year	AMG	IMG	Total	AMG	IMG Total						
1985	419	53	472	1,331	183 1,514	1,194	256 1,450	374	121 495	927	274 1,201
1986	330	37	367	1,360	124 1,484	1,334	162 1,496	508	143 651	984	259 1,243
1987	352	52	404	1,285	133 1,418	1,340	114 1,454	711	113 824	1,013	185 1,198
1988	279	43	322	1,360	151 1,511	1,324	125 1,449	1,179	102 1,281	708	116 824
1989	264	29	293	1,414	178 1,592	1,396	145 1,541	1,324	126 1,450	1,171	102 1,273
1990	425	54	479	1,452	204 1,656	1,419	174 1,593	1,372	146 1,518	1,301	133 1,434
1991	332	55	387	1,555	246 1,801	1,544	209 1,753	1,388	177 1,565	1,328	140 1,468
1992	295	65	360	1,609	295 1,904	1,533	248 1,781	1,512	208 1,720	1,378	172 1,550
1993	283	97	380	1,489	364 1,853	1,578	286 1,864	1,455	220 1,675	1,474	216 1,690
1994	170	111	281	1,402	471 1,873	1,471	372 1,843	1,547	324 1,871	1,511	230 1,741
1995	84	123	207	1,016	420 1,436	1,215	392 1,607	1,358	343 1,701	1,502	294 1,796
1996	246	334	580	641	432 1,073	886	373 1,259	1,101	353 1,454	1,427	344 1,771
1997	110	397	507	493	639 1,132	596	376 972	792	315 1,107	1,127	356 1,483
1998	140	367	507	496	729 1,225	435	566 1,001	590	349 939	840	333 1,173
1999	166	297	463	617	770 1,387	503	691 1,194	392	527 919	585	362 947
2000	234	212	446	811	642 1,453	632	707 1,339	471	634 1,105	393	526 919
2001	370	173	543	980	486 1,466	776	598 1,374	603	650 1,253	492	586 1,078

*The number graduating and in each year of anesthesiology residencies* 1985 – 2001.

by the American Board of Anesthesiology about the number of residents in training and graduating from anesthesiology residency programs. In addition, for the first time this year, data have been provided by the American Association of Nurse Anesthetists (AANA) about the number of nurse anesthetists graduating each year.

#### **Number of Anesthesiologists Graduating**

The lowest number recruited into the CA-1 year (1,073) occurred in 1996. This decline passed through the residency training programs, reducing the size of the graduating class to 919 in 2000. This year, the number of residents recorded as graduating has risen to 1,078, a 17-percent

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numbers indicate that the maximum number graduating will still be at least 20 percent lower than the peak.

# Number of Nurse Anesthetists Graduating and Being Certified

During the last 12 years, the number of nurse anesthetists graduating has varied from a low of 592 in 1989 to a high of 1,079 in 1996 [Table 2]. The number being certified has varied from a low of 574 in 1989 to a high of 1,082 in 1995 [Table 2]. However, the graphs of this data [Figure 2] show a marked rise during the first six years (13 percent graduating and 15 percent certifying). The decline in the number being certified in 1996 is not accompanied by a reduction in numbers graduating. This contrasts with the remainder of the graphs, which otherwise track each other reasonably closely.

#### **Number of Residents in Training**

The size of the CA-1 year remains the best indicator of trends in recruitment into anesthesiology. This year, a total of

Table 2

The number of nurse anesthetists graduating (Grad) and being certified (Cert) during the years 1989 – 2000.

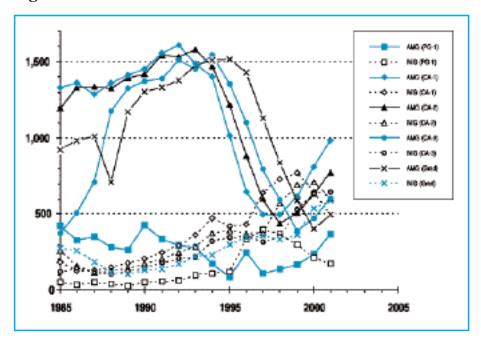
Year	Grad	Cert
1989	592	574
1990	642	660
1991	730	943
1992	791	793
1993	914	891
1994	990	1,003
1995	1,054	1,082
1996	1,079	703
1997	934	982
1998	942	975
1999	948	881
2000	1,075	997

Table 3

The number of American medical graduates (AMGs) and international medical graduates (IMGs) in anesthesiology residency programs 1960 – 2001.

Year	AMG	IMG	%IMG	Total		Year	AMG	IMG	%IMG	Total
1960	807	478	37%	1,285	П	1981	2,108	888	30%	2,996
1961	775	427	36%	1,202	Ш	1982	2,417	872	27%	3,289
1962	781	418	35%	1,199	Ш	1983	2,773	854	24%	3,627
1963	727	444	38%	1,171	Ш	1984	3,043	791	21%	3,834
1964	746	524	41%	1,270	П	1985	3,318	613	16%	3,931
1965	694	554	44%	1,248	Ш	1986	3,532	466	12%	3,998
1966	617	617	50%	1,234	Ш	1987	3,688	412	10%	4,100
1967	624	636	50%	1,260	Ш	1988	4,142	421	9%	4,563
1968	750	743	50%	1,493	П	1989	4,398	478	10%	4,876
1969	803	840	51%	1,643	Ш	1990	4,668	578	11%	5,246
1970	810	894	52%	1,704	Ш	1991	4,819	687	12%	5,506
1971	919	1,034	53%	1,953	Ш	1992	4,949	816	14%	5,765
1972	859	1,194	58%	2,053	Ш	1993	4,805	967	17%	5,772
1973	968	1,249	56%	2,217	Ш	1994	4,590	1,278	22%	5,868
1974	1,043	1,215	54%	2,258	Ш	1995	3,673	1,278	26%	4,951
1975	1,137	1,170	51%	2,307	Ш	1996	2,874	1,492	34%	4,366
1976	1,236	1,138	48%	2,374	Ш	1997	1,991	1,727	46%	3,718
1977	1,314	1,136	46%	2,450	П	1998	1,661	2,011	55%	3,672
1978	1,367	1,054	44%	2,421	Ш	1999	1,678	2,285	58%	3,963
1979	1,484	919	38%	2,403	Ш	2000	2,148	2,195	51%	4,343
1980	1,647	875	35%	2,522	П	2001	2,729	1,907	41%	4,636

Figure 1



Graph showing the numbers graduating and the composition of all four years of anesthesiology residencies 1985 – 2001.

1,466 residents were recruited into the CA-1 year, a less than 1-percent increase from 2000 [Table 1]. This is approximately the same as the number recruited in 1986 and well below the peak of 1,904 recruited in 1992. The number entering the PG-1 year, however, increased from 446 last year to 543 this year. This reverses the apparent trend of the last five years. With the exception of the unusual 580 recruited in 1996, this is the largest PG-1 group recruited in the last 19 years.

#### Residency Composition [Figures 1 and 3]

The numbers of international medical graduates (IMGs) in anesthesiology residencies has declined to 1,907 from a peak of 2,285 in 1999 [Table 3]. In addition, compared with the total in training (4,636), the percentage also fell from the peak of 58 percent to 41 percent this year. The trend is more marked in the critical CA-1 year [Table 1], where the numbers of IMGs declined this year to 486 out of 1,466 (33 percent) from a peak of 770 out of 1,387 (56

percent) in 1999. The PG-1 year also shows a decline in the number of IMGs to 173 out of 543 (32 percent) from a peak of 397 out of 507 (78 percent) in 1997.

#### Attrition

For the residents entering the CA-1 year from 1986 to 1993, attrition from anesthesiology residencies was approximately 4 percent during the whole three-year clinical residency. The same attrition rate affected Amerimedical graduates can (AMGs) and IMGs. In the following years [Figure 4], the attrition rate for the threeyear period rose to average 17 percent (AMGs 15 percent and IMGs 20 percent). This attrition may be declining again; the loss between CA-1 and CA-2 years has been about 4 percent for the last three years compared to 12

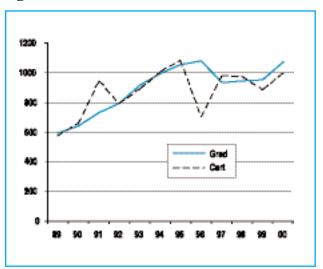
percent for the four years prior to that. The trends in attrition are more easily understood by averaging several years. For the five cohorts recruited into the CA-1 year from 1994 to 1998, there is actually an average attrition of 17 percent, nearly fivefold higher than the 3.8 percent average for the previous eight cohorts.

#### **Correction of an Anomaly**

Last year's article discussed an apparent aberration in 1996: the size of the 1996 CA-1 cohort apparently increased by 26 percent as it progressed to the CA-2 year. The article stimulated a careful review and update of the original American Board of Anesthesiology (ABA) data. The revised data eliminated this variation. The size of the 1996 cohort actually fell by about 10 percent, which approximates the fall for the 1995 and 1997 cohorts.

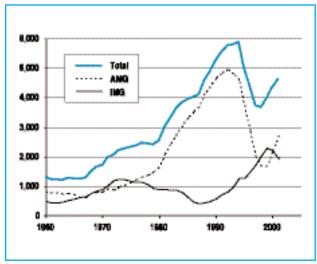
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Figure 2

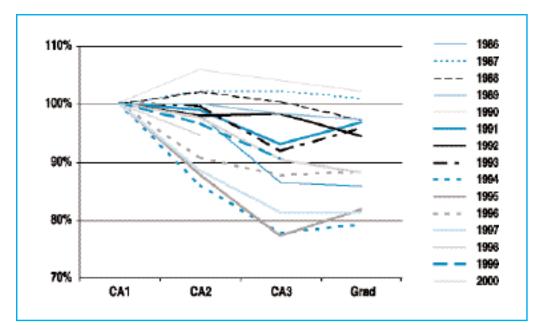


Graph showing number of nurse anesthetists graduating (Grad) and being certified (Cert) during the years 1989 – 2000.

Figure 3



Graph showing the number of American medical graduates (AMG) and international medical graduates (IMG) in anesthesiology residencies 1960 – 2001.



## Figure 4

Graph showing the variation in the size of each cohort as residents progress through their training. Each line represents the percentage change in the size of the group that commenced in the indicated CA-1 year.

#### Discussion

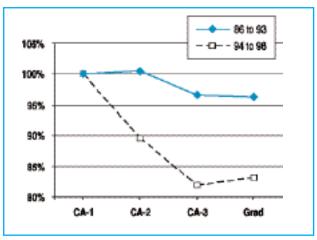
The numbers graduating from anesthesiology residencies and nurse anesthetist schools have both fluctuated. The decline from the maximum for residents graduating, which occurred over five years, was from 1,796 in 1995 to 919 in 2000 (49 percent). The maximum of nurse anesthetists graduating declined from a high of 1,079 in 1996 to 934 in 1997 (13 percent). However, the number of nurse anesthetists being certified is probably a more accurate reflection of the numbers entering the workforce. Here, the greatest decline was from 1,082 in 1995 to 703 in 1996 (35) percent). This decline in the numbers of nurse anesthetists being certified actually preceded the decline in the numbers graduating. For the next two years, however, the number being certified rose sharply and actually exceeded the number graduating. This may be explained by graduates opting to delay certification at a time when confidence and employment opportunities were diminished.

This year, the number entering the PG-1 year has risen by 22 percent. The number of AMGs in this group has risen by 58 percent. This is remarkable and suggests a contribution by factors outside the specialty of anesthesiology. The decline in the number entering the PG-1 year in the early 1990s was partly explained by the growth of interest in primary care and the reduction in the number of positions being made available to anesthesiology program directors. The growth in numbers now may be explained by the reverse process, a declining interest in primary care creating an increased availability of primary care internship positions for anesthesiology residents.

By contrast, the number entering the anesthesiology CA-1 year has only risen slightly, but it too is associated with a further growth in the recruitment of AMGs. If these trends are followed by a reduction in the attrition rate to one more characteristic of the specialty prior to 1993, then the number of graduates should continue to rise significantly for the next three years — for example, from 919 this year to perhaps 1,100, 1,250 and 1,350 in the next three years.

The marketplace and the way we all react to it will continue to govern recruitment for both anesthesiologists and nurse anesthetists.

### Figure 5



Average attrition during residency training for CA-1 groups commencing between 1986 to 1993 and for similar groups commencing between 1994 and 1998.

#### Acknowledgments

This year I particularly wish to thank Francis P. Hughes, Ph.D., his staff and the members of the American Board of Anesthesiology. Their personal support and additional effort this year provided the updated cumulated data about resident numbers and numbers graduating. It also is a pleasure to thank Steven Horton of the Bookstore and Resource Center of the American Association of Nurse Anesthetists for providing details of the numbers of nurse anesthetists graduating and being certified.

#### Web Site

To see previous articles, additional data about manpower and the results of the residency matching program, readers are invited to visit <www.grogono.com/nrmp>.

## 2002 SEE Program Provides Lifelong Learning Opportunity

**PROGRAM** 

SELF-EDUCATION

AND EVALUATION

Peter L. Bailey, M.D., Editor-in-Chief Self-Education and Evaluation (SEE) Program

The ASA Self-Education and Evaluation (SEE) Program continues to enjoy great popularity among ASA members; more than 6,200 subscriptions were sold in 2001. The success of the SEE Program, which hopefully reflects the quality of this continuing medical education

(CME) product, also contributes to the financial health of ASA.

The SEE editorial board continues to strive to improve the product and enhance its usefulness to ASA members. For example, much effort is being made to improve the CD-ROM version, which includes the same questions contained within the written program as well as an interactive format to enhance the learning experience.

One goal of the CD-ROM product is to increase subscribers' familiarity with a computer-based technique such as that currently used by the American Board of Anesthesiology (ABA) for the ABA Recertification Examination. Current questions are indexed according to the ABA-ASA Joint Council on In-Training Exami-

nations Content Outline as well as the ABA Recertification Content Outline so that review can be facilitated for specific topic areas. Electronic copies of these outlines are provided.

The SEE editorial board always reviews subscriber feedback. Because the SEE Program is also popular with anesthesiologists in training, feedback from residency pro-

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gram directors has also been solicited. It is hoped that a CME educational process begun during residency training will continue as a lifelong learning activity for many ASA members. Subscriber feedback indicates that the program is very well-received. Common requests are for more edi-

tions of the same product and for additional subspecialty-related questions. Considerations on how to expand the SEE product are being examined.

Each of the SEE Program's two volumes is composed of 100 multiple-choice questions and is mailed in two installments. Questions for the SEE Program are based on articles appearing in anesthesiology journals, other selected peerreviewed medical publications and the ASA Annual Meeting Refresher Course Lectures book. The group of anesthesiologists who contribute questions to the editorial board of the SEE Program continues to be augmented. The efforts of these individuals are indispensable, and their expertise helps to identify the

best literature and keep SEE content and focus contemporary and relevant to clinical practice.

Each 2002 subscriber will receive both SEE volumes that will include an answer/critique section, a list of references from related medical literature and a copy of the ASA 2001 Annual Meeting Refresher Course Lectures book. The CD-ROM version offers subscribers immediate feedback with each answer or it can be completed choosing the "rapid-fire" method, which gives an overall score upon completion. For CME credit, subscribers record their answers on the "answer sheet" diskette that accompanies the CD-ROM. They then return the diskette to ASA and keep the CD for future reference. The CD-ROM version requires no complicated installation and will run on Windows® or Macintosh® platforms.

The names of the SEE Program participants and their scores remain anonymous. Participants who submit both answer sheets receive 60 hours of category 1 CME credit

Continued on page 26

## Ventilations: Service Is for Now... and Research Is Forever

Continued from page 1

training start to recount horror stories of being neglected. The impending shortage of all medical specialists over the next five years will result in keen competition among department chairs to recruit adequate numbers into their respective programs. If it becomes common knowledge that the "House of Anesthesiology" has an unlocked door with nobody home, residents will seek other challenging fields where faculty is present for instruction. The Accreditation Council for Graduate Medical Education (ACGME) has recently redefined training requirements for most medical specialties. As clinical service became the almost exclusive mode of resident training, ACGME expressly required documentation of exposure to research, formal journal club sessions, visiting professor lectures and substantive didactic lecture programs. In addition, the Residency Review Committee scrutinizes the scholarly accomplishments of all faculty and their interactions with residents in supporting this activity. Finally, many states are limiting the number of hours and days a resident may work each week. Failure to comply with the various requirements can result in severe monetary penalties or program probation. Currently, a friendly survey among department chairs and program directors revealed that a significant number of training sites still subject residents to eight or nine calls per month.

Another insidious consequence of losing our academic sheen may be the perceived "equalization" of anesthesia practitioners. If physicians, nurses and anesthesiologist assistants all participate in daily clinical activity, but the physician no longer engages in the medical advancement of anesthesiology practice, our respect among other medical specialties may diminish. We cannot simply rely on both our surgical and nonsurgical colleagues to appreciate our medical supervisory contribution so essential to safe anesthetic practice — when it is often conducted beyond their view.

If AMCs become vestiges of the innovative research facilities that developed the third- and fourth-generation drugs and equipment that perfected anesthesia simulation, that support the certification process or that sponsor the advanced training fellowships, medical progress in our

specialty will never improve beyond what it is today. In all probability, safety will backslide, and the now nonexistent front-page headlines of anesthetic mishaps will begin to reappear.

There is, however, hope on the horizon that anesthesiology will not be abandoned by medical students, will not become a research wasteland or revert to a second-rate specialty. Under the leadership of 2001 President Neil Swissman, M.D., our current President Barry M. Glazer, M.D., and the other ASA officers, discussions with representatives from SAAC/AAPD, AUA and other academic organizations have begun to find solutions for the problems facing department chairs and program directors. New arrangements among private groups and anesthesiology faculty have also changed the traditional residency training paradigm.

As an example, in the State University of New York at Buffalo, referred to as the University of Buffalo (UB). anesthesiology residency program, previous full-time faculty continue to educate and train the majority of residents as volunteer faculty while strictly adhering to ACGME educational mandates. Moreover, since our university departmental governance exists in the absence of a feegenerating clinical department, these volunteer faculty contribute a significant amount of collected revenue to support the educational mission. With more than 44 residents in the program, their contributions total hundreds of thousands of dollars. However, since over 85 percent of all anesthesiologists in the Western New York region have trained at UB, they know that cultivating "their own" will guarantee highly trained, safe physician partners. The fulltime faculty then conduct the bulk of basic and clinical research and contribute heavily to resident lectures, board reviews, departmental governance and scholarly activity. Arrangements such as the one at UB are emerging across the country in order to preserve the training process for our residents during very challenging times.

Not all areas, however, can resolve town/gown rivalries, and residency programs are in jeopardy. A number of private and academic anesthesiologists, pain specialists and critical care specialists have dropped out of professional

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societies to save a few bucks (they will claim philosophical differences – yuh!). These are the same physicians who will not help in resident training because "it slows them down." They will, however, lure residents and faculty into their private practices and reap the benefits of ASA component and subspecialty societies' political and financial successes. Yet they will not contribute one minute or one dime to the effort.

This "me-first," narcissistic, gluttonous activity of non-participating anesthesiologists needs to be changed at the grassroots level. All ASA members must be introspective and decide how we can stop their metastatic spread of negativism. We can stop the backsliding by doing just **one** of the following actions **each year**. If 37,000 members each performed just one small act, I am confident that our specialty would thrive for years to come.

#### Lema's Good Deed Resolutions (pick any one)

- Offer to let just one medical student shadow you, and excite them about anesthesiology.
- Open your practice to residents or fellows one day each week if requested by department chairs.
- Sign up for one society/university/hospital/department committee and

actively participate.

- Offer to give one lecture, review session, journal club or board review session each year.
- Support your local medical society by becoming a member.
- Contact one non-ASA member or noncomponent society anesthesiologist and beg them to rejoin the ranks.
- Befriend a U.S. senator, U.S. representative or state legislator by contributing to his or her campaign.
- Give to all pertinent political action committees, even if it is only \$25 or \$50.
- Support your state anesthesiology society or local district society by attending the meetings.
  - Write letters when asked by your elected officers.
- Refrain from making disparaging comments (If you can't say something positive, don't say anything).

Over the next five or 10 years, everyone needs to "be a player." The power of 37,000 physicians doing just one additional task will have the same productivity as a beehive, anthill or ancient Egyptian workforce. Together we can do it. Together we must do it...or else.

— M.J.L.

## 2002 SEE Program Provides Lifelong Learning Opportunity

Continued from page 24

and will receive a Certificate of Participation in the program. ASA designates this continuing medical education program for 60 credit hours in category 1 of the Physician's Recognition Award of the American Medical Association.

The first installment of the 2002 program, SEE Volume 18A, will be available and distributed to subscribers in January 2002. The second installment, SEE Volume 18B, will be mailed to all subscribers in July 2002.

The cost of the 2002 SEE Program (both volumes) is \$200 for ASA members and \$350 for nonmembers for either the booklet version or CD-ROM. Individual resi-

dents who supply a letter from their program director confirming their residency status may purchase the examination for \$75. Group enrollment is available to residency programs for \$35 per resident. Residency program directors have been sent information regarding purchase of the program.

A limited quantity of a sampler CD-ROM containing 10 questions from previous versions is available to ASA members. This is a great opportunity to try the SEE product before purchasing the program.

For more information or for an order form, contact the ASA Publications Department at (847) 825-5586 or by e-mail at cpublications@ASAhq.org>.

## WHAT'S NEW IN ...

## Stress Management: Finding Your Purpose on the Ark

Jessie A. Leak, M.D.

"In the lives of many people it is possible to find a unifying purpose that justifies the things they do day in, day out — a goal that like a magnetic field attracts their psychic energy, a goal upon which all lesser goals depend...Without such a purpose, even the best-ordered consciousness lacks meaning."

Mihaly Csikszentmihalyi

are going to do, but it's what you are doing now that counts." Many of us have what could be termed "someday syndrome." Succinctly stated, we pass up opportunities to do things that could enhance the quality of our lives right now, preferring to put it off to "someday."

In my lectures to high school and college students who are contemplating a career in medicine and in particular the field of anesthesiology, I stress that it is absolutely critical to preserve some nugget of their individuality throughout their educational and training processes. In other words, they should continue to pursue family and outside interests with the same fervor that they devote to their career. The life that we lead must be one of balance and concurrence rather than serial pursuits if we are to minimize stress and maximize life fulfillment.

# Why Is It Important to Find and Acknowledge Our Purpose?

As physician anesthesiologists, we are particularly susceptible to stress. Several factors contribute to this phenomenon, but most importantly, we are involved in a nonreciprocal relationship with our patients, putting us in a position to be in emotional debt as the caregiver. Because we may have little contact or follow-up with our patients in the operating room, this may further intensify this experience, leading to loss of empathy, a chronic depersonalization, emotional exhaustion and burnout. Burnout is dangerous not only to the caregiver but also to the patient.

Additionally, production pressures appear to be subjectively increasing. In a frequently cited survey study done on California anesthesiologists, 49 percent of respondents had witnessed a situation in which they felt that patient safety was compromised due to pressure on the anesthesiologist. In this same study, 20 percent of the respondents agreed with the statement that "If I cancel a case, I might jeopardize working with that surgeon at a later date."

According to the study, "The economic pressures are obvious. Production pressure also leads to haste, a psychological precursor to the commission of unsafe acts." It was noted in this study that these and many other stresses were not particular to either academic practice or private-sector work.

When we are at the point of burnout, which may include such symptoms as irritability, subpar job performance, substance abuse, dreading going to work or the feeling that work is a dead-end, it becomes imperative to make changes to decrease stress and restore some balance to your life. Not infrequently during such an inventory, the inevitable question arises, "What is my life purpose and where am I going?"

## What Is Our Purpose in Life and What Makes it Meaningful?

As a basic premise, I believe that our greatest purpose and desire in life is the pursuit of happiness. Unfortunately, we often mistake happiness for success or pleasure. However, we cannot equate happiness or pleasure from material success to true happiness.

"Strange as it may seem, life becomes serene and enjoyable precisely when selfish pleasure and personal success are no longer the guiding goals.

Mihaly Csikszentmihalyi, The Evolving Self:
 A Psychology for the Third Millennium

The Dalai Lama states, "True happiness relates more to the mind and heart. Happiness that depends mainly on physical pleasure is unstable; one day it's there, the next day it may not be."

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#### How Do I Find My Life Purpose?

It is important to be open to viewing our lives in a totally different perspective as we pursue what our real life purpose may be. Carol Adrienne suggests in her book *The Purpose of Your Life*, several ideas that may be helpful:

- "Our purpose is unfolding constantly, although we may not be aware of it if we are fixated on a certain goal or timing."
- "The purpose of our life usually has something to do with learning how to love more fully, more deeply, more constantly, more unconditionally."
- 3. "The purpose of our life may be to aid the spiritual development of another."
- 4. "The purpose of our life is found in activities where we lose track of time."
- 5. "Our purpose in life is to be, as fully, as present, as authentically, as we can be."

#### A Practical Approach

Practically speaking, it may be helpful to develop a purpose statement. Items to be included might be: 1) the things that you *love* to do, the activities or pursuits that are easy for you; 2) the qualities that you love about yourself or that those close to you may have seen in you; and 3) the qualities that you would like to possess, such as creativity, courage, leadership or artistic or musical ability.

After compiling this set of data, your goal is to integrate these elements into a statement of life purpose and to subsequently let your conclusions show you the way. Being at a point in your life when you feel that you have hit a brick wall or are sitting in a rut is not infrequently when people choose to re-evaluate their life purpose. Bear in mind that you may have little in the way of emotional reserves for making changes or reassessing your life. Nonetheless, this exercise may be the most important thing you will ever do for yourself in terms of living in the present and not waiting for "someday."

"Lack of confidence is a crucial point as we feel the call to make changes in our lifestyle. People may be giving us messages about our next step, and yet if we lack the confidence to take action, we cannot take advantage of those messages."

— Carol Adrienne, *The Purpose of Your Life* 

### Some Practical Tools in Your Pursuit of Happiness and Working Toward Your Life Purpose

The basic premise of simplifying our lives allows us to reach the core of who we are and what we want. Elaine St. James, in her book *Simplify Your Life*, offers us several practical suggestions for decongesting our lives such that we can concentrate on our real goal: finding our purpose in life

- Reduce the clutter in your life.
- Move to a smaller house.
- Drive a simple car.
- Turn off the television.
- Stop junk mail.
- Take a vacation at home.
- Live on half of what you earn, and save the other half.
- Work where you live or live where you work.
- Do what you really want to do.
- Turn your hobby into a job.
- Trust your intuition.
- If it is not working, stop doing it.
- Stop trying to change people.
- Just say "no."

#### In Closing

Those individuals who take the time to examine their life purpose, follow their intuition and eventually put into practice what they discover will most assuredly be the happiest individuals and professionals they can be. This serenity can be infectious. Those who surround these individuals — your colleagues and your patients — benefit too.

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#### **Further Reading:**

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## PRACTICE MANAGEMENT

ost consultants seek to offer Lcorrect advice on billing, compliance and other practice management subjects. The government is concerned, however, that some consultants push the envelope too far when helping their clients to maximize revenues. On June 27, 2001, the Health and Human Services Office of the Inspector General (OIG) issued a Special Advisory Bulletin to alert providers to certain consultant practices, and the Government Accounting Office (GAO) released a report on consultants' billing advice requested by Senator Charles E. Grassley (R-IA).

## Beware the Aggressive Advice of Billing Consultants

Karin Bierstein, J.D. Assistant Director of Governmental Affairs (Regulatory) ent problem.) There is a legitimate concern that reporting a significant dollar amount of overpayment may trigger a Medicare audit. Moreover, most anesthesia practices will not have \$20,000 or \$50,000 on hand upon discovery of a large overpayment.

For smaller amounts, especially where the practice's selfaudit turns up every instance of the erroneous bill or payment so that there is no apparent need to check the universe of claims filed for the relevant time period, sending a check with a simple but dispositive explanation should not

lead to further Medicare review. One anesthesia group recently determined that the carrier had been multiplying time units by ten, resulting in overpayments worth tens of thousands of dollars, and was advised to contact the carrier with a proposed schedule for repayment over time without interest. The group specified in its letter that if the carrier did not respond, it would assume that the proposed schedule had been accepted. It may be advisable, when 5-figure amounts are in issue, to arrange the refund through an attorney.

The Medicare agency (then the Health Care Financing Administration) issued a Program Memorandum telling carriers how to handle unsolicited refunds in May 2000. The Program Memorandum gives the carriers a list of questions to ask the provider; the list is a useful guide to the information that physicians should include in letters accompanying refund checks. Readers may consult the "Practice Management" column in the July 2000 issue of the *NEWSLETTER* for further information.

The other two strategies of special interest to the GAO present fewer problems for anesthesiologists. Evaluation and management services are not a major part of most anesthesiologists' livelihood. Patients with poor insurance coverage may not be the most popular, but their access to anesthesia care cannot be blocked by scheduling shenanigans. Denying labor epidurals to Medicaid patients may be a breach of a participation agreement or of a contract with a hospital — not to mention the source of ugly publicity — but it is not covered by billing rules. Although other laws

### **GAO Report**

The executive summary of the GAO report reveals three revenue-enhancing practices of particular concern:

- not reporting or refunding overpayments by insurance carriers
- performing unnecessary tests and procedures to support claims for higher-level evaluation and management services
- attempting to deflect patients with low-paying insurance plans such as Medicaid by limiting services provided to them and by scheduling their appointments for inconvenient times.

The GAO had sent a physician and a criminal investigator to workshops titled "How to Run a More Profitable Practice" and "Creating a 7-Step Compliance Plan/Audit-Proof Your Practice." The workshop presenters, according to the report, advocated the strategies listed.

The first strategy addresses an issue that many anesthesiologists have raised, in various contexts. Overpayments that must be refunded are those resulting from clear errors and not simply differing interpretations. Errors arising from outright ignorance of billing requirements, for example, or from improper programming in either the practice's or the carrier's computer systems tend to grow very quickly into thousands of dollars of overpayments. (They may also result in huge underpayments, but that is a differ-

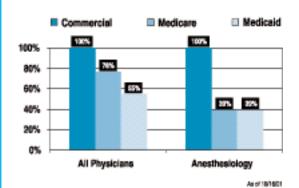
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may be violated by discrimination against patients on the basis of their insurance status, the fraud and abuse laws cannot. Anesthesiologists should read between the lines, though and keep in mind the government's general concern with upcoding and billing for "medically unnecessary" services, as well as with Medicare and Medicaid patients' access to care.

# How Badly Is Medicare Underpaying You?

nesthesiologists know all too well that Medicare pays them less, relative to private payers, than it does other physicians. In connection with our ongoing efforts to obtain an increase in the anesthesia conversion factor, Alexander A. Hannenberg, M.D., chair of the Committee on Economics prepared the stark comparison in Figure 1 below:

## Figure 1



#### Data Sources:

ALL PHYSICIANS: 1998 Values

Gallagher PE, Smith SL, eds. Medicare RBRVS: The Physicians Guide. American Medical Association, 2000:119.

Commercial RBRVS CF value raw average of nongovernmental payers cited (\$48.02); Medicaid (\$26.31); Medicare (\$36.68).

See also: Physician Payment Review Commission Annual Report to Congress. 1996:216.

ANESTHESIOLOGISTS

Commercial Anesthesia CF: Bierstein K. Fees paid for anesthesia services: 1999 survey results. ASA Newsl. 63(8):23. (Frequency wtd average of 235 payers cited in February 1999 survey = \$43.52). Medicaid: 1998 ASA Survey of 29 states' Medicaid CF for programs using Base+Time methodology = \$17.19. Medicare 1998 Anesthesia National Avg CF = \$16.88.

#### **OIG Special Advisory Bulletin**

On the same day as the GAO sent its report to Senator Grassley, the OIG issued its special bulletin regarding "Practices of Business Consultants." The OIG's intent was to warn physicians and other providers about "a small minority of unscrupulous consultants" by listing some of the latters' hallmark marketing practices. The OIG advises providers who engage consultants to be alert to the following:

- *Illegal or Misleading Representations*. Any claim to have "inside access" or some form of approval or certification by Medicare is suspect. Consultants may improperly use Medicare or CMS logos or symbols in their marketing materials, or suggest that attending their programs is a prerequisite for keeping a provider number.
- *Promises and Guarantees*. Promising a prospective client that hiring the consultant will produce a specific percentage increase in collections may lead to the submission of false claims.
- Encouraging Abusive Practices. If a consultant recommends that a client use billing codes that could generate higher payment than the correct codes and especially if the consultant discusses ways to avoid detection, the practice should be leery. Anesthesiologists report that some consultants advise them to interpret laws and regulations in ways that are clearly inconsistent with the intent of the Medicare program. There are many, many perplexing questions as to the correct interpretation of anesthesia billing regulations can you perform pain blocks while medically directing other cases is one of the most frequently asked but a trustworthy consultant will make sure that you know both the conservative and the practical interpretation (if they differ).
- Discouraging compliance efforts. Advice to skip self-audits or refunds of overpayments, as discussed in the GAO report, or not to cooperate with a Medicare audit should raise suspicion.

In the concluding words of the OIG, "In general, if a consultant's advice seems too good to be true, it probably is." It is crucial that the consultant be honest as well as knowledgeable. Given that anesthesia practice management is unique in many respects, it is most important that your consultant have specific and extensive anesthesia experience – which restricts the field of potential consultants considerably. Recommendations from anesthesiolo-

gists whom you trust are one of the best forms of protection in selecting your own advisors.

### OIG Workplan for 2002—Are You Vulnerable?

Anesthesiologists need to be familiar with the OIG's workplan for each year in order to understand which billing practices are targeted for particular attention. Compliance consultants should be able to explain precisely the relevance and application of the targeted practices to anesthesia. For 2002, in the area of physician services, some of the "studies" and "initiatives" will focus on:

- Evaluation and management services visits and consultations. Recall the second improper strategy in the GAO report discussed above; the OIG is clearly concerned with upcoding and documentation.
- "Incident-to" services. Pain medicine specialists are more likely than most anesthesiologists to bill for the services of physician assistants or nurse practitioners that are incident to their own professional services. The incident-to rules do not apply to billing for nurse anesthetists, but they do give ample scope for leveraging the work of other allied health providers in the employ of physicians. The OIG's questions relate to the "quality and appropriateness of these billings."
- *Teaching physicians*. Following numerous audits of teaching hospitals, the OIG remains quite suspicious of compliance with the teaching rules.

• Moonlighting residents. Residents may bill Medicare only when they are moonlighting, defined as "providing medical treatment, other than in their field of study, in an outpatient clinic or emergency room." This issue may arise in the context of anesthesiology residents or fellows moonlighting in a pain clinic. Arguing that such work is "other than in their field of study" may be difficult.

#### **Source Materials:**

- OIG Special Advisory Bulletin on Practices of Business Consultants: <a href="http://www.dhhs.gov/progorg/oig/frdalrt/consultants.pdf">http://www.dhhs.gov/progorg/oig/frdalrt/consultants.pdf</a>>.
- GAO Report, "Consultants' Billing Advice May Lead to Improperly Paid Insurance Claims: <a href="http://www.gao.gov/cgi-bin/getrpt?gao-01-818">http://www.gao.gov/cgi-bin/getrpt?gao-01-818</a>>.
- Program Memorandum on Voluntary Refunds: <a href="http://www.hcfa.gov/pubforms/transmit/AB004160">http://www.hcfa.gov/pubforms/transmit/AB004160</a>
   .pdf>.
- OIG workplan for 2002: <a href="http://www.dhhs.gov/progorg/oig/wrkpln/2002/CMS.pdf">http://www.dhhs.gov/progorg/oig/wrkpln/2002/CMS.pdf</a>.

## **Continuing Medical Education on the Internet**

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#### **Acknowledgements:**

To produce just three hours of CME, many hours of behind-the-scenes preparation took place. This program came about through the encouragement and interest of James C. Eisenach, M.D. (past chair, ASRA Education Committee), Douglas G. Merrill, M.D. (past chair, ASA Committee on Pain Medicine), Joanne M. Conroy, M.D. (past chair, ASA Committee on Outreach Education) and Michael F. Mulroy, M.D. (past President of ASRA).

ASA staff members (Janice L. Plack, Jill A. Formeister, Jennifer M. Braun and Karen Bieterman) provided expert advice and support for the program, including the tedious task of sorting and obtaining copyright permissions for the many graphic images used. Much of the credit for the quality of the final product goes to Dr. Neal and Dr. Panchal, who invested great effort in creating this new program.

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## RESIDENTS' REVIEW

## What Is ACGME and What Is Its Role in Residency Education?

Carlos L. Moreno, M.D., Chair Resident Component Governing Council

pon graduation from medical school, I recall hearing for the first time a reference to the Accreditation Council for Graduate Medical Education (ACGME). I remember wondering what this national organization had to do with my residency training. Since then, I have become enlightened as to their function. I would like to share some information that describes what ACGME is and what role it plays in our residency training.

The ACGME is a private, professional organization responsible for the accreditation of nearly 8,000 residency education programs nationwide. It is one of the largest private accrediting agencies in the country, if not the world. Residency programs, their sponsoring institutions, residents, medical students, the specialty boards of the American Board of Medical Specialties (ABMS), patients, payers, government and the general public have a vested interest in ACGME's accreditation process. Accreditation offers these interested parties assurance that a given residency program and its sponsoring institutions meet an accepted set of educational standards.

ACGME accredits residency programs in 110 specialty/subspecialty areas of medicine in addition to all programs leading to primary board certification. Completion of an ACGME-accredited residency program is a prerequisite for certification in a primary board. Completion of an ACGME-accredited subspecialty program is required before an individual can sit for board certification in the majority of subspecialties. ACGME does not accredit training in combined programs (i.e., internal medicine-pediatrics or internal medicine-psychiatry).

ACGME relies on experts in the various medical specialties to develop its accreditation standards. Twenty-six specialty-specific committees, known as Residency Review



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Committees (RRCs), periodically revise the standards and review accredited programs in each specialty/subspecialty. Residency programs are expected to comply with the accreditation standards for their discipline in order to obtain and maintain accreditation. In addition, institutions sponsoring residency programs are expected to comply with a set of institutional requirements. The RRC contacts for anesthesiology are:

Executive Director Judith S. Armbruster, Ph.D. (312) 464-4642, <jsa@acgme.org>; Associate Executive Director Linda Thorsen (312) 464-5366, <lmt@acgme.org>; Accreditation Administrator Dawn Foster (312) 464-4645, <dfoster@acgme.org>; Senior Secretary Betty Cervantes (312) 464-4644, <bac@acgme.org>.

Compliance with ACGME's standards is measured through periodic review of all programs. Each accredited residency program is site-visited every 3.7 years. The interval between site visits ranges from one to five years. Programs that have demonstrated compliance with the accreditation standards receive full accreditation. If a program is found to have deficiencies, ACGME lists these as specific citations in its accreditation letter to the program and expects the program to come into compliance. If a program has significant deficiencies, it may be given a warning or placed on probation. The intent is to alert the program and its sponsoring institution to the need for improvement in the areas identified as deficient or face more serious action by ACGME. Ultimately, programs that fail to comply with the standards have their accreditation withdrawn. It is rare that a program's accreditation is withdrawn because of failure to comply with a single standard, but this can occur for very serious deficiencies. ACGME's actions in establishing standards and in withdrawing the accreditation of programs that fail to demonstrate compliance have been affirmed by several court decisions.

Complaints specifically related to alleged noncompliance of institutional and program requirements (see <www.acgme.org> for specific institutional/program requirements) may be made by anyone associated with a residency program, such as a resident or a staff member or by anyone who has knowledge of the residency program. Those wishing to submit a complaint alleging noncompliance with requirements should identify the specific requirements with which there is alleged noncompliance. It should be clearly understood that ACGME and its review committees will not adjudicate individual disputes between

persons and residency programs. Residents who are involved in disputes with a program regarding promotion, nonrenewal of contract or dismissal, sexual harassment or discrimination should refer to their institution's formal grievance procedures and familiarize themselves with the ACGME institutional requirements. If the sponsoring institution lacks grievance procedures described in the institutional requirements, use of these ACGME complaint procedures may be appropriate.

Residents also may contact any of the national resident physician organizations, including those of the American Medical Association, Association of the American Medical Colleges, Council of Medical Specialty Societies, National Medical Association, Bureau of Health Professions (Consortium of Resident Specialty Groups) or their specialty for advice. If appropriate, they may choose to seek legal counsel. Persons having evidence of noncompliance with requirements should be aware of the options available to them for expressing concern either as an individual or as a member of a group. These options are listed below in the recommended order in which they should be utilized depending on the complainant's relationship to the program:

- 1. Contact the program director to try to resolve the issue
- 2. Inform the graduate medical education committee of the sponsoring organization
- Contact the resident organization of the institution, if one exists, or the appropriate institutional forum or individual appointed to address resident concerns as outlined in the institutional requirements
- Send a signed, written communication to the executive director of the appropriate review committee as listed on the ACGME Web site.

All communications to the ACGME regarding alleged noncompliance with ACGME institutional and/or program requirements must be signed by the complainant and be addressed to the executive director of the appropriate review committee at 515 N. State Street, Suite 2000, Chicago, IL 60610.

Anonymous complaints will not be considered by ACGME. Failure of the program or institution to comply with ACGME institutional and/or program requirements must be documented and specific details provided. This must include reference to the program and/or the institu-

tional requirements allegedly being violated and documentation supporting the complaint and a statement of the steps that were taken in an attempt to resolve the issues within the institution and the results of those efforts.

At the discretion of the executive director, a complaint may be brought to the attention of a review committee, the program director and/or others outside ACGME without revealing the name of the complainant. If the executive director decides that the issues or incidents involved require the disclosure of the name of the complainant to a review committee, a program director and/or others outside ACGME, he/she will be so informed, and written authorization to use his/her name will be requested. A complainant's name will not be disclosed to any party without written consent.

The executive director will notify the complainant whether the complaint falls within the scope of these procedures and, if so, how it will be processed. If the criticisms are vague as to the situation that constitutes alleged noncompliance, the executive director will ask the complainant to provide more specific information. If the complaint does not fall within the scope of these procedures, the complainant will be so informed and no further action will be taken. If the complaint is considered valid, the issues of noncompliance outlined in it may be dealt with as part of the next scheduled review of the program or be brought to the attention of a review committee at one of its regular meetings. The executive director in consultation with the chair of the review committee will determine if the complaint has validity. If it is determined that the complaint should be brought to the attention of the review committee prior to the next scheduled survey of the program, the executive director will inform the program director and/or the designated institutional official for graduate medical education of the complaint and request a written response. This response must be co-signed by the corporate executive officer of the sponsoring institution and by the designated institutional official.

After receiving the written response of the program director and/or the designated institutional official, the executive director will forward the case to the review committee. The review committee may exercise the following options:

a. The review committee may conclude that no action

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## SUBSPECIALTY NEWS

## **SOAP Working Hard to Resolve Labor Issues**

Valerie A. Arkoosh, M.D., Committee on Obstetric Anesthesia President, Society for Obstetric Anesthesia and Perinatology

The mission of the Society for Obstetric Anesthesia and Perinatology (SOAP) includes the education of anesthesiologists and other health care professionals in the comprehensive anesthetic and pain management of women during pregnancy and the puerperium. Toward this end, SOAP directs significant resources to the planning and

implementation of our Annual Meeting. SOAP 2002 will be held in Hilton Head, South Carolina, May 1-5, 2002, and will offer something for both the occasional and routine practitioner of obstetric anesthesia. Meeting planners Gary Vasdev, M.D., and Joy L. Hawkins, M.D., will offer sev-



Society for Obstetric Anesthesia and Perinatology

eral new educational opportunities including an optional Neonatal Advanced Life Support certification course and an optional Hands-On Airway Management Course. Abstract submission will be online, with the Web site going live on November 1, 2001, and abstracts will be due in January 2002. In order to formally recognize the importance of education to our Society, the 2002 meeting will be the first opportunity to compete for the new SOAP Research in Education Award. The criteria for this award, as well as Annual Meeting information and registration, can be found on the SOAP Web site at <www.SOAP.org>.

The practice of obstetric anesthesia continues to face challenges on several fronts. Two areas in particular stand out. Questions persist from several constituencies as to the safety of neuraxial labor analgesia and its impact on obstetric and neonatal outcome, and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN)



Valerie A. Arkoosh, M.D., is Professor and Chair, Department of Anesthesiology and Professor of Obstetrics and Gynecology, MCP Hahnemann University, Philadelphia, Pennsylvania.

newest guidelines continue to substantially limit the ability of perinatal nurses to assist anesthesiologists in managing epidural infusions in any way.

Last spring, several SOAP members were invited to attend a symposium sponsored by the Maternity Center Association (MCA) and the New York Academy of Medi-

cine and titled, "The Nature and Management of Labor Pain, An Evidence-Based Symposium." The MCA is a not-for-profit organization founded in 1918 whose stated mission is to improve the quality of maternity care in the United States through innovative woman- and fam-

ily-centered approaches to maternity care. MCA is involved in prenatal care, childbirth education, nurse-midwifery education and care in out-of-hospital birth centers. The objectives of the symposium included making accurate information about labor pain and methods to relieve it easily available to relevant health care professionals, childbearing women and the general public; to improve women's access to a choice of reasonably safe and effective pharmacological and non-pharmacological methods for pain relief during labor and assure that women receive full information on all methods of labor pain relief available in their place of birth; and to identify gaps in our knowledge base and develop research priorities. Obstetricians, nurse midwives, childbirth educators, pediatricians, epidemiologists and public health researchers attended the meeting. A unique aspect of this meeting was that all presentations were put in paper format and submitted for peer review prior to the meeting. These papers were critiqued and the presentations modified accordingly. Lawrence J. Saidman, M.D., (former editor-in-chief of *Anesthesiology*) was the reviewer representing anesthesiology. The quality of presentations was quite high. SOAP was well-represented by Donald Caton, M.D., Barbara L. Leighton, M.D., and Mark A. Rosen, M.D., each of whom spoke on various aspects of labor analgesia. There was minimal to no debate that epidural analgesia is the safest and best form of labor analgesia for women with any sort of complicated delivery or significant co-existing medical problem. The real issue for many of the attendees was that for healthy women with normal pregnancies and labors, the increasing predominance of epidural analgesia has resulted in decreased availability of alternative techniques (jacuzzis, birthing balls, Doulas, etc.). For those women who truly want an unmedicated labor, these alternatives are increasingly scarce. Although some participants were clearly antiepidural, I had the sense that the majority were more interested in assuring the continued availability of nonpharmacologic options. Despite an unusually high quality of science around the presentations and the predominance of positive data about neuraxial labor analgesia from prospective, randomized trials, it is this author's opinion that emotion continues to hold sway over many of those who participated. Thus, these issues are likely to be with us for many years to come. The proceedings from this symposium are scheduled for publication in a supplement to the American Journal of Obstetrics and Gynecology in early 2002.

AWHONN published guidelines in 1998 limiting the role that perinatal nurses could have in assisting an anesthesia care provider with an epidural infusion. Those guidelines were in conflict with the established practice patterns of many anesthesia groups. AWHONN stated that they would review the guidelines in early 2001. The new position paper can be found at: www.awhonn.org/

sitemap/ebg/Cardiovascular\_Health\_Backroun/positionstat ements/Epidural/epidural.html. The following are contained in the new position statement: nonanesthetist registered nurses should not:

- rebolus an epidural either by injecting medication into the catheter or increasing the rate of a continuous infusion;
- increase/decrease the rate of a continuous infusion; re-initiate an infusion once it has been stopped;
- manipulate patient-controlled epidural analgesia doses or dosage intervals;
- be responsible for obtaining informed consent for analgesia/anesthesia procedures (The nurse, however, may witness the patient signature for informed consent prior to analgesia/anesthesia administration.) ASA's Committee on Anesthesia Care Team continues to attempt constructive dialogue with AWHONN. Should this position statement impact your practice stress that these are guidelines, not standards of care. Education is our best recourse.

SOAP looks forward to addressing these and future challenges by stimulating and supporting education and research in the field of obstetric anesthesia.

## What Is ACGME and What Is Its Role in Residency Education?

Continued from page 33

- on the complaint is warranted. The complainant, program director and/or the designated institutional official will be so advised.
- b. The review committee may decide to investigate the issues raised in the complaint through a site visit that will be scheduled immediately or during the next regularly scheduled site visit and review. The complainant, program director and/or the designated institutional official will be informed of the decision.
- c. The residency review committee that has handled a complaint against a particular program may notify the ACGME Institutional Review committee for further investigation at the institutional level.

In conclusion, the mission of ACGME's accreditation activities is to improve the quality of residency education while establishing safe and effective patient care guidelines for residency training programs. I hope that by sharing this information, anesthesiology residents nationwide are better informed of how ACGME influences their residency training and what options are available to residents if questions, issues or concerns are raised regarding individual residency training programs.

#### Source:

1. Accreditation Council for Graduate Medical Education <a href="https://www.acgme.org">www.acgme.org</a>>.

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## AMA Section Council Requests House of Delegate Attendee Names

fficials from the Society's Section Council on Anesthesiology of the American Medical Association (AMA) would like to know the names of the ASA members planning to attend the AMA's House of Delegates on December 1-5, 2001, in San Francisco, California.

The Section Council is open to all anesthesiologists who attend the AMA House of Delegates meeting. The Section Council meets to discuss resolutions and other issues of importance to anesthesiologists. Meetings usually take place on Saturday and Monday of the AMA House of Delegates meeting. If you are attending the House of Delegates meeting, the Society would welcome your participation.

To be placed on the mailing list to receive information on the Society's AMA Section Council meetings, please send your name, address, telephone number, fax number and reason for attendance to Ronald A. Bruns, ASA Executive Office, 520 N. Northwest Highway, Park Ridge, IL 60068-2573; fax (847) 825-1692; e-mail <R.Bruns@ASAhq.org>.

## 'Calendars for Meetings' on the Web

ocating anesthesia-related education courses and meetings has never been easier. New features on the ASA Web site allow members to search for relevant events and meetings by date, location, keyword, 25 different subject categories or by simply choosing to show all events on the site.

Submission of courses, events and meetings in anesthesiology has also been simplified. One simply clicks the "Submit An Event" button on the Meeting Calendar Web page, fills out the necessary information electronically and clicks "Add New Event" to add it to the hundreds of other anesthesiology events already listed.

Due to the efficiency and easy access of the Web version of "Calendars for Meetings," the printed version is set to be phased out after the July 2002 edition. For those who wish to submit information for the January 2002 booklet version, information must be received *no later than December 1, 2001.* As usual, no telephone submissions will be accepted, and entries are limited to anesthesia-related, physicians' continuing education and meetings.

Submissions to the Web version can be sent any time and will be posted to the Web within three days after submission.

For further information, contact the ASA Communications Department, 520 N. Northwest Highway, Park Ridge, IL 60068-2573; telephone (847) 825-5586; e-mail <K.Yetsky@ASAhq.org>. Web submissions can be sent by accessing <a href="http://events.ASAhq.org">http://events.ASAhq.org</a>>.

## In Memoriam

Notice has been received of the death of the following ASA members:

Henry C. Guynes, M.D. Rockwall, Texas July 9, 2001

Robert E. Heckman, M.D. Dover, Delaware July 24, 2001

Robert M. Kintner, M.D. Wenatchee, Washington July 25, 2001

Marcos Krausz, M.D. Media, Pennsylvania March 24, 2001

James R. McKlveen, M.D. Ames, Iowa July 11, 2001

Juan A. Nesi, M.D. Caracas, Venezuela August 5, 2001

William E. Rhodes, M.D. Melbourne, Florida August 4, 2001

Allan E. Talbot, M.D. Cecil, Wisconsin July 10, 2001

Michele Trotta, M.D. Juno, Florida August 3, 2001

## LETTERS TO THE EDITOR

# Finding Time for Subspecialty Care

As an academic anesthesiologist/intensivist splitting my time between anesthesiology and pediatric critical care, I enjoyed the articles in the August 2001 NEWSLETTER pertaining to critical care. But I think there are many reasons that I am only one of 900 anesthesiologist-intensivists among 9,000 from other specialties. Medical students choosing anesthesiology are usually attracted by the intense but predictably brief patient contact of the operating room. That is not a criticism, but it accurately predicts that few anesthesiology residents would seek the ongoing (often socially complex and emotionally challenging) patient and family contact, lengthy differential diagnoses and often frustratingly slow therapeutic responses of intensive care unit patients.

Further, intensivists from other specialties can provide economical continuing care beyond the intensive care unit, even to the ambulatory clinic — something few anesthesiologists can provide.

Although the incomparable airway management that all anesthesiologists should provide, and the expert pain management that some can provide, may help selected intensive care patients, neither those skills nor the systems and safety knowledge of our specialty are the essence of critical care. That essence is defined not only by the fundamentals but also the arcana of internal medicine and pediatrics, topics often merely tangential to the daily work of most anesthesiologists.

Although many of us find it wonderfully rewarding to practice the two specialties simultaneously, I do not think most of us see one as flowing naturally from the other. Rather, we accept limitations on our anesthesiology practice while we struggle to maintain competency and currency in two very different and equally demanding specialties.

Critical care pep talks to anesthesiology residents probably do no real harm, but they will have little impact.

Thomas J. Poulton, M.D. Omaha, Nebraska

## Raising Better Consciousness About Sedation Guidelines

I would like to offer another perspective on "conscious sedation" and the comments made by John M. Freedman, M.D., and Mark J. Lema, M.D., Ph.D., in the "Letters to the Editor" section of the September 2001 ASA NEWSLETTER. Dr. Freedman argues, and many have agreed, that the term "conscious sedation" be abandoned. Hence, the development of the more logical terminology created by ASA and adopted by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which defines the continuum of sedation from "least" (minimal) to "most" (general anesthesia) with "moderate" and "deep" in between. Dr. Freedman's call for the term "procedural sedation" to supplant "conscious sedation" is unnecessary and potentially confusing. The new definition of moderate sedation is very functional. In addition, sedation is administered for diagnostic tests, too. Creating a definition that links what the patient is undergoing (e.g., procedure, test) risks fragmentation of the well-conceived new definitions.

Dr. Lema comments that the administration of sedation by nonanesthesiologists is a compromise associated with added risks for patients. As a cardiac anesthesiologist, this perspective reminds me of the cardiologists perceiving my performance of transesophageal echocardiography as inevitably substandard. Regardless of how much of a compromise exists, there are certainly not enough anesthesiologists and/or nurse anesthetists to administer all necessary sedations. Even if there were, who would pay for all this additional service?

The views and opinions expressed in the "Letters to the Editor" are those of the authors and do not necessarily reflect the views of ASA or the NEWSLETTER Editorial Board. Letters submitted for consideration should not exceed 300 words in length. The Editor has the authority to accept or reject any letter submitted for publication. Personal correspondence to the Editor by letter or e-mail must be clearly indicated as "Not for Publication" by the sender. Letters must be signed (although name may be withheld on request) and are subject to editing and abridgment.

As the liaison individual for sedation issues within my hospital, my approach is to emphasize the now standardized terminology, but, for the time being, couple it with the old, as in "moderate (conscious) sedation." The real work for anesthesiologists, however, is to take a proactive role and do more than help their hospital when JCAHO comes to town. Anesthesiologists need to help educate and train their colleagues (we should stop calling them nonanesthesiologists) so that they too can administer safe and effective sedation. Toward that end, I have put together a one-day course as well as an ongoing simulator-based course to credential individuals for moderate sedation. These courses help interested clinicians acquire and test much of the knowledge and skills related to moderate sedation. I believe that these types of efforts are what will really help patients.

Peter L. Bailey, M.D. Rochester, New York

## 'Mickey Mouse,' 'Alexis de Toqueville' Reap Benefits of Supermarket Bonus Card

I enjoy Dr. Lema's "Ventilations" and just had to comment on the September installment. While I, too, think it is ridiculous to provide personal information in return for a supermarket "bonus card," there is certainly no reason that you can't get the card without providing the information. My favorite cashier at the local Safeway tells me that there are thousands of Mickey Mouses in their files, though I am the only Alexis De Toqueville that she knows of. The supermarkets out here readily acknowledge that you really just need to fill in any seven-digit number under "telephone number," and the rest can be left blank.

Unfortunately, accommodating the Health Insurance Portability and Accountability Act won't be as simple.

David M. Joseph, M.D. Tucson, Arizona

## Thanks to Those Who Scripted Our Success

Lenjoy reading your "Ventilations." You always have pithy comments that are quite pertinent to the every day life of the anesthesiologist.

I was working in an operating room the other day with a gynecologist. Somehow the conversation turned to the good care we give our residents by giving them breaks, lunch, letting them go home after call, etc. He then turned to his resident and said, "You know, these anesthesiologists are really smart. When managed care came in years ago, they closed a bunch of their residencies to keep manpower down. Sure, they worked hard for a couple of years, but now they are in the driver's seat. They are in demand. Their salaries are great. They are so smart!"

I must say I had never heard that spin put on our situation of several years ago. Could it be that this is how the rest of medicine sees us? Great tacticians? If this is the "truth," I'd like to commend the private practitioners among us who temporarily closed down the job market, the academicians who continued training and wooing whatever medical students came our way under severe constraints, the "powers that be" who thought up the whole idea and all of us who worked ourselves to the bone waiting for the turnaround!

Saundra E. Curry, M.D. Chappaqua, New York

Editor's Note — We can't even get everyone to agree on the severity of the nurse anesthesia assault on the practice of medicine, so to think that this crisis was contrived and well-executed is mere folly. The Federal Trade Commission and the nurse anesthetists' organization would have been "all over us like white on rice!"

It has been part of anesthesiology's history to live from crisis to crisis. The last drought occurred in the early to mid-1980s. What may make this shortage unique is the concurrent shortage of nurse anesthetists in an aging and surgically expanding environment. At least we are not driving taxis like the deans predicted, which started the downward spiral of residency positions.

-MJL.

## FAER REPORT



## **Announcement of Recent Recipients, Part III**

This article represents the final installment of FAER's award recipients. Previous winners, Timothy Angelotti, M.D., Ph.D., and Hong Liu, M.D., were featured in the August NEWSLETTER; Steven E. Hill, M.D., Douglas G. Ririe, M.D., and Wei C. Lau, M.D., were featured in October.

#### **Education Research Grant**

**Joseph Kras, M.D., D.D.S.**, Washington University, St. Louis, Missouri: "Clinical Simulation: An Anesthesia Skills Assessment Program for Residents."

The purpose of this study is to test 10 simulated acute perioperative scenarios that evaluate clinical judgment in critical situations. Forty residents will participate in six of 10 simulated scenarios in a single 90-minute individual teaching session. Four faculty will score each videotaped performance. The specific aims of this project are 1) to develop a method to evaluate skills in crisis settings, 2) to assess how residents' skills in different critical situations generalize among a broad range of acute care scenarios, 3) to determine how experience



alters performance in acute care situations and 4) to assess the inter-rater reliability for faculty raters scoring resident performance. Our long-term goal is to develop an acute care skills curriculum to teach and evaluate judgment in critical clinical situations.

## **FAER Welcomes New Director; Ups the Ante on Grants**

The Foundation for Anesthesia Education and Research (FAER) Board welcomes a new director who will

help in our mission of developing the next generation of physician scientists. Suzanne T. Anderson, FAER's first public member, is currently Vice-President of Meaghan Jared Partners, Inc., a health care management consulting firm in Bellevue, Washington. She has extensive experience advising academic medical centers in staffing models, physician productivity, financial analysis and compensation, strategic planning, information systems, governance and organization, ambulatory care and managed care practices. She completed her undergraduate studies at the University of Notre Dame and earned her Masters in Busi-

ness Administration from Vanderbilt University. She has served on the review board for the Health Care Financial Management Journal since 1990. Ms. Anderson recently completed six years of service as a public member of the American Board of Medical Specialties (ABMS). She received the 2001 ABMS Distinguished Service Award for her significant contribution to the broad field of medical



Suzanne T. Anderson

education and specialty certification. Her dedication to the overall goal of improvement of patient care through train-

ing and evaluations of physicians has been evidenced in her many contributions. We look forward to her insights and their benefit to the specialty of anesthesiology.

Please get the message out to apply for FAER grants. The funding amounts have increased, the grant periods have been lengthened and participatory mentors are mandatory. By restructuring the FAER grants, the board sought to create a renewed enthusiasm for pursuing research in anesthesiology. The Foundation has been encouraging clinical research and will soon publish requests for proposals in various areas of interest such as

cardiovascular, ambulatory, pain management, geriatrics, pediatrics, obstetrics, trauma and critical care as well as biomedical technology. The survival of our specialty depends on continued knowledge. We must reverse the downward trend seen in numbers of grant proposals to FAER and to the National Institutes of Health. Table 1 shows the decrease in proposals. As this article is submit-

## FAER REPORT

# Report (continued)

ted, the FAER Board has not yet heard the recommendations for funding from the review committees, ASA Committee on Research and the Education Study Section.

Currently, there are four grants offered through FAER.

Table 2 summarizes information about applications reviewed and grants awarded. Please see the Web site <a href="https://www.faer.org">www.faer.org</a> for complete application details.

Table 1

Program	Research Starter Grant (RSG)	Research Training Grant (RTG)	Research Fellowship Grant (RFG)	Research Education Grant (REG)
Purpose	Support to initiate project for which investigator will seek further support.	Allow applicant to become independent investigator.	Provide significant training in research techniques and scientific methods.	Improve quality and productivity of education and research in anesthesiology.
For whom	Instructor or Assistant Pro- fessor with a continuing appointment within 5 years of appointment.	Instructor or Assistant Pro- fessor with a continuing appointment.	Anesthesiology Resident after CA-1 training and 6 months of Clinical Scientist Track.	Anesthesiology Resident or Faculty.
% Research Time	40%	80%	80%	20%
Duration	2 Years	2 Years	1 Year	2 Years
Amount	Yr. 1 \$35,000 Yr. 2 \$50,000	Yr. 1 \$75,000 Yr. 2 \$100,000	\$50,000	\$25,000
Deadlines	February 15 or August 15	February 15 or August 15	February 15 or August 15	February 15 or August 15

Table 2

Year	Number of Applications Reviewed	Number of Grants Awarded	Percent Funded
1995	69	21	30%
1996	63	17	27%
1997	60	19	32%
1998	52	14	27%
1999	38	14	37%
2000	38	11	29%
2001	38	In process	N/A