2008 CSA Annual Meeting

2008 Leffingwell Memorial Lecture: Excerpts from "Fixing Healthcare from the Inside Out or Physician Accountability in Health System Reform" by Jack Lewin, M.D.

By Kenneth Y. Pauker, M.D., Chair, Division of Legislative and Practice Affairs, Associate Editor

Dr. Jack Lewin delivered the Forrest E. Leffingwell Memorial Lecture at the CSA Annual Meeting on May 31, 2008. Outgoing CSA President Virgil Airola, M.D., selected Dr. Lewin for this honor and introduced him as his long-time personal hero at the CMA, likening Dr. Lewin to Dr. Leffingwell as an advocate of physicians and their patients. Dr. Lewin is at present CEO of the 34,000-member American College of Cardiology, and an advocate of universal access to physician-directed health care. He trained in Internal Medicine at USC, served in the Indian Health Service in Arizona for seven years, practiced primary care in Maui, was the Hawaii Director of Health for seven years, ran for Governor of Hawaii, was a consultant for President Bill Clinton on healthcare issues, and was CEO/EVP of the CMA for 11 years, before moving to the ACC in November 2006.

Dr. Lewin's lecture was recorded in its entirety, and is accessible as a podcast from the CSA Web Site:

http://www.csahq.org/podcasts.php

Dr. Lewin's underlying premise is that no matter what we say or do, "health system reform is *essential* and *imminent*," and that physicians must not act defensively, nor find themselves in a secondary mode, but rather get up front and be involved, not at all like we behaved in relation to the attempted reforms proposed by Mrs. Clinton in the 1990s. At present, physicians have not been "at the table" effectively, as have been big players like the health insurers and hospitals, who have brought to bear their considerable financial resources. Physicians have not donated effectively to influence political outcomes, nor has the House of Medicine spoken coherently, divided often between specialties and differing modes of practice.

> *The CSA has been beating this drum for some time. We need more CSA members to dance to this beat.*

He painted the view from Washington as focused upon the unsustainable Sustainable Growth Rate and no rational method to fund the fix; advancing

health information technology, such as electronic medical records and prescribing; addressing comparative effectiveness of different approaches to care, and whether this is something the government or a public/private partnership should take on; and issues of quality reporting and transparency. The schizophrenic cognitive dissonance in D.C. can be summarized as, "We have the best healthcare system in the world, and we need to fix it fast."

> *Governments, both in Washington and Sacramento, appear to address issues not so much because of a logical and coherent policy process, but rather because of political expediency. The CSA and ASA work hard to influence how political issues play out.*

Dr. Lewin posed what for him are four "very interesting questions": Can health care professional societies be self-regulating? Can physicians overcome conflicts of interest to do this effectively? Will professional society members accept this? Will the government take over quality measurement, regardless of what the medical profession does?

He talked about a couple of very large cardiology practices that invested in EMRs, built on top of them decision support software, and embedded (with the help of the ACC) all guidelines and standards—even technology appropriateness criteria—to set up a comprehensive system. Their compliance with evidence-based care rose from 50 percent to 99 percent. Their hospital admissions for CHF and MIs fell dramatically, and they used appropriate imaging techniques for the first time, causing them to feel "all warm and fuzzy," but their reimbursement fell by 10 percent, thus highlighting a major problem. Cardiologists' payments have been procedure-based, and the system of payment must be dramatically reformed if it is to encourage efficient, quality care. He said that in the last seven years, cardiovascular morbidity and mortality has been reduced 29 percent by new procedures, drugs, and techniques, but there have been no rewards for this quality improvement.

> *The CSA has adopted policy that rejects financial incentives applied to an individual physician, on a "micro" level, that seek to improve quality—so-called Pay for Performance—because in practice it is a flawed and arbitrary methodology. The CSA believes that as professionals, we are obliged to improve quality as part of our ethical obligations to our patients and professionalism. Re-engineering a payment system to reward quality on a group or specialty or "macro" level, with the help of professional societies, is strongly preferable, but there is still a significant potential for such a system to be designed to move money from one specialty to another, or to be used to accomplish political or philosophic objectives.*

Dr. Lewin believes that there are overwhelmingly powerful forces at play which inevitably will reward physicians on an individual level, but, if this is for adherence to guidelines, then it is a process measure and not an outcome measure, and hence to him reasonable and appropriate to stimulate quality improvement. To me, if the cardiologists' reimbursement fell by 10 percent, perhaps it should have. To Dr. Lewin, on the other hand, there does need to be some recognition of the investment required to "translate science" and implement it at the point of care.

Dr. Lewin described the predicted financial demise of the Medicare Trust Fund by 2017, and the vast sums needed to fund Medicare for baby boomers thereafter. He described examples of uneven care, and of vast resources being consumed disproportionately. He then came to his central tenet: we have come to a fork in the road, and we will either have to choose a path of dramatic changes proposed and implemented by professional forces, or another path in which outside forces will step up (and are already beginning to do so) and assume control. He reported surveys by the ACC that demonstrate that two-thirds of the public prefer professionals and their societies to do this work, as opposed to government, insurers, or a new public/private entity.

He described how the ACC is approaching this with its National Cardiovascular Database Registry (NCDR). The ACC is translating science into standards, guidelines, performance measures, and appropriateness criteria on a massive scale, aiming to construct decision support resources for use at the point of care, giving clinical data (not claims-based data) back to those measured in a focused, coherent, and professional way. It seeks to shine a bright light into areas previously illuminated only dimly by opinion, training, and variable clinical judgment and, in so doing, further aligning with patients and physicians.

*The scale of ACC's effort in this area is staggering, and how it is done and its fruits are on display in the "Practical Science" link under the "Chapters" title (**http://www.acc.org/about/chapters/chapters.htm**) of the ACC home page. The ACC has been constructing Guidelines since 1980, and the number available upon which to base performance measures reflects this long time-frame and prioritized effort. Dr. Lewin reports that there are hundreds of cardiologists and more than 30 staff involved in panels which do this work. He relates that this process is the major focus of what ACC does for its members' dues.*

This notion of constructing decision support resources for use at the point of care is extremely interesting as well. It is notable that the ASA has just unveiled at the August Board of Directors meeting a plan to form the ASA Quality Institute within the next two years, intending to develop a vast

clinical database to be used for many purposes, including research, confidential benchmarking, and macro quality initiatives.

Dr. Lewin concluded by stating that the biggest threat to physician autonomy is physician autonomy. Physicians must coalesce, cooperate, and strive to measure and to improve what they do in a very transparent way, no longer being able to assert professional prerogatives to subvert participating in a process that must and will go forward with us, or in spite of us. We cannot reject *systems of care*, but we rather must help to design systems of care. We must align ourselves with patients. We must participate in a kind of "macro level peer review." There is no one but ourselves to save our profession. We must get to the table, rise to the occasion, be integral to the process, and advance us back to where our professional societies came from, and that is to being advocates for patients and quality.

He calls this "our solution and our destiny, and it's really where we came from … all of these societies … we came out of a need to create quality of care, and education, and professionalism, and debunk quackery, and move together toward what was really important to patients. We've got to find our way back to that. It's hard when we're so fractionated, but we have to do it because it's critical."

Bravo, Dr Lewin! This is a rousing call to action, completely consistent with CSA philosophy, and one that CSA members ought to embrace. To do otherwise would be at their peril.

2008 Distinguished Service Award

Presentation to Benjamin Shwachman, B.S., R.P.H., M.D., J.D.

By Clyde W. Jones, M.D.

Mr. President, Officers of the CSA, Honored Guests, Ladies and Gentlemen, it is a singular honor and extreme pleasure for me to introduce Dr. Benjamin Shwachman for the highest honor this Society can bestow.

In February 1968, while stationed at Camp Pendleton, California, I was deployed to Viet Nam with a Regimental Landing Team with 48 hours notice. It was here I first met Ben Shwachman. I was skittish at my first assignment in a Combat Zone, but Ben was a combat-seasoned veteran, known throughout the Combat Zone as "El Shwacho." His facility with conduction anesthesia was valuable to me, enabling us to augment our anesthetic capability. Possessed of

a wry wit that occasionally borders on the macabre, he was a great entertainer in the Club, enabling us to pass our time much easier. Ben served in the Medical Corps of the United States Navy in Viet Nam in 1967-1968 and then at the Naval Hospital, Long Beach, California, 1968-69.

When I met Ben again, he had acquired a law degree and was speaker of your House of Delegates, where I was a representative from San Diego. Each year Ben appointed me Sergeant-at-Arms, with a preamble that stated, "Don't let his diminutive size fool you. They don't come any meaner." Then he went on to say that he and I were the reason America lost the war. These flattering accolades were not confined to this House of Delegates. Once I was on a cable car in San Francisco, laden with passengers, when Ben boarded the vehicle. He proceeded to render me the full honors, much to the amusement of all passengers, the conductor, and the brakeman.

Clyde Jones, M.D., and Ben Shwachman, M.D.

Ben is also known as a parliamentary catalyst in the House of Delegates of the American Society of Anesthesiologists. When there is a thorny issue being discussed, Ben is known to intone in a floor microphone, "Shwachman, California." This is followed by a motion that all discussions cease and a vote is taken. If Ben is seen on a line approaching a microphone, there is a flurry of activity. Ben may only be rising to a point of information. Such a character is my friend Ben—one whose friendship I have treasured over the years.

Ben Shwachman was born on July 20, 1937. He received a B.S. in Pharmacology at the Illinois College of Pharmacy in 1959, and his Doctor of Medicine from the University of Illinois College of Medicine in 1964. He completed a Rotating Internship at the Milwaukee County General Hospital in 1965. This was followed by a Residency in Anesthesiology at the University of Illinois and the Los Angeles County General Hospital, 1965-1967. An overachiever, he attained a Juris Doctor degree from Loyola University, Los Angeles School of Law, in 1974. He holds licensures in Pharmacology, Medicine, and

Law. Presumably, Ben can write a prescription, fill it, and then defend himself if there is a problem.

He is a Diplomate of the American Board of Anesthesiology and of the American Board of Pain Medicine. He holds memberships in the California and the American Societies of Anesthesiologists, the California and American Medical Associations, the State Bar of California, California Health Attorneys, the American Academy of Pain Medicine, and the International Spinal Intervention Society. He has worked as both attorney and physician and has contributed to the literature in both fields.

He is a past member of the House of Delegates, Speaker of the House and President of the California Society of Anesthesiologists; Delegate to the American Society of Anesthesiologists; Past President, Los Angeles County Medical Association; and member of the Board of Directors and Advisory Committee for Medicare for the American Academy of Pain Medicine.

He holds several hospital memberships—at Citrus Valley Health Partners, Intercommunity Hospital, Queen of the Valley Hospital, Arcadia Methodist Hospital, San Dimas Community Hospital, Presbyterian Inter-community Hospital, and Whittier Hospital Medical Center as anesthesiologist and dolorologist.

It is with extreme pleasure that I present my friend and wartime buddy, Ben Shwachman, physician and lawyer, for the highest award this Society can bestow.

DSA Acceptance Speech by Benjamin Shwachman, M.D.

First, let me thank you all for this honor. My thanks go to the officers of this society, the House of Delegates, the Board of Directors, the wonderful devoted staff, and most of all, the members of the CSA who supported my efforts through the years—and, of course, to my old war buddy, Clyde Jones, for introducing me.

Clyde was always so patient and always so caring. Each year when I was speaker, I would ask Clyde to serve as my Sergeant-at-Arms, and each year he would say, "OK, but no more dumb stories about how we lost the war because we were both there." Each year as he aged, he thankfully forgot about the previous year.

I also want to take this opportunity to introduce my sister, Frieda Schwartz, who—14 years my senior—really was more a mother to me and really raised me; my daughter, Amy, and her husband, Ofer Gabay; and my grandchildren, Emily and Aaron. Of course, there is also the woman who stood by me and literally put me back on my feet, the woman I adore and love, my wife Karen.

Because this may be the last time I address you and because I sort of have you captured, I would like to tell you of my concerns for the CSA, and for anesthesiology and the patients we serve. To do so, I want to give you a history of anesthesia—not that of Morton and Long, but a legal history of this specialty. I was stirred to this talk by a young man's posting on the Web site that he was so happy that an exclusive contract had been signed by his group and the hospital. It raised serious and profound concerns that there was lacking a history of where we came from and its trials and tribulations. I fear we have become too fat, and in that, too comfortable with where we are, to realize the dangers that may lie ahead. To paraphrase Santayana—If we forget the past, then we will come back to it.

So let me begin. Soon after Morton and Long and the discovery of anesthesia, its dangers seemed to become apparent. Hannah Greener in 1848 was a 15-year-old girl. She was to have an ingrown toenail removed. As I recall from a report in *JAMA* citing the event over 100 years later, she did not want the chloroform anesthetic, but her mother talked her into it. Reading it is so sad. The cause of death is not clear but may have been aspiration. But the lesson of the dangers and risks was not learned.

In the late 19th century, "kitchen surgery" in rural America was fairly common. The kitchen would be scrubbed and the kitchen table would be used for the procedure. The Mayo brothers, as children, gave the anesthetics for their physician father practicing kitchen surgery in rural America. As the Mayos took their father's place and the Clinic came into being, they brought in nursing to do the anesthesia.

There are two legal cases that I will cite in this talk. They are, in my opinion, critical to an understanding of anesthesiology as a medical specialty. In 1917 the issue of anesthesia as a practice of medicine reached the Kentucky courts in the case of *Frank vs. South,* 175 Ky. 416, 194 S.W. 375. This was a seminal case, and I urge you to read it. The question before the courts was simple: Did the providing of anesthesia services require a physician? The court said anesthesia did *not* require a physician. The court made the following statements:

> She (the nurse anesthetist) has not opened an office nor announced to the public in any way a readiness to treat the sick or afflicted, nor

> has she ever prescribed for anyone or treated any ailment or infirmity by any method unless the administration of anesthetics to patients under circumstances stated is a treatment of a human ailment.

Further, the court noted that:

> It was, however, shown that in the country at large, while the most usual practice was to employ licensed physicians for such services, at many of the large and most noted hospitals, trained nurses were employed for the service by many of the most learned and most skillful surgeons—notably at the Mayo Clinic. …

And finally:

> The evidence discloses a variety of opinions as to whether women or men make the most safe and efficient anesthetists, or whether trained nurses educated for the purpose or licensed physicians are most competent for the work of administering anesthesia to patients undergoing surgical operations. Some of the opinions are to the effect that the work of an anesthetist is most responsible, and that upon his or her competency and efficiency depends in some measure the success of the operation and in a large measure the safety of the patient, while others seem to hold to the opinion that the administering of the anesthetic should be attended with little danger to the patient, if the surgeon has properly performed his studies in the examination of the patient beforehand to discover his physical condition and whether there is any reason existing why a certain anesthetic should not be administered, and to what extent and in what quantity it should be administered, and thus equip himself to be able to give the necessary direction to the anesthetist.

From about 1917 forward, anesthesiology as a medical practice seemed to die. If the gases were just breathed in and out, then anything in between was a mechanical effect and could be handled by technicians. This was the basic philosophy. Anesthesia became primarily a nursing field.

In the 1920s Haldane did uptake studies on ether and could not account for about 20 percent or so of the drug. Rather than pronounce the heresy that the drugs were like any other drug—metabolized—he felt this was a result of his inadequate collection systems. It wasn't until the late 1950s or early '60s that carbon 14-labeled anesthetics were used in research and, lo and behold, these drugs were metabolized!

In about 1938, Pentothal (thiopental) was introduced, and in 1941 the Japanese bombed Pearl Harbor. When I started my residency in 1965, my teachers had been in World War II only 20 to 25 years earlier. I was told that the surgeon general at Tripler Army Hospital was sent around the country to teach the handling of mass bombing casualties. When asked about Pentothal, he was reported to have said that Pentothal was the ideal drug of choice for euthanasia. He claimed Pentothal killed more GIs than the Japanese bombs.

In order to answer the dilemma, the Army looked around at the few people left practicing anesthesia and went to one of them, Dr. Ralph Tovell. He was asked to be the consultant in anesthesia and really to reverse this problem. After the war, the various consultants were asked to write a treatise on their experiences, and these were compiled into a compendium called *Surgery in World War II*. Dr. Tovell was surprised to be told that he was to come quickly. He thought he would be made a major, but instead overnight he was a Lt. Colonel and subsequently a Colonel. A constant recurring theme was the lack of trained physician anesthesia as opposed to the British and Canadians. Even equipment such as endotracheal tubes was lacking for the Americans but available to the British.

The American physicians trained in anesthesia in this war came out and started residency programs, but anesthesia was not growing.

Subsequently, at an ASA meeting held secretly in about 1950, the ASA leadership (ASA had only a few thousand members for all of America) met and decided that in order to make the specialty grow, they had to mimic surgery. Surgeons were not employed by hospitals and so they decided to make it unethical to be contracted or employed by a hospital. Dr. Gerry Nudell, whom a few of you may know, attended this meeting as a young man at the invitation of his chief of service. I heard the story from him.

By the time I came into anesthesiology in 1965, it was listed as an economically depressed medical specialty by the California Medical Association. There was no money to be made in this field compared to our surgical colleagues. It was unethical for us to contract with a hospital. Anesthesiology was poorly regarded as a medical practice. In the Marine Corps the surgeons were nervous when I tried to help in the triage area and preferred corpsmen. Dr. Sol Statman, the first winner of this award, recalled to me that when he told his father he was going into anesthesiology, his father asked him, "If you want to do that, why did you go to medical school?"

In the 1970s the antitrust laws were held to apply to the learned professions. The Relative Value Guides by which we all—specialty and state medical

societies—used to determine our fees were held by the governmental agencies to be in violation of antitrust, and they ordered us to cease and desist. Action was brought by the FTC and the Justice Department. The ASA was ready to surrender, but the Justice Department insisted that we uniquely give up our Noerr Pennington rights. Noerr Pennington is the doctrine that allows us to appeal to and work with the legislature on any matter, including fees. No one else was asked to do this. The ASA stood firm. I tell you of this case because it shows you the attitudes toward and the history of anesthesiology.

U.S. v. American Soc of Anesthesiologists Inc. (473 F. Supp. 147 (S.D.N.Y.)) is the second case I urge you to read. Judge Duffy, in analyzing this case, went into the history of anesthesiology and the RVG. By the way, the ASA by then had 9,463 active members. Today it has over 40 thousand. Judge Duffy noted that prior to 1928 (10 years after *Frank v. South*), administration of anesthesia was regarded as a relatively simple procedure that did not necessarily require the expertise of a medical doctor. For the most part, nurses and technicians were utilized to administer anesthetic drugs. He noted that development started when Dr. Ralph Waters started the first Department of Anesthesia at the University of Wisconsin in 1928, and the American Board of Anesthesiology was started in 1939.

BUT he noted:

> It was World War II that provided the impetus for the widespread development of the specialty. The government required that physicians be utilized to administer anesthesia wherever possible, and accordingly, young doctors were given crash courses in the area. As a result of this experience, surgeons began to recognize the value of physician-administered anesthesia and demand their expertise when they returned to civilian life. In addition, many of the young physicians who practiced anesthesia during the war decided to pursue that specialty.

Here we obviously see the hand of Dr. Tovell.

The court, after a review of the ASA RVG development, noted that the RVG produced by the ASA did not have an adverse effect on interstate commerce. Moreover, the court, before it held for the ASA, made the following comment:

> The need (for the ASA RVG) undoubtedly arose because of the unique problems anesthesiology faced as compared with other medical specialties. **In a real sense it was long the stepchild of medicine**: (emphasis added) Its rapid development into a full-

> blown medical specialty called for an equally rapid development of a rational method for arriving at fees."

Look at the ASA RVG guide and know this—it is the only such guide existing. Know the reason it exists as outlined by Judge Duffy. Understand the potential terrible harm of hospital administrator-controlled medicine through these contracts!

Indeed, following the malpractice crisis when anesthesiology raised rates comparable to surgical levels, there was an influx of anesthesiology residents. When Cedars-Sinai started the first exclusive contract in 1976, it stirred Dr. John Bonica just as that young man's comment about his "exclusive" contract stirred me.

I urge you to listen to the CD of Dr. Bonica's 1976 talk describing this matter and the terrible problem he had as the American Hospital Association was set to take over the practice of medicine completely. The CD is available from the CSA office, and I urge you to listen to it and listen carefully. It was such a terrible fight to establish the private practice of anesthesia free of hospital controls that you will hear Bonica at one point break down in tears as he recalled it. The contracting issue has led to very painful and destructive situations, and this is personal as well.

First understand there ARE NO EXCLUSIVE contracts for anesthesia services held by a physician in California that I know of. All these contracts have a "clean sweep provision," usually in 90 days. The "clean sweep provision" states that when the contract terminates so do your anesthesiology privileges.

Think! The administrator of the hospital calls you in, as an example, and says his brother just finished his residency, and he wants you to include him from day one as a full partner. You say, "No, we have an exclusive contract." The administrator can say, "In 90 days, you are out. My brother will then take over and replace all of you." So tell me—who holds the exclusive contract? The administrator, of course! You can obviously think of other scenarios that can imperil patient safety, all controlled by a nonphysician hospital administrator.

Nonprofit hospitals are subject to "revenue procedures" dictated by the IRS to assure that there is no private inurement. Yes, the revenue procedures require no more than one year on an exclusive contract to avoid private inurement, but there is no requirement in the "revenue procedures" that requires surrender of privileges by such a contract. But all the contracts have this clean sweep provision, and administrators will tell you the IRS requires it, but **it does not!**

Actually you have greater security without the contract, as we did for years. If you are competent, friendly, and provide good service, then surgeons are not interested in getting into an anesthesia squabble and will stick with your group. Judge Duffy noted (and this was the mode of practice when I came into this field):

> It is common practice for a group of anesthesiologists, organized as a single business entity, to carry on all of the anesthesia practice in a single hospital.

Frankly, it worked, and we had stability in hospital anesthesiology without any contracts, and the success we have had in patient care came from physician-controlled anesthesiology in the days before contracts with hospital administrators!

Thank you.

Roger A. Moore, M.D., ASA President-Elect, and Linda B. Hertzberg, CSA President-Elect, at the 2008 CSA Annual Meeting