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Legislative and Practice Affairs Division

GASPAC: Essential to Political Advocacy

By William E. Barnaby, Esq., and William E. Barnaby III, Esq., CSA Legislative Counsel and Legislative Advocate

Political advocacy repeatedly has been named as a top priority for the CSA in internal membership surveys. The CSA was the first California medical specialty society to have independent lobbying representation. It was also the first specialty to establish an independent political action committee–the Greater Anesthesia Service Political Action Committee (GASPAC).

GASPAC has become well known since it was founded in 1976 even though its treasury is far smaller than most political action committees. Its name is catchy and easy to remember. It has served CSA extremely well. In short, GASPAC is an essential component to the political advocacy desired by the CSA membership.

In 2002-03, member donations to GASPAC exceeded $120,000, the most ever for a single year. Last year, however, the total dropped to $90,000. The percentage of CSA members making voluntary docations to GASPAC fell from 31% to 19%. **This being an election year, it is important for GASPAC to have sufficient resources to be a visible participant in the political process.**

Political advocacy sometimes is described as a three-legged stool. One leg consists of a well organized, active constituency. CSA qualifies on that count. Another leg has to do with having representation before the Legislature and state agencies when relevant actions are at issue. That is the role we play with guidance from the CSA Board of Directors and the Legislative and Practice Affairs Division. The final leg is the political action committee, the arm that helps those legislators who are sensitive to the issues of concern to CSA and who are accessible to CSA members and representatives. Without all three legs in place, political advocacy cannot function properly.

State government plays a critical role in health care and the practice of medicine. Government and politics undeniably have a huge impact on the quality and availability of health care to the public. The reach of state government into medical practice includes physician licensing, medical education, lawful prescribing, *scope of practice of ancillary health practitioners*, medical malpractice insurance and tort law, hospital and clinic licensing and surveys, Medi-Cal, Workers' Compensation, and managed care. The list seems endless. Indeed, it is hard to cite an area

of medical practice that is not closely regulated by either the state or federal government.

Besides advancing medical science, improving medical practice and promoting quality care and patient safety, a critical function of all voluntary physician organizations involves government relations. **Government ordinarily does not reach out to affected parties to solicit their views.** Public agencies presume, perhaps incorrectly, that interested parties monitor legislation and rule-making activities and are prepared to defend themselves and assert their interests as necessary. Hence, there is a distinct need for political advocacy that tracks pending and proposed government actions and advocates proactively for organizational interests.

GASPAC simply is essential to CSA's political advocacy. GASPAC helps give CSA a seat at the table. Even though the amounts of individual GASPAC contributions are small in comparison to those of many other political action committees (PACs), its donations provide some tangible recognition to office holders who are sensitive to CSA concerns. Rest assured that even relatively small amounts are appreciated by those decision makers who receive timely GASPAC support.

GASPAC needs and deserves the help of all CSA members. Some may have philosophical objections to political contributions. Yet the reality is that political decisions heavily impact medical practice and patient care. To a great extent, an organization's participation in the political process requires some degree of campaign involvement. GASPAC gives CSA credibility in that regard.

Most GASPAC donations pay for attendance at fundraising events. Many are "third house" (lobbyist) events in Sacramento when one or both of us attend. GASPAC also buys tickets for GASPAC donors to attend local fundraising events for supportive incumbents/candidates in their home communities.

The requested annual donation to GASPAC is $200. It is an important investment in CSA and your practice. In responding to your CSA membership dues notice, we respectfully urge that you include the $200 GASPAC donation. It is money well spent.

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What Juries Think

By Linda Crawford, J.D.

It is a well-established fact that although many plaintiff outcomes are catastrophic and although juror sympathy levels are high, jurors find for the defendant the majority of the time. A better understanding of why this is the case can help defendant physicians as they suffer through the trial process. Linda Crawford, trial attorney and educator, has spent 12 years studying juries to discover how they arrive at their verdicts in medical malpractice cases. The studies have involved more than 400 cases, gathering information through juror interviews and by reviewing videotapes of mock trials and the jury's deliberations. Here, she and Sissie Friedman of ProMutual write about some of her findings.

Linda S. Crawford, J.D., teaches trial advocacy at Harvard Law School and has been consulting with defendants prior to deposition and trial since 1985. She is currently consulting with Lifespan insureds.

–Stephen Jackson, M.D., Editor

Although only a small percentage of all medical malpractice cases ever go to trial, defendants' concerns about "facing the jury" rank among the highest on the stress meter. During a trial, medical professional defendants feel trauma, anxiety, depression, job strain, shame and fear.[1] They are facing a lay jury that will decide their fate. How can defendants survive–even thrive–in this foreign, hostile environment?

What Are Jurors Thinking?

Jurors take their role in the courtroom very seriously. They use every tool available to them to decide the case. Since trials may last two weeks or more, jurors have a lot of time–and they spend a lot of it watching. While the jury might hear a defendant testify for four hours, they will watch him/her for two weeks both inside and outside the courtroom. Where is most of their data coming from? What they see.

And jurors see everything! They–and the defendant–are much more sensitized to the courtroom environment than judges, attorneys, experts and other witnesses are. The stakes are high for both jurors and defendants–jurors want to make the right decision and the defendants report that the trial is a major life event for them. We are all more sensitized to new environments than we are to environments we are accustomed to. Consider a dripping faucet. If the faucet is dripping when you first move into a building, and you don't fix it when you first get there, six months later you won't even know that the faucet is dripping. For jurors and the defendant, this is that new environment.

What are jurors looking for in the courtroom? … a defendant who is trustworthy, competent, and compassionate. Before they ever get to the medicine in the case, they decide whether the defendant meets the test. Jurors watch the defendant's demeanor and make judgments about who that professional is.

According to feedback from jurors, if the defendant seems to be concerned, competent and professional, the jury will assess the medicine and the facts in a light favorable to the defendant. Jurors believe that health care providers who are invested in their work and their patients make better judgments about the care they deliver. After many years of working with defendants, I have come to understand that jurors are right.

The good news is that jurors want to like and believe defendants. They relate the health care professional to their own provider. They ask themselves, "If I was in medical need, would I be in 'safe' hands with this person?"

Dispelling the Myths

Jurors do not expect perfection. In interview after interview, jurors have revealed that their assessment of the case hinged on whether they felt the defendant did the best job he/she could under the circumstances. Indeed, that is the jury's test: Did you do the best you could? This contradicts many of the myths about what matters in malpractice cases:

- *It is not true that the facts and medicine alone dictate the outcome of a case. Before jurors ever get to the medicine and the facts, the defendant's credibility must first be firmly established.*

Let me give a recent example in a case where the journalist covering the trial for *The Wall Street Journal* won the Pulitzer Prize for her work on it.[2] This was a physician who was charged with misconduct regarding one of his patients. The issue was whether the jury believed the doctor or the patient. At the first trial, the jury found the doctor guilty. The case was overturned on appeal, and the doctor's new attorney asked us to consult with the physician before his second trial. The stakes were high. The defendant had a highly competent and dedicated defense team, but we all knew that the trial hinged on the jury's assessment of the defendant. Not only did the jury find for the physician the second time around, but in talking with his attorney after the trial, jurors said, "This is not the kind of person who would have done what he was accused of." The facts hadn't changed, but the jury's perception of who the defendant was had.

- *It is not true that the side with the best expert wins.*

In a recent survey of jurors, they reported that the biggest waste of time during the trial was the credentialing of the experts–a discouraging finding when we go to such effort to get experts with the best possible credentials to support our cases. But that doesn't mean that experts aren't important to the jury. It is really a two step process for them. First they decide whether they "buy" the defendant. Secondly, they listen to the expert that supports that assessment. If the jurors believe the defendant is an honest, competent, concerned provider, they listen to the defense experts. If they don't "buy" the defendant, they listen to the plaintiff's experts. And what the jurors want from an expert is someone who explains the technical medical information in a way that the jury's learning is expanded.

The defendant is the real expert to jurors. Jurors want to trust and believe health care providers–and the best test of an expert as far as the jury is concerned is someone who has personal knowledge. The defendant was there, caring for the patient. The jury is best served by hearing from someone who can explain what they saw, what they were thinking and why they made the decisions that they did. This is more helpful to jurors than hearing from an expert who never even saw the patient but is paid to come to the courtroom and testify for one side or the other. Paid experts can be helpful, but it is the defendant the jury most wants to hear from.

- *It is not true that the defendant's appearance and demeanor have little bearing on the case.*

Studies show that 15 percent of the human brain is used for language. The other 85 percent is left for everything else–and in the courtroom it is used for observing.[3]

Jurors report that how well defendants present themselves is something they watch throughout the trial.[4] Research has shown the importance and impact on the jury of the defendant's body language, personal interaction and appearance. They are trying to figure out whether the defendant meets "the test." While people remember only a fraction of what is said, they remember how it is said. Indeed, even when the medicine is stellar, if the jury believes that the defendant is arrogant, hostile, or unsure of himself, the defense will have a very difficult time winning the trial. Because medicine is about judgment, the jury first makes a decision about the person who made the judgment call primarily based on what they see and how the defendant testifies. Only after they do that, can they evaluate the medicine in a way that favors the provider.

There is no question that the defendant has to live with the facts, whatever they are. Research has shown, however, that while the facts are important, the jury is

affected by the defendant and the type of person and professional he or she seems to be. The defendants' attitude and the ability to present well to the jury can improve his or her chances of winning the lawsuit.

References are available upon request from the CSA Office (800)345-3691.

One More Form of Kickback?

By David E. Willett, Esq., CSA Legal Counsel

The last *Bulletin* described kickback demands by ambulatory surgery centers, particularly those hit by reductions in workers' compensation payments to ASCs. The focus of that article ("Have I Got a Deal for You, Says the ASC Operator," January-March 2004) was anesthesia services, and specific Labor Code proscriptions against workers' compensation kickbacks.

Now members practicing pain medicine are asking whether "administrative fees" sought by referring specialists would constitute illegal kickbacks. A likely reaction when the question is asked is that these specialists are using Capone-era tactics to cut themselves into the pain medicine practice. The "administrative fee" may sound like a kickback.

Efforts to disguise kickbacks as administrative or management fees have been commonplace. Generally, arrangements which involve payment for personal services, such as "administrative" services, will survive scrutiny only when the services are reasonable and necessary for the legitimate business purposes of the payer and payee, payment does not exceed fair market value and payment is not determined in a manner which takes into account the volume or value of any referrals or other business generated between the parties. The broad California laws' prohibitions against kickbacks are found in California Business & Professions Code Section 650 et seq. There are separate prohibitions in California Labor Code 3219 et seq., where workers' compensation is concerned. Federal anti-kickback laws appear in 42 U.S.C. Section 1320a-7b(b). Even though the federal laws do not apply to practices providing no services for which payment is made under federal programs, such as Medicare, Medi-Cal and CHAMPUS, federal regulations are useful in evaluating administrative service agreements which call for the payment of fees to referring physicians.

Because such arrangements are suspect, the Office of the Inspector General, Department of Health and Human Services, adopted specific rules which provide a "safe harbor" for participants. In the situation under discussion, where referring specialists would receive administrative fees from the pain specialist, it appears that the pain specialist uses the office resources of the referring group to make

appointments and schedule treatment, and to otherwise interact with patients. These activities, which are separate from billing and collection, can be substantial, generating significant costs. These payments are not intended to be kickbacks. However, the participants would be wise to structure their arrangement so that it complies with the federal safe harbor, even though this is essentially a workers' compensation practice which is not subject to federal prohibitions. That is because the federal safe harbor takes the same issues which arise under the California laws, and draws clear lines between permissible and potentially unlawful arrangements.

The federal safe harbor (42 C.F.R. 1001.952(d)) contains the following requirements:

- The compensation to be paid is specified, is not dependent on the volume of referrals, and is consistent with the fair market value of the services provided, in arms-length transactions.

- The services to be provided do not exceed those reasonably necessary to accomplish a commercially reasonable business purpose.

- There should be a written and signed agreement between the parties.

- The agreement should apply to all services provided to the payer by the party being paid the fee.

- If the agreement applies to services being provided on other than a full time basis, the schedule on which services are provided should be described.

- The agreement should be for not less than one year, absent termination for cause or because of circumstances outside the parties' control.

Pain specialists who are asked to pay fees to referring specialists should be sure that the arrangement meets the first two criteria, and that the request is not for a kickback. A written agreement, approved by legal counsel, is recommended. An agreement meeting all these requirements offers enhanced protection against challenges by regulatory agencies.