

# California and National News

**Olympic Athletes Who Became Physicians:** The California Connection: California has been part of the life story of several Olympic athletes who have become physicians. Perhaps the most famous is **Debi Thomas**, whose hometown is San Jose. She won the bronze medal in figure skating in Calgary in 1988 after winning the United States National and World Championships. She attended Northwestern University Medical School, and currently is an orthopedic surgeon in Indiana.



Whereas figure skating is a “pretty individual sport,” she reflects that she now enjoys being part of a team of healthcare practitioners. **Eric Heiden** hails from Madison, Wisconsin. The year following his failure to win a medal at the 1976 Olympics in Innsbruck, Austria, he became the first American to win the World Speedskating Championship. At the 1980 Olympics at Lake Placid, he won five gold medals, while breaking five Olympic records and one world record. Returning to Stanford as an undergraduate, he then became a professional cyclist and even won the United States Cycling Championship in 1985, and captained the first American team to be invited to the Tour de France in 1986. He graduated from Stanford Medical School in 1991, and then became an orthopedic surgeon, currently practicing in Salt Lake City, and specializing in arthroscopic procedures and anterior cruciate ligament repair. He currently also serves as the medical director for the United States Speedskating and Cycling Teams. (Extracted from the *Wall Street Journal* article written by Dennis Nishi, February 16, 2010.)

**Michael Jackson’s Death Declared a Homicide:** A Los Angeles coroner’s report concluded that Michael Jackson died from “acute propofol intoxication,” and thereafter the District Attorney charged Dr. Conrad Murray, a cardiologist, with homicide. Specifically, Dr. Murray was charged with involuntary manslaughter, alleging that he acted “without due caution and circumspection,” but “without malice.” Dr. Murray had indicated that he prescribed propofol as a sleep medication, allegedly supplemented by lorazepam. However, anesthesiologist Dr. Selma Calmes, hired as a consultant to the coroner, stated that to her knowledge, “There are no reports of its use for insomnia relief ... [and that] ... the only reports of its use in homes are cases of fatal abuse, suicide, murder and accident ... [and further that] ... the standard of care for administering propofol was not met” [and that] “propofol was administered without the recommended equipment being present, including a continuous pulse oximeter, EKG and blood pressure cuff.” Moreover, she declared that propofol administration requires “full monitoring by a person trained in anesthesia.” Dr. Calmes also stated that “Multiple open bottles of propofol were found,”

apparently in violation of the boxed warning to discard open ampoules within six hours of their opening. Moreover, she indicated that “the levels of propofol found on toxicology are similar to those found during general anesthesia for major surgery.” (Extracted from the *CNN Justice* article written by Alan Duke, February 10, 2010.)

### **Hospice Use Continues to Grow, But Late Referral Causes Concern:**

In 2008, two of every five deaths in the United States occurred under the care of a hospice program. However, one-third of those patients died within a week of enrollment, a 4.6 percent increase in what is considered to be a “short hospice experience.” Nonetheless, an average length of service increased to 69.5 days from 67.4 days in 2007, the median length of stay being 21.3 days. Sixty-nine percent of hospice patients died at home or in a residential facility, while 21 percent died in a hospice inpatient facility. Service provided to those of Latino origin (5.6 percent) or of mixed race (9.5 percent) increased in 2008, while services to African American decreased from 9 percent to 7.2 percent. Sixty-eight percent of patients enrolled in hospice constituted non-cancer malignancies, a continuing trend that has been found since 2003. These include heart disease (11.7 percent), lung disease (7.9 percent), stroke or coma (4 percent), kidney disease (2.8 percent) and dementia (11.1 percent). (*National Hospice and Palliative Care Organization*, November 2009.)

**Surgical Deserts in the United States:** The supply of surgeons in the United States is unevenly distributed and even presents potential problems with access to surgical services. Yes, there are places without surgeons in the United States! With greater than 130,000 surgeons in active practice in 2006 in the U.S., the national surgeon-to-population ratio is 45/100,000 persons. The minimum acceptable ratio has been determined to be between 4-6/100,000. However, reflective of a maldistribution of all physicians, 30 percent of the 3,107 counties in the U.S. (comprising 9.5 million citizens) lacked a single surgeon! Most of these counties are located in rural America with older populations, lower than national per capita incomes, higher proportions of their populations living below the Federal Poverty Level, and populations averaging only 10,000. Regional maldistribution also exists, as most of these surgical deserts are located in the Midwest, South and West, and these same counties are underserved for primary care as well. Interestingly, although counties without hospitals are unlikely to have general surgeons, half of those counties without surgeons do have hospitals, the majority of which are titled Critical Access Hospitals. These small rural hospitals provide 24/7 inpatient and emergency services, incentivized to do so by enhanced payments from Medicare and Medicaid. (Summarized from D Belsky, T Ricketts, S Poley, K Gaul, E Fraher, G Sheldon. *Surgical Deserts in the U.S.: Places Without Surgeons*. American College of Surgeons Health Policy Research Institute, July 2009.)

### **General and Family Practice Physicians Offered Less Salary Than**

**CRNAs:** The shortage of general and family practice physicians across the nation will only be exacerbated by the fact that medical centers offered CRNAs an average base salary of \$189,000, greater than the \$173,000 offered to primary care physicians, according to the data released by Meritt Hawkins and Associates, a physician recruiting and consulting firm. This obtuse situation has held sway for the past four years, even though many primary care physicians already are on shaky financial grounds with their costs continuing to increase while private as well as public insurers continue to ratchet down their payment. The United States currently has a shortage of about 60,000 primary care physicians, but this figure is almost certainly going to increase dramatically should healthcare reform materialize and extend health care insurance to millions of previously uninsured Americans. These stark economic facts assuredly do not encourage medical students to choose primary care, especially in light of the approximately \$100,000 of debt facing the average medical school graduate. (Parija Kavilanz, Yahoo! Finance, March 12, 2010.)

### **Critical Care Module 8**

#### **ICU Sedation**

#### **CORRECTION**

Dr. Joan Flacke advised us that an error in the module that appeared in the Winter 2010 issue of the *Bulletin* identified dexmedetomidine as an alpha-2-adrenoreceptor antagonist. The correct information is that dexmedetomidine is an alpha-2-adrenergic agonist.