ANESTHESIOLOGY – A CLOSER LOOK

By Anne Oakley, MD
SCMS President

ANESTHESIOLOGISTS VOICE FRUSTRATION OVER CONTINUED DRUG SHORTAGE

MEDICARE PAYMENTS TO CRNAS IRK ANESTHESIOLOGISTS, AGAIN

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"Life’s greatest happiness is to be convinced we are loved."

Victor Hugo
Anesthesiology – A Closer Look

By Anne Oakley, MD
SCMS President

As you can tell by the cover, this month’s The Message is devoted to providing information to our members about Anesthesia as a specialty. It’s an odd coincidence that your new president is an Anesthesiologist and rather knowledgeable about the subject.

Most of our Spokane County Medical Society membership has only a vague recollection of that masked person behind the screen twirling the dials they observed while they were rotating through surgery as a medical student. Our surgical colleagues and interventional doctors work with us daily, but many still do not know a lot about our training or our goals as physicians of peri-operative medicine. I hope this issue of The Message will be a valuable look into our world!

So let’s explore a day in the life of an anesthesiologist.

I practice at Providence Sacred Heart Medical Center in a large practice doing all types of cases. I treat patients of all ages, in all states of health and at all hours of the day and night. On my very first day of work I showed up bright-eyed and optimistic, only to see one of my senior partners shaking his head (practically banging it on the desk). He looked at me and said, “Do you know the problem with this job? Every day you show up, put your head on this desk and hope the axe doesn’t fall.” I never found out what horrible case he had just dealt with, but his description was quite accurate and the reason that anesthesia is not the job for everyone. The old description of “hours of boredom punctuated by moments of terror” is very true. A good day is when you have no “exciting” stories to tell.

Our day starts earlier than most of our colleagues—patient satisfaction dictates that we start our work before the surgeon. We begin by checking in with the partner in charge of the schedule each morning to obtain our assignments for that day or we relieve a partner who is still working from the night before. We can be assigned to work alone or to supervise up to four nurse anesthetists. We could have a medical student, resident or paramedic student wandering around looking for instruction. We do clinical instruction for Gonzaga’s school of Nurse Anesthesia, so we usually have a certified registered nurse anesthetist (CRNA) student partnered with the CRNA in our supervised rooms. Most of my colleagues would agree that our easiest days by far are the ones where we just have our own room to manage, even if those are frequently the more complicated cases.

If I am in my own room, the day then involves the preoperative evaluation of the patient. For a scheduled case this is usually fairly straightforward, but is often complicated by a lack of data, a change in the patient’s health since they were scheduled or new history coming to light. The surgeon’s most dreaded calls come from us at 6:45 a.m. - “Did you know that your healthy knee scope patient had chest pain all night?” or “Has a room air saturation of 88?”, or “Has a blood sugar of 377 and is not being treated as a diabetic?” It messes up everyone’s day, but our first job is patient safety, not the schedule.

If all is well, the next step is to set up the operating room. In the old days this meant checking the gas connections and backups, the suction equipment, airway equipment and routine and emergency drug supplies. Now an anesthesia machine requires a check list similar to an airplane check list to ensure all the electronics are functional. The monitoring evolution in anesthesia has changed the practice, ensuring a much higher level of safety for our patients.

We then do what we do: follow the anesthetic plan we formulated by evaluating the patient and the planned operation, finish the case, ensure a safe recovery and then go on to the next assignment. We deal with the bad airways, hemodynamic shifts etc., that turn up as part of the day.

This all sounds rather boring to most of you, which is why you did not choose anesthesia as a career! But I can promise that you could give anesthesia to identical twins, having the same procedure, with the same anesthetic plan, on the same day and it would not be the same.

Most anesthesiologists belong to our specialty society, The American Society of Anesthesiologists (ASA), an organization of which we are quite proud. I will share our society’s history and mission, taken from our web page at asahq.org.

Anesthesia Fast Facts

» Anesthesiology is the practice of medicine dedicated to the relief of pain and total care of the surgical patient before, during and after surgery.

» The American Society of Anesthesiologists (ASA) is an education and professional association of approximately 48,000 physicians. Its purpose is to raise the standards of medical practice by fostering and encouraging education, research and scientific progress in the specialty and to improve the care of the anesthetized patient.

» An estimated 40 million anesthetics are administered each year in this country. Anesthesiologists provide or participate in more than 90 percent of these anesthetics.

» In 1985, the Anesthesia Patient Safety Foundation was created to raise the levels of consciousness and knowledge of patient safety issues.

» In early 1986, ASA was the first medical specialty to adopt standards of care for its members. Today more than 30 standards, guidelines and statements developed by the society address standards for the care of patients before, during and after surgery.

Continued on page 2
» Complications from anesthesia have declined dramatically over the last 50 years. Since the 1970s, the number of anesthesiologists has more than doubled and at the same time patient outcomes have improved. While perioperative deaths attributed to anesthesia were approximately 1 in 1,500 some fifty years ago, today that number has improved nearly tenfold; that’s a dramatic increase in patient safety despite older and sicker patients being treated in operating rooms nationwide. At present, the chances of a healthy patient suffering an intraoperative death attributable to anesthesia is less than 1 in 200,000 when an anesthesiologist is involved in patient care.

» As physicians, anesthesiologists are responsible for administering anesthesia to relieve pain and for managing vital life functions during surgery. After surgery, they maintain the patient in a comfortable state during the recovery, and are involved in the provision of critical care medicine in the intensive care unit. Anesthesiologists’ responsibilities to patients include: Preanesthetic evaluation and treatment; Medical management of patients and their anesthetic procedures; Postanesthetic evaluation and treatment; On-site medical direction of any non-physician who assists in the technical aspects of anesthesia care to the patient.

» The role of the anesthesiologist in the operating room is to: provide continual medical assessment of the patient; monitor and control the patient’s vital life functions -- heart rate and rhythm, breathing, blood pressure, body temperature and body fluid balance; and control the patient’s pain and level of unconsciousness to make conditions ideal for a safe and successful surgery.

» There are three places where anesthesia is administered for surgery: a hospital or medical center, an ambulatory surgical center or a doctor’s office.

As a profession, we often forget about the challenges of running an office practice. We thank all of you for caring for patients day in and day out—not just for their procedures—and for helping us be sure patients are ready when they need our services. A patient’s healthcare team is made up of a lot of diverse talents – from the primary care physician to the vast array of other specialists and all of the allied healthcare providers in between. Anesthesiologists are a part of that team. Please contact me or any of my colleagues to discuss how we can assist you in providing the best care to our patients.

Anne Oakley, MD with anesthesia equipment.

Evolving Anesthetic Safety

By Eric Johnson, MD
Past President, Washington State Society of Anesthesiologists
UW Anesthesiology Residency, Class of 1981

As I look back on 30 years of providing anesthetics in Spokane I am struck by one amazing statistic. In 1980 the stated overall incidence of anesthetic mortality was 1:20,000. Today, the best estimate of mortality is closer to 1:400,000, an improvement by a factor of 20! How did that happen?

When I began my anesthetic training at the University of Washington in 1979 monitoring of surgical patients consisted of a real time ECG, blood pressures were obtained by auscultating brachial pulses with a stethoscope (that was inconvenient), we regularly took a feel of the skin to assess temperature and perfusion, and oxygenation was “measured” by estimating the pinkness of the mucosa and nail beds. We re-used some anesthetic supplies, washing the “circle systems” and double lumen endotracheal tubes between patients. The anesthesia machines could be accidentally disconnected from the patient and no alarms would sound. The only confirmatory evidence that an endotracheal tube had been properly placed in the trachea were equal breath sounds (difficult in the obese) and a failure to produce cyanosis. Halothane was the most commonly used inhalational agent and it seemed every Internal Medicine Resident in the universe just couldn’t wait to make a diagnosis of “Halothane hepatitis” for patients with post-operative jaundice, even when the patient’s sole anesthetic was a spinal. Despite these significant limitations, it was with some bravado that I would inform patients that their chance of dying from the anesthetic was “only 1 in 20,000”.

Meaningful medical advances almost always become manifest in a step-wise fashion. So it was with anesthesiology. Discoveries in the basic sciences and their application to our clinical practice led us into the “Age of Anesthetic Safety”. Beginning in the early 1980s came the use of the automated non-invasive blood pressure device (more accurate and easier to use), the ability to quantify the level of oxygen in the blood with the pulse oximeter (no more, “His lips look pink to me.”), and then the grand-daddy of them all, the end-tidal carbon dioxide monitor, which for the first time absolutely confirmed the placement of the endotracheal tube in the trachea (and also loudly served notice of many anesthesia machine failures). Those three monitors were key reasons why our malpractice premiums nearly halved in a decade, though there were other positive forces at work as well.

Difficult or failed intubations and lost airways found relief in the invention of the laryngeal mask airway (LMA), fiber-optic intubating scope, and the video-assisted laryngoscope (Glidescope). Patient assessment was aided by the use of pulmonary artery catheterization, intraoperative trans-esophageal echocardiography, continuous cardiac output measurement, and point of service lab testing.

Continued on page 3
We realized the importance of measuring and maintaining core body temperature in all patients, so fluids were warmed, and warm air blown over anesthetized patients resulting in more predictable drug metabolism, fewer coagulopathies and better delivery and utilization of oxygen. Anesthetic medications were developed that were quicker in onset and shorter in duration with fewer adverse side effects. EKG monitoring is now 5 lead with automatic ST segment analysis and trending. Intra-arterial and central venous pressure monitoring and cerebral oximetry are commonplace. Our current anesthesia machines themselves are complex devices that measure, notify, limit, ventilate, store data and reliably deliver precise amounts of anesthetic. Ultrasonography is utilized routinely for regional anesthesia ensuring that the local anesthetics are placed in close proximity to the nerve bundles. The acquisition of advanced monitors and diagnostic devices do not fully explain the improved results. Certainly a better understanding of complex disease states such as arteriosclerotic cardiovascular disease, diabetes mellitus, brain injury, prematurity, renal failure, ARDS, sepsis and pain control have all translated into better anesthetic care, as have surgical innovations such as the use of endoscopy, cautery, more thorough pre-operative patient evaluations with CT, MRI, echocardiography and PET scans. As an intern, I marveled at the use of something called TPN which over three days gave strength enough for a young man with Crohn’s disease to survive a major intestinal resection.

There are numerous groups of providers not directly mentioned in this short article whose dedication, vigilance and innovation have directly impacted the anesthetic care of our patients, including the skilled nurses standing guard in the pre and post anesthesia care areas, on the wards and in the intensive care units.

There is no doubt there remain significant challenges with tight-fisted administrators and governmental officials masquerading as doctors exerting a presence in the operating room, plus more patients are much bigger, older and sicker. But with the collective effort of physicians, nurses and scientists someday soon some fresh faced anesthesiologist will stand before his/her patient and say, “mortality from anesthesia is about one in a million.”
A Round Trip for Buford
T. Pringlewater

By Jay Reynolds, MD

As I have become inured to the life of an anesthesiologist, it has
curred me less over time that anyone would have any interest
in what we do or know. How wonderful to be invited to babble
ont our practice lives and the growing number of practices
that we can find for ourselves. For most of my 33 years in Spokane
being invisible seemed like a good idea. Like it is for surgeons, the thing you do
clips the knowledge and wisdom involved in deciding what to do,
when to do it and how best to do it. Buford T. Pringlewater tells the
pre-op nurse that he has no heart problems. Upon his late arrival to
the admitting area, he confirms that since his heart attack “that other
guy put it in the shocker thing, started me on the blasting caps and
water pills, so now I can walk almost to the garage without ear pain
so my heart trouble must have gone pretty much away”. What do
you do? When do you do it? How do you do it best? What is in the
garage? The daily practice life of all anesthesiologists has its Buford
moments. As is the case for many specialties, though, there are
more practice niches into which we can fit ourselves as we face our
daily Buford.

After 24 years in a local community hospital, I was offered and
accepted (sounds so businesslike) a position with Northwest
Orthopaedic Specialists as the Medical Director of their outpatient
surgery center. For a newly minted anesthesiologist, such an offer
may have sounded like an insufficient challenge and not intense
enough. To close your coronary arteries by age 50 you need more
stress than doing ortho on healthy folks. Wrong, wrong, and wrong.
You can close your arteries just fine in any anesthesia practice. I
am so fortunate to have said yes to this scary adventure when
it was offered. It was rare 30 years ago to do much outpatient
surgery. Knee arthroscopy was for diagnosis only. And most
meniscectomies were open procedures removing most if not all of
the joint protecting structure followed by days in the hospital. Now
days, nearly 70% of the orthopaedic surgery is done in an outpatient
setting and many of the settings are not hospital owned. From
diagnostics to post-op rehab, there are many differences in spirit and
mechanics of patient care that probably influence patient experience
in some or many ways. I would like to define those differences in an
organized and insightful fashion. Maybe you will indulge a series of
comments that do not come up to that level:

» Ownership makes a difference in commitment to price and
quality a.k.a. value in patient care. Large organizations use
mission statements, policy and professional commitment to
achieve that end. Smaller freestanding facilities are staffed
with teams of clinicians who own their results - seal teams,
perhaps, but not such good swimmers. I advocate for all
forms of ownership by as many clinical staff as possible,
including anesthesia staff.

» A good strategy for pre-op screening is very important. We
all fashion a plan that depends on screening criteria, the
assessable EMR, easy communication and all those factors
that help you know of Buford before he appears for surgery.

» Freestanding facilities are reimbursed at 56% of what the
hospital is paid by Medicare for the same procedure. That
is a nationwide fact, but for some reason the reimbursement
for outpatient orthopaedics in Spokane County is among the
lowest in the country - lower by 38%. Yes, 38% lower than the
rest of the country. Every cost is important. Anesthesiologists
in outpatient facilities know the costs, as do the surgeons.
Surgeons are not known for their flexibility in reducing costs to
the hospital, although most have come to begrudgingly obey
traffic signals. I believe the education of operating a surgical
facility helps our surgeons better understand the plight of
hospitals that also need to control costs.

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For orthopaedic outpatient surgery, a high skill level in providing regional blocks is essential. If done before surgery, the block becomes part of the anesthetic and allows for reduced doses of sedatives, narcotics and other centrally acting drugs. Patients awaken with less pain, physiologic stress, dysphoria and nausea, and fewer comments about the genetics of the anesthesia staff. Nearly all patients receive some manner of regional block other than the use of analgesics and sedative drugs for pain control. About 10% of patients return on subsequent days for repeat blocks which can be quite helpful for patients with narcotic intolerance or dependency, procedures that were more intrusive than was planned and so forth. We do not yet do regional anesthesia as a drive through procedure, but who among us knows with certainty what will happen in coming years.

For surgeons, their own surgery center is much easier to fit their preferences, with equipment that they favor and staffed with clinical staff well experienced with the scheduled procedure. We have not ordered an applause sign, yet, but they should be less expensive than video towers.

I was really fortunate to fall heir to a fabulous staff. A few key staff can create chemistry and a personality for a facility that can really influence patient experience. You have seen it in some clinical setting or felt it as a patient. We have it, but I do not know why. Patients notice and comment on it in satisfaction surveys. We already checked the air handling equipment, and it preceded the legalization of recreational marijuana. Nurture it where you find it for the benefit of patient experience.

Other observations or questions may come to mind for many of you and I would like to hear them. I could go on about our use of medical supervision of anesthetists rather than medical direction and our excellent relationship with the Anesthetists. I could get all exuberant about mixing pain practice and a surgical practice. I do not know, though, if you have just indulged yourself two carisoprodol and a glass of wine making for a dangerous combination. I am certain that the evolution to less expensive and high value care will continue. After nearly a quarter-century in an acute care hospital, I believe I am very fortunate to have found such a good home for my anesthesia crew. I have enormous respect for my Orthopaedic partners and all the staff who support them. With some luck we will continue to enjoy the responsibility that comes with being trusted by our patients. And after some delay to discuss Buford with a cardiologist, the surgery went ahead and went well. He loved his post-op nurse, liked the gluten-free cookie and thought the coffee was too weak.

Choosing Anesthesiology as a Career

By Konrad Kennington PGY-1

Skiing or snowboarding—which do you prefer? Some diehards believe you can only be true to one. But I enjoy both. A similar thing happened when I had to make up my mind regarding a medical specialty and applying to residency. When faced with the question of medicine or surgery, I chose anesthesiology. I loved so many aspects of both surgery and medicine as a medical student—which was why selecting anesthesiology as a career was an easy choice. Anesthesiology has a great amount of variation in what you see. Taking care of the very young or elderly and frail keeps things fresh and exciting. Depending on what kind of practice you end up in, you can be part of simple outpatient procedures or mix it up and manage very sick patients undergoing high-risk surgery. I also enjoy the perioperative aspect of anesthesiology, which allows me to manage the patient before and after a case, making sure they will tolerate surgery and getting them “tuned up” and ready for the surgery or ready to go home after it is all over with. Whenever there is a code in the hospital, anesthesia usually responds and are heavily relied upon when it comes to airway management and responding to trauma. Making the quick decision to treat a decompensating patient in an efficient manner can be stressful, but also very rewarding when you see good outcomes and patients pull through.

It is also a great opportunity to work in various environments when working in anesthesia. I like the challenge of the emergency room and ICU, as well as bringing comfort to women in labor. The work of Intensivists is more than making an appearance and helping a person with their pain one time, but rather throughout a series of visits and day-to-day management that helps people. It was rewarding as a student to see how chronic pain management could be utilized effectively to allow patients to live more manageable lives in a very real way.

Anesthesiology is a field where problem-solving capabilities are necessary, and an area where I feel I do well. The outside-of-the-box thinking that is applied in anesthesiology has allowed me to help others in my own creative way. Although anesthesiology is much more than creative problem solving, the thought processes and hands-on involvement required to manage complex patients are some of the things I find particularly rewarding. They can help a patient with extensive pain and discomfort into a happy and relaxed patient in just a matter of minutes and diagnose a patient with raising blood pressure and treat them right away. The immediate care of patients and understanding their needs in the moment is essential to the successful treatment of those that anesthesiologists have in their care.

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COLUMBIA MEDICAL ASSOCIATES is currently seeking a BC/BE Internist to join our Northside Internal Medicine Group in Spokane, Washington to meet our increased service utilization. We are a group of over 40 physicians providing comprehensive medical care to families and individuals of all ages within the Spokane region. The position offers the following:

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Continued from page 5

I find the satisfaction in problem solving, research, and caring for sick patients to be some of the most rewarding experiences and these reasons encompass why I became a doctor. There is always something to learn and discover. The field of anesthesiology is ever-changing and expanding, and I plan to be there growing right alongside it and contributing to its future success and evolution. “Be the change you want to see in the world,” said Gandhi. I want to be the change and impact future of the field in a positive manner as it goes forward in an ever-changing medical landscape.

Fun and Challenging Job Opportunity

By Deb Harper, MD
WWAMI Program
Clinical Assistant Dean for Eastern and Central Washington

In the summer of 2004 Phil Cleveland announced he was retiring from his job helping organize clerkships for the University of Washington School of Medicine students. “Hot puppies” thought I, “this sounds like a great job for me!” And I was right (for once). I began the job of Clinical Assistant Dean for Eastern and Central Washington on April 1, 2005.

That year I put together my ten-year goals, modestly called “My Ten-Year Plan for World Domination”. These were the things I truly believed the Spokane and eastern Washington community could accomplish for regional medical education in the coming decade. My colleagues in Seattle were doubtful and encouraged me to guard against unrealistic goals and ensuing frustration.

In 2013 the Spokane medical, business, political and education communities will make those goals a reality - two years early. Well done and strong work by our people!

I could, and, with help, did, create a second ten-year plan. This one is draft status because it is both irrational and infinite. But, I realized I participated in establishing my goals and now it is someone else’s turn.

The job is a half-time job. You know what that means. The new Clinical Assistant Dean for Spokane will work with John McCarthy, MD, Clinical Assistant Dean for Eastern and Central Washington as well as the Spokane County Medical Society, clinics, hospital systems, Washington State University, Eastern Washington University, business community, residencies, medical students, PA and ARNP programs and golly, just a lot of very fine people and organizations.

The job description will be posted sometime soon. I hope in February. The search committee is being formed as I write. I have had a wonderful eight years. I encourage you to think about whether this challenge sounds like one you would find interesting. I’m happy to chat with anyone who has questions and will continue to be involved with medical education precepting students in my pediatric practice as well as in other venues. Please feel free to contact me at djharper99@gmail.com.

Survey: Seven Deaths From Anesthesia Drug Shortage

By Jane E. Allen (@JaneEAllenABC), ABC News Medical Unit

Seven U.S. anesthesiologists have reported that drug shortages resulted in deaths of their patients, according to a new survey from the American Society of Anesthesiologists.

Although the online survey completed by 3,063 of the organization’s 28,000 practicing anesthesiologists cannot be considered scientific, it opens a window to the growing shortage of anesthetics and painkillers used before, during and after surgery, and the potentially fatal consequences when those are unavailable.

Seven doctors responded to the question “How has a drug shortage impacted your patients?” by checking the option, “Has resulted in death of a patient,” according to survey results exclusively obtained by ABCNews.com.

“We have a warning here. We are bound to trace this warning down and find out the extent of it,” American Society of Anesthesiologists President Dr. Jerry A. Cohen said in an interview. “Are these the canary in the mine? I don’t know. I worry that they are.”

Because the survey was anonymous, Cohen said he couldn’t determine where the reported deaths occurred, how the patients died, or be sure all seven reports were reliable. “Six we’re absolutely sure were reported,” Cohen said.

ASA had questions about “data points” in one responder’s answers that cast doubts on one of the death reports, he explained. “It’s unusual to have anybody report a death due to a drug shortage,” Cohen said.

Responses to a similar ASA survey in 2011 included two reports of patient deaths, but those weren’t made public, Katherine Looze, an ASA spokeswoman, revealed in response to a question from the ABC News Medical Unit.

Going forward with surgeries when they’re short of needed drugs can put anesthesiologists in a legal bind, Cohen said. “We are at risk,” he added. “If I proceed, if I don’t have the drug I need -- and I don’t have the drug I need -- and I have a bad outcome, I’m responsible.”

Among survey respondents (3,033 Americans and 30 from abroad), 97.6 percent reported being currently short of at least one drug and 96 percent said shortages forced them to use substitutes for particular patients and procedures. When they used alternatives to their top-choice drugs, some of their patients experienced nausea and vomiting, spent longer in surgery or took longer to recover from sedation or anesthesia, the survey revealed.

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Pathology Services, P.S. has been providing pathology services in Eastern Washington since 1979, and serves Deaconess Hospital, Shriners Hospital, Okanogan Douglas Hospital, Lincoln County Hospital, Veterans Administration Medical Center-Spokane and many clinics in Eastern Washington.

As well as having 4 great pathologists in Spokane, we offer over 25 subspecialty areas of expertise to Spokane patients through effective use of telepathology and slide imaging. This allows remote internal consults at no additional cost to patients.

Pathology Services, P.S. has been providing pathology services in Eastern Washington since 1979, and serves Deaconess Hospital, Shriners Hospital, Okanogan Douglas Hospital, Lincoln County Hospital, Veterans Administration Medical Center-Spokane and many clinics in Eastern Washington.
Continued from page 7

The drugs survey respondents most often couldn’t get were the workhorses of local and general anesthesia, such as propofol, a milky white intravenous sedative and anesthetic that works in just 40 seconds. It’s best known as the drug that led to the death of pop superstar Michael Jackson. Another is succinylcholine, a quick-acting paralytic agent frequently given to help insert a breathing tube into a patient’s airway. There’s also fentanyl, a powerful synthetic opioid used to knock patients out and to treat operative and post-op pain.

Anesthesiologists also reported problems getting thiopental, also known as sodium pentothal, an ultra-short acting barbiturate that’s used less frequently today in hospitals, but remains in demand for the lethal cocktail many states use in executions. The shortage has left some prisoners longer on death row.

**Shortages Lead to Substitutions, Delays, Canceled Surgeries**

If supply problems force anesthesiologists to switch from shorter-acting to longer-acting drugs, it can be harder to bring some patients out of anesthesia. More than half of doctors who answered the ASA survey questions said they’d altered procedures to accommodate shortages. Those changes could have included switching from general anesthesia to epidural or regional anesthesia. Among survey respondents, 7 percent said shortages forced them to postpone a procedure; 4 percent said they had to cancel procedures.

Sometimes, second-choice drugs have unwanted side effects, said Cohen, an associate professor emeritus at the University of Florida in Gainesville. If fentanyl isn’t available, he can substitute morphine, but "morphine causes nausea and vomiting systemically. If I use morphine in an epidural, it creates itching."

He might try Dilaudid, but “it doesn’t quite have the same safety margin” and it lasts longer, he said. "I will have a delay in waking the patient up."

The association undertook the survey, in part, to have something to share with the Congress and other policymakers grappling with a nationwide crisis that has sent hospitals scrambling for antibiotics and anesthetics and brought them to the brink of being unable to treat some childhood cancers. Other medication shortages have forced parents to drive among pharmacies looking for medications to help their hyperactive children sit still and pay attention in class.

President Obama issued an executive order in the fall that, among other things, gave the Food and Drug Administration power to respond more quickly to drug shortages. The FDA has since begun allowing overseas imports of key drugs for leukemia and cancer, and approved new suppliers to alleviate shortfalls.

But no one has yet determined how to alleviate a perfect storm of manufacturing problems, shrinking numbers of generic drug makers and increasing demand.

“One solution I think is to have a supply of drug that is not going to go away if we have several days of delay in a component for a drug reaching the manufacturer,” Cohen said. "The only way to get around that is to stockpile."

“I’ve seen a lot more of this that I never dreamed would happen,” said Cohen, who completed his residency in 1977. “When I started practicing, I thought whatever drugs I needed would always be there. Now I open the drawer and occasionally something isn’t there.”

**Anesthesiologists Voice Frustration Over Continued Drug Shortage**

By Caroline Helwick

Despite "summits," public workshops, and executive orders from the White House, drug shortages remain critical and clinicians continue to scramble to procure necessary drugs or acceptable substitutes.

At a session held during Anesthesiology 2012: American Society of Anesthesiologists (ASA) 2012 Annual Meeting, speakers addressed the current status of the drug shortage while anesthesiologists seized the opportunity to air their frustrations.

“I feel like a drug dealer for what I am forced to do to obtain the drugs I need,” one attendee shared.

Barbara Leighton, MD, chief of obstetric anesthesiology at Washington University in St. Louis, Missouri, told Medscape Medical News she was currently trying to find preservative-free morphine for intrathecal and epidural use. She has just learned that her current supplier, Ameridose — already a back-up choice — shares the same owners as New England Compounding, the source of the ongoing fungal meningitis outbreak, and was also being investigated for possible safety issues.

“We quit using Ameridose morphine immediately,” she said. “I have spent enormous time over the last 2 days looking for other legitimate suppliers instead of enjoying the meeting.”

**Drug Shortages Not Easing**

In 2011, there were 267 drugs in short supply, and 75% of these involved sterile injectables. On the basis of current figures in 2012, “we are on track to bypass the 2011 shortage,” said Peter Schoenwald, MD, from the Cleveland Clinic in Ohio.

Captain Valerie Jensen, RPh, associate director of the Center for Drug Evaluation and Research (CDER) Drug Shortage Program at the Food and Drug Administration (FDA), maintained that the government is doing all it can to assuage the problem and pave the way for a more secure future.

Continued on page 10
Continued from page 9

“Our mission is to prevent, mitigate, and help resolve shortages,” she said, noting that the CDER employs 11 full-time staff to attend to the crisis. “Most shortages do get resolved,” she said. “We prevented 195 shortages in 2011, mostly due to firms notifying the FDA of early problems.”

But she acknowledged that “FDA authorities are very limited.” The agency can require notification by manufacturers of supply disruptions, delays, and discontinuations (under the new FDA Safety and Innovation Act [FDASIA] requirement). In the case of controlled substances, the FDA can request that the attorney general increase quotas so that other manufacturers can address the gap.

But, she added, there is no penalty for not reporting. The FDA cannot mandate a company to make a drug or even make more of a drug, nor can it dictate how much and to whom a drug is sold or distributed.

Sterile Injectables: Reasons for Shortages

Quality issues account for about 50% of the shortages of sterile injectables. Often, this pertains to the detection of particulate (foreign matter such as glass, metal, fibers) in the product, bacterial and mold contamination, and equipment breakdown. As facilities age, these issues are growing, Jensen said.

The good news — but still 5 years away — is that many companies are “retrofitting” to upgrade their production facilities and others are building new facilities altogether.

ASA 2012 Survey

Arnold J. Berry, MD, MPH, from Emory University in Atlanta, Georgia, who is ASA vice president for scientific affairs, reported the results of a survey assessing the impact on anesthesiologists. This is a follow-up to the first survey conducted in April 2011.

In March 2012, of the 3063 responders, 98% were currently experiencing a drug shortage, especially for fentanyl (66%), succinylcholine (21%), propofol (15%), and pancuronium (15%). In 2011, the most frequent shortages were propofol (88%), succinylcholine (80%), neostigmine (52%), and epinephrine (17%).

More than two thirds reported that their patients experienced a suboptimal outcome, such as postoperative nausea and vomiting, and more than half said procedures and recovery time were longer. Six deaths (0.2%) were suspected of being related to a drug shortage. In addition, 96% of respondents had to use alternative drugs, 50% had to alter procedures, and 11% had to postpone or even cancel cases.

The survey indicates “clear concerns for patient safety,” Dr. Berry said. He cited the potential for infection risk from splitting 50-mL or 100-mL vials of propofol among more than one patient, along with medication errors, such as incorrect doses due to unfamiliarity with substituted drugs.

The alternative pathway, the “gray market,” also creates cause for concern, he added. Although complaints have centered on the high cost of drugs obtained through these channels, anesthesiologists should be concerned about the quality of these products as well, he said.

“These drugs pass through multiple middlemen. Not only does each mark up the price, but their facilities may not be equipped for proper storage that would help ensure quality. You have to understand the pedigree, the history, of the product.”

Complaints about the gray market are being forwarded by the FDA to the Department of Justice for investigation.

Beyond the Gray Market

But Joel Zivot, MD, from Emory University, said the gray market is “not the real problem” but a “red herring.” Dr. Zivot helped lead the ASA/Emory-sponsored Consensus Conference on the Ethics of Drug Shortages in June 2012.

Noting that gray markets are not illegal, he suggested that the term given for this alternative supply route “suggests it’s something nefarious, but it’s not.” Instead, Dr. Zivot maintained the root of the problem lies within the complex purchasing contracts between manufacturers and groups that join together to create pricing leverage.

“There are not enough manufacturers, but there are also not enough buyers. Fewer people in the marketplace affect the supply chain,” he said. “It’s not a free market or a regulated market. It’s the worst of both worlds.”

Anesthesiologists Say Their Hands Are Tied

John Sconzo, MD, an anesthesiologist practicing at Glens Falls Hospital, New York, drew applause when he questioned the need to use a single vial for a single patient. “What is the data showing it is unsafe to take a 5-mg vial of midazolam and break it down for different patients? I’m talking about one physician using different syringes, not handing it off. We have been doing this for years, and it’s gotten vilified. We are facing these shortages, we can’t use our clinical judgment, and we are wasting drug.”

Dr. Berry responded, “There are rules in place on appropriate sterile techniques to prevent catastrophic outcomes. If all goes okay you may be able to do this, but you can look in the literature and find outbreaks where prescribed infection control practices led to significant infection of patients,” he said. “We have to advocate for best practice. The downside is this leads to drug wastage in a time of shortage. That’s the tension we are facing.”

Dr. Zivot had the final word. “We don’t want to be in a situation to have to do that. Our interest is taking care of patients,” he said. “The problem is that other people in this story have different interests. Being responsible stewards of a little supply and dividing that into smaller and smaller portions is not the real issue. This is a man-made problem, and it can be fixed by man, but so far it’s not.”

Dr. Schoenwald, Dr. Berry, Dr. Zivot, Dr. Sconzo, and Dr. Leighton and Ms. Jensen have disclosed no relevant financial relationships.


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Medicare Payments to CRNAs Irk Anesthesiologists, Again

By Alexandra Wilson Pecci, for HealthLeaders Media, November 6, 2012

Another battle in the war between anesthesiologists and advanced practice nurses is under way.

The final rule on physician fees for 2013 allows Medicare to pay Certified Registered Nurse Anesthetists for services to the full extent of their state scope of practice.

Specifically, CMS says this applies to "anesthesia and related care [which] includes medical and surgical services that are related to anesthesia and that a CRNA is legally authorized to perform by the state in which the services are furnished."

According to the American Association of Nurse Anesthetists (AANA), nurse anesthetists have been getting paid by Medicare for their services for more than 20 years. But a challenge came in early 2011 when Medicare contractor Noridian decided to stop reimbursing CRNAs.

"This policy really restores reimbursement," Christine Zambricki, DNP, CRNA, FAAN, senior director of federal affairs strategies at AANA, tells HealthLeaders Media. "It was necessary for the Medicare agency to make a strong policy."

Zambricki describes Noridian’s quick decision to stop reimbursing CRNAs as “going rogue,” since CRNAs had been being reimbursed by Medicare for years.

"It’s very disappointing that something like this could take place when the goal in our healthcare system is to...really remove burdens to healthcare providers," she says. "This is a case study in the opposite."

She’s not alone in her thinking. Obviously, CMS agrees with AANA’s position, since it restored reimbursements, but other organizations showed their support as well. In April, state hospital associations in Missouri, Iowa, Kansas, and Nebraska wrote a letter to Acting CMS Administrator Marilyn Tavenner arguing that rural hospitals, especially critical access hospitals, rely on CRNAs to provide care.

"It is very troubling that Medicare contractors are able to change the policy at their discretion without a public comment period or at minimum, education to providers," the letter said.

"The creation of a "black box" policy has the potential to create real hardship and access problems for many of the most vulnerable Medicare beneficiaries who reside in the rural areas of our states."

The non-profit advocacy group, AARP, also weighed in on the issue in a September letter to Tavenner, saying, "Without the availability of CRNAs’ pain management services, many Medicare patients—particularly in rural areas—would either be forced into nursing homes for this chronic care or go without the treatment and greatly suffer."

Zambricki also adds that the CMS decision is consistent with Institute of Medicine recommendations.

"It’s a wonderful example with the federal government making healthcare policy that’s consistent with some of the best thinking" about medical care, she says.

Despite support for the ruling from a variety of organizations, there is a predictable outlier: The American Society of Anesthesiologists, which says the "policy jeopardizes patient safety, lowers the quality of health care and increases the risk for fraud and prescription drug abuse."

It argues that the Medicare contractors stopped paying CRNAs because it "concluded the assessment skills required for the diagnosis and treatment of chronic pain are not part of nurses’ training curricula. By contrast, anesthesiologists’ extensive medical training also includes a rotation in pain care during residency training, and those choosing to specialize in pain medicine must complete a minimum one year multidisciplinary pain fellowship."

If this refrain sounds familiar, that’s because it is. The American Academy of Family Physicians released a report in September, arguing that despite the primary care shortage in the United States, "substituting NPs for doctors cannot be the answer. Nurse practitioners are not doctors, and responsible leaders of nursing acknowledge this fact."

"The interests of patients are best served when their care is provided by a physician or through an integrated practice supervised directly by a physician," report said. "We must not compromise quality for any American, and we don’t have to."

Despite losing their reimbursements for nearly two years (the new rule won’t go into effect until January 1st and doesn’t allow for retroactive payments), Zambricki says some nurse anesthetists have continued to provide services for free, knowing how much their patients rely on them.

She says one CRNA she talked with had more than 800 unpaid bills, but never stopped taking care of his Medicare patients, reasoning, "I can’t stop taking care of them; they’re my neighbors."

"They really made the sacrifice," Zambricki says. "And they really hoped that this would be remedied."
Below are opinions by two Spokane physicians.

This letter is written to express deep concern and opposition to CRNAs being able to practice chronic or acute pain medicine in the United States. Performing interventional procedures for acute and chronic pain, prescribing controlled substances for chronic and acute pain and the ability to direct a multidisciplinary pain program is the practice of medicine.

I am a board certified Anesthesiologist with subspecialty certification in Pain Medicine. I graduated with an AB in Physiology from the University of California Berkeley and an MD from Georgetown University School of Medicine. I completed a residency in Anesthesiology at the University of Colorado Health Sciences Center and a fellowship in Pain Medicine at The Mayo Clinic. Overall, I have spent 13 years in higher education learning to practice medicine. Furthermore, I have 15 years of experience practicing Pain Medicine.

I have worked with a number of CRNAs over the years that are very proficient at administering an anesthetic under the direction of an Anesthesiologist. They were also proficient at performing spinal, epidural and regional anesthesia. This is not the practice of Acute or Chronic Pain Medicine and CRNAs receive no formal training in this area. They also do not receive significant clinical training on how to work up a patient and formulate a care plan. The skill to place a needle for an epidural, spinal or regional anesthetic does qualify an individual to practice Acute or Chronic Pain Medicine.

It is now standard of care to perform most injections under fluoroscopic guidance. Being able to identify structures appropriately under fluoroscopy takes a great deal of time and experience. I must be able to pick up intravascular uptake under digital subtraction XRAY to avoid injecting a particulate steroid into an artery causing spinal cord or cerebellar infarct. Paralysis and Stroke are real complications from inadvertent injections. These complications are minimized greatly when experienced hands perform these procedures. I have also spent hours learning how to read MRIs and CT scans to help direct interventional therapies and to learn when and when not to perform a particular injection.

I have had the opportunity to review chronic pain procedures performed by CRNAs. Rarely if ever, have I seen an appropriate history and physical performed prior to the performance of an interventional procedure by a CRNA. Rarely if ever, have I seen documentation that the imaging studies or even the reports of the imaging studies have been reviewed by a CRNA. A full workup prior to an intervention is imperative to rule out contraindications and to more fully understand the etiology of the patient's pain. Rarely if ever, have I seen a care plan formulated by a CRNA. Often, there is not even an appropriate procedure note formulated. There is only an anesthetic record with vitals and medications utilized. I have seen documentation of needles being placed in the wrong location, unsafe contrast dyes being utilized, extremely large doses of steroid being used, and procedures being performed "blind" without the use of fluoroscopy.

These procedures will not be beneficial for the patient, will be performed too frequently and will drive up the cost of healthcare. There will serious complications that could have been avoided by the care being performed by a pain trained physician.

The medical management of pain is also something that CRNAs have no formal training for. It is thought that because CRNAs administer opioids during anesthetics, that they will be able to manage systemic opioids for chronic pain. We have an “Opioid Epidemic” in this country. Opioids are prescribed at high doses and to inappropriate patients. A detailed program with appropriate policies must be in place prior to prescribing these medications. Opioid contracts, psychological evaluations and urine drug testing are among some of the imperative aspects involved with prescribing opioids. To my knowledge, a CRNA’s education does not include any of this training. ARNPs who have worked closely with a pain physician are far more qualified to perform medical management of chronic pain than CRNAs.

I highly recommend that this legislation be revisited. This will lead to poor outcomes and higher costs. Practicing Chronic Pain Medicine is a needed specialty that should only be practiced by experienced physicians and/or physicians with formal training in the specialty.

By John A. Hatheway, MD
Diplomat of the American Board of Anesthesiology
Subspecialty Certification in Pain Medicine

I am writing in concern for new legislation which facilitates CRNAs to practice interventional pain management.

I am an anesthesiologist. I am also a fellowship trained, interventional pain management specialist. I have been practicing here in Spokane for 12 years.

During my fellowship and later as a staff physician at a large teaching hospital I instructed anesthesia residents and pain management fellows in interventional pain management. I also instructed and worked with CRNAs in the operating room.

It is my opinion that the days of any anesthesia personnel, regardless of training, picking up pain management as a side line are over. Interventional pain management techniques have evolved far beyond the “blind epidural” which is the only technique currently held in common between pain management and operative anesthesia. Fluoroscopically monitored interventional techniques are now standard and have been shown to have improved outcomes and fewer significant complications. In fact most CPT codes require fluoroscopic monitoring. These techniques cannot be learned by anyone, regardless of their training, on cadavers during a weekend course.

A safe implementation of interventional pain management techniques requires advanced training, usually a one-year fellowship. Currently the standard of care in Spokane is either fellowship training, or extensive experience, safely perform these techniques. I consider this appropriate as only a limited number of these procedures can be effectively done, and complications of these procedures, if done improperly, can be catastrophic.
Until such time as “those who are legally allowed to do a procedure" becomes more concordant with “those who can do a procedure appropriately and safely”, we need to be careful. The tenant Caveat Emptor is not valid in this situation. The buyer, the patient, is not capable of determining his best interests, and as such needs his physician’s guidance.

By William L. Weigel, MD

For Your Information

M.D.s and D.O.s Moving Toward a Single, Unified Accreditation System for Graduate Medical Education

The Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine (AACOM) have entered into an agreement to pursue a single, unified accreditation system for graduate medical education programs in the United States beginning in July 2015. Over the coming months, the three organizations will work toward defining a process, format and timetable for ACGME to accredit all osteopathic graduate medical education programs currently accredited by AOA. AOA and AACOM would then become organizational members of ACGME.

“This is a watershed moment for medical training in the U.S," noted Thomas Nasca, M.D., M.A.C.P., chief executive officer of ACGME. "This would provide physicians in the United States with a uniform path of preparation for practice. This approach would ensure that the evaluation and accountability for the competency of resident physicians are consistent across all programs," he added.

Graduate medical education is the period of clinical education in a specialty that follows graduation from medical school, and prepares physicians for independent practice. Currently, ACGME accredits over 9,000 programs in graduate medical education with about 116,000 resident physicians, including over 8,900 osteopathic physicians (D.O.s). The AOA accredits more than 1,000 osteopathic graduate medical education programs with about 6,900 resident physicians, all D.O.s. The transition to a unified system would be seamless so that residents in or entering current AOA accredited residency programs will be eligible to complete residency and/or fellowship training in ACGME accredited residency and fellowship programs.

Among the topics of discussion for the three organizations will be:

- Modification of ACGME accreditation standards to accept AOA specialty board certification as meeting ACGME eligibility requirements for program directors and faculty;
- Programs in graduate medical education currently accredited solely by AOA to be recognized by ACGME as accredited by ACGME; and
- Participation by AOA and AACOM in accreditation of programs in graduate medical education to be solely through their membership and participation in ACGME.

"Americans deserve a health care system where continuously improving the quality of care and the health of our patients is the driving force," stressed AOA President Ray E. Stowers, D.O. "A unified accreditation system creates an opportunity to set universal standards for demonstrating competency with a focus on positive outcomes and the ability to share information on best practices.”

Stephen C. Shannon, D.O., M.P.H., President of AACOM, adds that “AACOM is undertaking this historic initiative because we believe that a unified accreditation system will improve the quality and efficiency of graduate medical education.”

The Accreditation Council for Graduate Medical Education (ACGME) is a nonprofit organization responsible for the accreditation of over 9,000 programs in graduate medical education and about 700 institutions that sponsor these programs in the United States. Its accredited residency programs educate over 116,000 resident physicians in 135 specialties and subspecialties. Its member organizations are the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association of American Medical Colleges, and the Council of Medical Specialty Societies. The ACGME’s mission is to improve health care by assessing and advancing the quality of resident physicians’ education through exemplary accreditation.

The American Osteopathic Association (AOA) is the largest professional membership organization for osteopathic physicians (D.O.s), representing more than 100,000 D.O.s and osteopathic medical students. Headquartered in Chicago, the AOA serves as the primary certifying body for D.O.s; is the accrediting agency for osteopathic medical schools; and has federal authority to accredit hospitals and other health care facilities.

The American Association of Colleges of Osteopathic Medicine (AACOM) serves as a unifying voice for osteopathic medical education. It represents the 21,000 osteopathic medical students as well as the administration and faculty of the 29 osteopathic medical schools in the United States. Guided by its Board of Deans and various other member councils and committees, AACOM promotes excellence in osteopathic medical education, in research and in service, and fosters innovation and quality among osteopathic medical schools to improve the health of the American public.

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If you are a contributor to the United Way, don’t forget that Project Access can be one of your designated agencies as a 501(c)(3) organization.

*This would be a tax-deductible contribution.

Project Access
Spokane
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Survey Identifies Factors That Could Affect Future Workforce Supply of Anesthesiologists

A large, first-of-its-kind national survey of older anesthesiologists has gathered important data that could be used by physicians and their employers to prepare for an expected undersupply of anesthesiologists in the near future. The resulting study was published in the November issue of Anesthesiology.

Findings from the study include:

- Older anesthesiologists’ long workweeks (49.4 hours per week on average) are similar to other physicians, but substantially longer than other professionals, such as attorneys (44.9), engineers (43) and registered nurses (37.3).

- Older anesthesiologists devote 81 percent of their time to clinical care, particularly those specializing in critical care medicine or pain management.

- Anesthesiologists participated in clinical care well into their 60s; forecasts predict that 30 percent of anesthesiologists are expected to work past age 65, approximately 18 percent past 70 years, and perhaps 10 percent will likely work at age 80.

- Concurrently, it was found that as anesthesiologists age, time spent in clinical care decreased and the number of anesthesiologists working part-time increased, particularly for women. One-sixth of the survey population reported working in a self-defined part-time mode.

"Anesthesiology is among 21 medical specialties experiencing or expected to experience physician shortages in the near future," said lead study author Fredrick K. Orkin, M.D., an adjunct professor at Yale University School of Medicine. "Workforce shortages reflect many trends, including an aging physician population, medical debt, static production of new physicians, reduced physician work hours, a growing and aging patient population with complex medical conditions, and expansion of and enhanced access to health care services."

According to Dr. Orkin, identifying older anesthesiologists’ practice patterns and retirement plans is an important first step in dealing with the consequences of an undersupply of anesthesiologists.

"In designing interventions to retain practitioners in the workforce, initiatives may need to be age-specific or perhaps even subspecialty-specific," said Dr. Orkin.

For example, pain management and critical care subspecialists leaving practice cited loss of clinical autonomy as a major influence, and most anesthesiologists leaving clinical practice in their 50s cited poor health.

"Our study lends further support for increased attention to potentially modifiable factors that could affect future workforce supply," said Dr. Orkin. "Such factors might include workplace wellness programs and other initiatives that enhance professional satisfaction. Our study also highlights the under-recognized trend toward part-time work and how this trend could be managed to help retain larger numbers of older, but skilled, anesthesiologists in the clinical setting."

For more information, visit the Anesthesiology website at anesthesiology.org.

WSMGMA Salary and Benefit Survey

In January WSMGMA sent an “invitation e-mail” that contained a link to the WSMGMA survey tool.

The survey reports on wages and benefits for the entire state, broken down into several subcategories. Be sure to mark the Spokane area choice to receive local survey results.

If you have questions, please contact Kris Linden at OB/GYN Associates of Spokane (klinden@inwhealth.net) or Aaron Milligan at the WSMGMA office (abm@wsma.org) to obtain another unique link to the survey. The survey results are FREE to participants.
Membership Recognition for February 2013

Thank you to the member listed below. His contribution of time and talent has helped to make the Spokane County Medical Society the strong organization it is today.

20 Years
Michael C. Ferries, MD 2/5/1993

Continuing Medical Education

Update in Internal Medicine 2013: This seminar is jointly sponsored by the Spokane Society of Internal Medicine and the Spokane County Medical Society. Conference will be held on February 22, 2013 from 7:00 a.m. – 6:00 p.m. at the Spokane Convention Center. For additional information please contact Jennifer Anderson at (509) 448-9709 or email spokanesocietyim@gmail.com.

Rockwood Health Systems Breast and General Tumor Boards: These tumor boards are jointly sponsored by Rockwood Health Systems and the Spokane County Medical Society. Tumor Boards will be held weekly January – June 2013. Each Tumor Board is worth 1.0 Category I CME credits. For more information please contact Sharlynn M. Rima CME Coordinator at SRima@rockwoodclinic.com.

STD Update – Join the Seattle STD/HIV Prevention Training Center and the Spokane Regional Health District March 21 and 22 at St. Luke’s Rehabilitation Institute in Spokane for this two-day STD Update. This course provides participants with training in the most recent advancements in the epidemiology, diagnosis and management of viral and bacterial STDs, and was designed for clinicians in the Spokane area who diagnose and treat patients with sexually transmitted infections. CMEs and CNEs are available. The cost to register is $100. Lunch and a continental breakfast will be provided each day. Seating is limited and pre-enrollment is required by March 14. CME: The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The University of Washington School of Medicine designates this educational activity for a maximum of 13.5 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity. Please visit www.seattlestdhivptc.org for online registration and payment information. Any additional questions can be directed to Anna Halloran, Health Program Specialist at the Spokane Regional Health District at 509-324-1635 or ahalloran@srhd.org.

Promoting Healthy Families (Practice Management Alerts from the American Medical Association) is designed to help physicians successfully talk about healthy behaviors with their adult patients in a way that may spark—and help sustain—positive changes for the whole family. The continuing medical education activity includes a video module, a detailed monograph and patient handout. These activities have been certified for AMA PRA Category 1 Credit™. For more information www.ama-assn.org.

Meetings/Conferences/Events

Institutional Review Board (IRB) - Meets the second Thursday of every month at noon at the Heart Institute, classroom B. Should you have any questions regarding this process, please contact the IRB office at 509.358.7631.

Spokane Guild of the Catholic Medical Association - Meets second Wednesday of each month at 6 PM at Providence Sacred Heart Medical Center Administrative Board Room in Administration on the Main Floor. All are welcome. For inquiries contact Phil Delich, MD at (509) 465-1554 or e-mail at delichphil@gmail.com.

Upcoming Aging and Mental Health Conference, Friday, March 8, 2013 8:00 a.m. to 5:00 p.m. The purpose of this conference is to raise awareness of the issues involved with mental health and older adults, as well as provide concrete tools for assessment and intervention. Mark your calendars now. More details to follow. For more information contact Jamie McIntyre, MSW Aging and Long Term Care of Eastern Washington Assistant Planner/ Title V Coordinator (509) 458-2509 x211.

Medical Reserve Corps of Eastern Washington General Membership Meeting – Spokane Regional Health District Auditorium, 1101 West College Avenue, 6:00 – 8:00 p.m. Wednesday, 13 February 2013. Everyone is welcome to attend. Meeting topics include a briefing on local bomb squad capabilities and I.E.D.s, training, exercise, equipment, recruitment and communication update and the Coordinator’s report. Disaster response and preparedness involves all of us at home or at work. For more information contact David Byrnes at DByrnes@srhd.org.

Caduceus Al Anon Family Group - Meets every Thursday evening from 6:15 pm until 7:15 pm at 626 N. Mullan Rd., Spokane, WA. Non-smoking meeting for spouses and significant others of Healthcare Providers who are in recovery or who may need help seeking recovery. Facilitated 12 Step Al Anon Format. No dues or fees. Contact (509) 928-4102 for more information.

Physician Family Support Group - Physicians, physician spouses or significant others and their adult family members share their experience, strength, and hope concerning difficult physician family issues which may include medical illness, mental illness, addictions, work-related stress, life transitions, and relationship difficulties. The meetings are on Tuesdays from 6:30 pm – 8 pm at Providence Sacred Heart Medical Center. Format: 12 Step principles for everyone, confidential and anonymous personal sharing; no dues or fees. Contact Bob or Carol at (509) 624-7320 for more information.
VOLUNTEERING ABROAD
is the focus of the April 2013 issue of
the SCMS monthly newsletter The Message.

If you are an SCMS physician or physician assistant
involved in volunteering abroad, please submit an
article and photos for The Message.

We are looking for articles about individuals in
our medical community who generously give back
through their dedication and participation.

Due to space
limitations, please
confirm your interest by
February 20.

Article Due Date March 10
Email article & photos to Michelle@spcms.org
Length of article 750+/- words
Questions? (509) 325-5010

Spokane County Medical Society
Orange Flag Building
104 South Freya Street, Suite 114
Spokane, WA 99202-4868
Project Access: Thank You Donating Providers for an Outstanding 2012

2012 was Project Access' ninth year of operations. It was also our largest, most successful year. With a nearly 35% increase over last year, Project Access served over 960 clients and scheduled 1534 appointments in 2012.

Our success was only possible due to the continued generosity of our donating providers. Project Access has more than 660 providers who actively participate in Project Access. We are grateful to each and every provider who willingly gives their time and resources to help the medically vulnerable of our community. With any group, a few outstanding participants rise to the top. Project Access has a number of providers who deserve special recognition for their tremendous donations to the program. We want to take this opportunity to give special thanks to our top fifteen donating physicians of 2012.

» Dr. William Bender, Columbia Neurology
» Dr. R. Steve Brisbois, Providence Center for GYN, Robotics and Minimally Invasive Surgery
» Dr. Jeffery Bunn, Spokane ENT
» Dr. Petru Groza, Providence Kidney Care of Spokane
» Dr. David Maccini, Spokane Digestive Disease Center
» Dr. David Malone, Spokane ENT
» Dr. Robert Milligan, Associates for Women's Health
» Dr. Brian Mitchell, Spokane ENT
» Dr. Dan Murray, Inland Imaging
» Dr. Russell Oakley, Providence Inland Orthopedics
» Dr. Alan Pokorney, Spokane ENT
» Dr. Stephen Reese, Rockwood General Surgery
» Dr. Michael Ryan, Dermatology Associates of Spokane
» Dr. Damon Sheneman, Rockwood General Surgery
» Dr. John Wurst, Columbia Neurology

Thank you to all of our donating providers for your continued support of Project Access!

Inland Neurosurgery and Spine Associates Physicians: Drs. Giac Consiglieri, Jonathan Carlson, Dean Martz, Benjamin Ling, Rasha Germain and David Gruber

The PACT Project representatives: Jessica Dingwall and Becky Rivea

The PACT Project (Project Access Cycling Team) worked on fundraisers and events all year to raise money for Project Access. Inspired by receiving a much-needed surgery by Dr. Gruber at Inland Neurosurgery and Spine Associates through Project Access, former client Lori Mage organized a fundraising cycling team. The team members organized several events over the course of a year to raise funds for Project Access, culminating in their final event, completing the 200-mile Seattle to Portland bike ride.

Project Access greatly appreciates their dedication and hard work this past year. Thank you also to Inland Neurosurgery and Spine Associates for their continued support of Project Access.
Inland Imaging’s innovative specialty MRI system allows your patient to recline in a comfortable chair with only the arm or hand, leg or foot in the magnet.

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The following physicians and physician assistants have applied for membership and notice of application is presented. Any member who has information of a derogatory nature concerning an applicant’s moral or ethical conduct, medical qualifications or such requisites shall convey this to our Credentials Committee in writing 104 S Freya St., Orange Flag Bldg #114, Spokane, Washington, 99202.

PHYSICIANS

Harbour, Chad M., MD
Orthopedic Surgery
Internship & Residency: Loma Linda Medical Center (2009)
Fellowship: Duke U. Medical Center (2010)
Practicing with Providence Medical Group- Orthopedic Specialties 03/2013

Payne, Erik J., MD
Anesthesiology
Internship & Residency: Loma Linda Medical Center (2006)
Fellowship: Massachusetts General Hospital (2007)
Practicing with Anesthesia Associates 02/2013

Ordonez Castellanos, Miguel, MD
Gastroenterology
Fellowship: U of S Alabama Hospitals (2013)
Practicing with Rockwood Digestive Health Center 07/2013

PHYSICIANS PRESENTED A SECOND TIME

Atkinson, Benjamin E., MD
Neurology
Internship: Sinai Grace Hospital (2006)
Residency: Detroit Medical Center (2009)
Fellowship: Detroit Medical Center (2011)
Practicing with Providence Medical Group 01/2013

Tehrani, Hassan Y., MD
Thoracic Surgery
Internship: Boston Medical Center (1995)
Residency: St Elizabeth’s Medical Center (1999)
Fellowship: Northwestern Memorial Hospital (2001)
Fellowship: Jackson Memorial Hospital (2003)
Practicing with Rockwood Clinic 02/2013

Wood, Anthony J., MD
Anesthesiology
Med School: Oregon Health Sciences U (1994)
Internship and Residency: Oregon Health Sciences U (1996)
Residency: Oregon Health Sciences U (1999)
Practicing with Anesthesia Associates 02/2013

PHYSICIAN ASSISTANT

Moore, Carly M., PA-C
Physician Assistant
School: U MEDEX Northwest (2012)
Practicing with Alpine Orthopedic & Spine 12/2012

POSITIONS AVAILABLE

PHYSICIAN OPPORTUNITIES AT COMMUNITY HEALTH ASSOCIATION OF SPOKANE (CHAS) Enjoy a quality life/work balance and excellent benefits including competitive pay, generous personal time off, no hospital call, CME reimbursement, 401(k), full medical and dental, NHSC loan repayment and more. To learn more about physician employment opportunities, contact Toni Weatherwax at (509) 444-8888 or hr@chas.org.

QTC MEDICAL GROUP is one of the nation’s largest private providers of medical disability evaluations. We are contracted through the Department of Veterans Affairs to manage their compensation and pension programs. We are currently expanding our network of Family Practice, Internal Medicine and General Medicine providers for our Washington Clinics. We offer excellent hours and we work with your availability. We pay on a per exam basis and you can be covered on our malpractice insurance policy. The exams require NO treatment, adjudication, prescriptions to write, on-call shifts, overhead and case file administration. Please contact Gia Melkus at (800) 260-1515 x5366 or email gmelkus@qtcm.com or visit our website www.qtcm.com to learn more about our company.

PRIMARY CARE INTERNIST WANTED (Pullman) - Immediate opportunity for BE/BC primary care internist to join a privately owned, multi-specialty, physician practice. Palouse Medical offers a competitive employment package, guaranteed first year salary, comprehensive benefits and partnership potential. Dedicated to delivering quality care, we are proud to offer an extensive array of patient services and on-site laboratory and imaging departments. We can’t wait to introduce you to the communities that we love and serve. Call Theresa Kwate at (509) 332-2517 ext. 20 or email tkwate@palousemedical.com. Contact us today and discuss your future at Palouse Medical!

CONTRACT BACK-UP PHYSICIAN 4 + HOURS/MONTH - Octapharma Plasma is hiring a Contract Back-Up Physician in our Spokane, WA Donor Center! This position requires just 4 hours per month. GENERAL DESCRIPTION Provide independent medical judgment for issues relating to donor safety, health and suitability for plasmapheresis and immunization. Provide federal and international mandated training and supervision of donor center medical staff to assure compliance with applicable laws. We provide on-the-job training. WHO IS OCTAPHARMA PLASMA? Octapharma Plasma, Inc. is dedicated to improving the health and lives of people worldwide. OPI owns and operates plasma collection centers critical to the development of life-saving patient therapies utilized by thousands of patients globally. Learn more at www.OctapharmaPlasma.com. Apply today by sending your resume/CV to Careers@OctapharmaPlasma.com!

FAMILY MEDICINE SPOKANE Immediate opening with Family Medicine Spokane (FMS) for a full time BC/BE FP physician who has a passion for teaching. FMS is affiliated with the University of Washington School of Medicine. We have seven residents per year in our traditional program, one per year in our Rural Training Track and also administer OB and Sports Medicine Fellowships. This diversity benefits our educational mission and prepares our residents for urban & rural underserved practices. We offer a competitive salary, benefit package and gratifying lifestyle. Please contact Diane Borgwardt, Administrative Director at (509) 459-0688 or e-mail at borgwaD@fammedspokane.org.

Continued on page 20
PREMIER CLINICAL RESEARCH, an independent dedicated research facility here in Spokane with 20 years of research experience is looking for a Pediatrician to be a part of our physician network for future studies. For more information please contact: April Gleason, Director of Business Development, (509) 390-6768, premierclincalresearch@gmail.com.

PROVIDENCE HEALTH & SERVICES has immediate opportunities for BE/BC Family Physicians to join our expanding primary care team in Spokane, eastern Washington's largest city. Newborns to geriatrics, no OB. Regular 8-5 hours, five-day week. New physicians will join Providence Medical Group, our physician-led multispecialty medical group with clinics throughout the metropolitan area. Excellent compensation and benefits. Providence Medical Group (PMG) – Eastern Washington is our physician-led network of more than 200 primary and specialty care providers in multiple clinic locations in Spokane and Stevens County. PMG partners with some of the region’s most advanced hospitals: Providence Sacred Heart Medical Center & Children’s Hospital, Providence Holy Family Hospital, Providence Mount Carmel and Providence St. Joseph’s Hospital. Contact Mark Rearrick at mark.rearrick@providence.org or 509-474-6605 for more information.

PROVIDENCE MEDICAL GROUP (PMG) - Eastern Washington is recruiting for an excellent Family Medicine physician to join our care team in this scenic suburb of Spokane. Full-time opportunity with our growing medical group in what will be a large, state-of-the-art medical ambulatory center (construction completion target is spring 2014). No OB. Outpatient only. Competitive compensation and comprehensive benefits. Providence Medical Group – Eastern Washington is our physician-led network of more than 200 primary and specialty care providers in multiple clinic locations in Spokane and Stevens County. PMG partners with some of the region’s most advanced hospitals: Providence Sacred Heart Medical Center & Children’s Hospital, Providence Holy Family Hospital, Providence Mount Carmel and Providence St. Joseph’s Hospital. Contact Mark Rearrick at mark.rearrick@providence.org or 509-474-6605 for more information.

EASTERN STATE HOSPITAL PSYCHIATRIST - ESH is recruiting for a psychiatrist. Joint Commission accredited, CMS certified, state psychiatric hospital. 287 beds. Salary $161,472 annually with competitive benefits and opportunity for paid on-call duty. Join a stable Medical Staff of 30+ psychiatrists, physicians and physician assistants. Contact Shirley Make, (509) 565-4352, email mailkeshi@dshs.wa.gov. PO Box 800, Medical Lake, WA 99022-0800.

SPRINGDALE COMMUNITY HEALTH CENTER ARNP or PA-C N.E. Washington Health Programs (NEWHP) has an immediate opportunity for an excellent Physician Assistant (certified) or Nurse Practitioner with Family Practice experience to join our Springdale Community Health Center located in rural Springdale, WA. This position is for Family Practice outpatient care; urgent care experience is a plus but not required. NEWHP offers competitive compensation, comprehensive benefits. NHSC eligible site. EOE and provider. Application Deadline: Until filled. Send resume to: N.E. Washington Health Programs Attn: Human Resources PO Box 808 Chewelah, WA. 99109 or electronically to desirees@newhp.org.

PHYSICIANS NEEDED FOR WORKERS COMPENSATION EXAMS
Let us help you get started in earning additional professional income! We are an established I.M.E. practice currently looking for Active Practice and Board Certified Orthopedic and Neurological Doctors, to perform Workers Compensation Exams. Located just minutes away from Rockwood Clinic in North Spokane, we offer a flexible schedule in a helpful, working environment. Previous experience performing Workers Compensation Exams is not required. Please contact Lorraine Stephens for further information at (509) 484-0380.

MEDICAL DOCTOR (MD/DO) (PRN openings in Spokane, WA) Physicians needed to perform physicals and health screenings at a non-commercial medical facility. MD/DO must have a current active, license from any state, available 1 to 3 mornings a week. Send CV to or call: Gil: (210) 424-4008 meps@thi-terra.com EOE

PARTNERING FOR PROGRESS is a humanitarian Spokane-based nonprofit that is committed to ensuring that residents of the Kopanga, Kenya community have improved access to healthcare, clean water, sanitation and education. Through generous donors, P4P built a clinic for the Comprehensive Rural Health Project that is run by Alice Wasilwa RN with two other Kenyan nurses and provides primary care. Some of the common diseases include malaria, water borne illness as well as the diagnosis and treatment of HIV. There are approximately 12 deliveries per month and the clinic staff treats 900-1000 patients monthly. We are in need of medical providers, optometrists and dentists to travel to Kopanga to provide primary care on Oct. 18 – 28, 2012. If you would like to volunteer please contact Stacey Mainer at info@partneringforprogress.org.

NORTHWEST MEDICAL SPECIALTY EVALUATIONS - Physicians wanted for medical disability exams in our Spokane office. Excellent pay. Work is low stress with minimal paperwork and no ongoing patient care responsibilities. We can schedule around your availability seven days per week. For more information call (509) 588-7340.

Office Space for Lease

- Open to medical and nonmedical professional tenants.
- Rates start at $13/sq. ft. Full service leases.
- 1 month of free rent for each year of the lease.
- Suites range from 920 to 4,931 rentable square feet.
- T.I. allowances are available.
- 4% commission to outside brokers.

If interested, please contact Mann Jones at (509) 755-7526.

Northpointe Medical Center - 9631 N. Nevada
REAL ESTATE

Luxury Condos for Rent/Purchase near Hospitals. 2 Bedroom Luxury Condos at the City View Terrace Condominiums are available for rent or purchase. These beautiful condos are literally within walking distance to the Spokane Hospitals (1/4 mile from Sacred Heart, 1 mile from Deaconess). Security gate, covered carports, very secure and quiet. Newly Remodeled. Full appliances, including full-sized washer and dryer. Wired for cable and phone. For Rent $850/month. For Sale: Seller Financing Available. Rent-to-Own Option Available: $400 of your monthly rent will credit towards your purchase price. Please Contact Dr. Taff (888) 930-3686 or dmist@inreach.com.

Comfortable Three-Bedroom Home in quiet neighborhood for rent. Good storage in kitchen, gas stove, dishwasher, refrigerator, washer/dryer and fireplace. Comes furnished or can negotiate. Close to Hamblen Grade School, Sac Middle School and Ferris High School. Three bedrooms, three baths, large living room, family/TV room, master bedroom has private bathroom, two-car garage. Large windows in living room look out into large fenced yard with automatic sprinkler system (front and back). Snow blower and lawn mower provided. Call (408) 594-1234 or (509) 993-7962.

Outstanding View Condominium - 214 West 6th Avenue, unit #303 in South Cliff Plaza Condominium. 2 BR, 1 1/2 bath, W/D, fireplace, elevator, covered parking, storage locker. 1096 square feet, patio, AC/baseboard heat. Ideally located midway between Providence Sacred Heart and Deaconess hospitals. Full appliances, walk in master closet with dresser built in, new windows and slider door creates quiet and temperature control environment, HOA pays all utilities except electric. Wired for cable and phone. By owner, for lease $850/month, will consider sale. Contact Dr. Fred Viren at (509) 710-5732

MEDICAL OFFICES/BUILDINGS

South Hill – on 29th Avenue near Southeast Boulevard - Two offices now available in a beautifully landscaped setting. Building designed by nationally recognized architects. Both offices are corner suites with windows down six feet from the ceiling. Generous parking. Ten minutes from Sacred Heart or Deaconess Hospitals. Phone (509) 535-1455 or (509) 768-5860.

Clinical Space for Lease - Built in January 2011. 1128 sq ft, four exams rooms, two administrative offices, one office with a counter (electronic bar for laptops, etc.), restroom, reception area and waiting room. Rates are negotiable. Interested parties contact Sharon Stephens at Bates Drug Stores, Inc. 3704 N. Nevada, (509) 489-4500 Ext. 213 or Sam@batesrx.com.

North Spokane Professional Building has several medical office suites for lease. This 60,000 sf professional medical office building is located at N. 5901 Lidgerwood directly north of Holy Family Hospital at the NWC of Lidgerwood and Central Avenue. The building has various spaces available for lease from 635 to 6,306 usable square feet available. The building has undergone extensive remodeling, including two new elevators, lighted pylon sign, refurbished lobbies, corridors and stairways. Other tenants in the building include pediatricians, dermatology, dentistry, pathology and pharmacy. Floor plans and marketing materials can be emailed upon request. A Tenant Improvement Allowance is Available, subject to terms of lease. Please contact Patrick O’Rourke, CCIM, with O’Rourke Realty, Inc. at (509) 624-6522 or cell (509) 999-2720. Email: psrourke@comcast.net.

Office space located at 1315 North Division. This location is two miles north of downtown Spokane and just west of Gonzaga and the university district. It consists of 902 sq. ft. and rents for $1015 per month plus 20% of the building Avista and City of Spokane bills. The rest of the building is occupied by a physiatry and pain management medical practice. The space would be ideal for an ancillary medical, chiropractic or therapeutic clinic. Parking is ample and convenient. The space has a nice waiting area and receptionist-enclosed area, with several office, storage or exam rooms. Call (509) 321-2276 for more information or for a showing of your ideal location.

OTHER

Ten (10) adjustable rolling physician stools, teal - $35.00 each, all in great condition. For more information contact Colleen Kins at Internal Medicine Residency (509) 744-3965 or email Colleen.Kins@Providence.org.
Spokane County Medical Society
2012 PHYSICIAN CITIZEN OF THE YEAR
NOMINATION FORM

DEADLINE for nominations is February 22, 2013.

Any member of the Spokane County Medical Society is eligible for nomination.

Nominee:______________________________________________________________

EXAMPLES FOR EACH OF THE FIVE SECTIONS MUST BE INCLUDED:
(Attach pages as needed.)

1. Contributed to public understanding and appreciation of the role of medicine and to an improved public image of our profession and its members.

2. Demonstrated high standards of competence, ethics, and professionalism.

3. Showed outstanding ability in medicine.

4. Worked for the advancement of the medical profession.

5. Contributed to the betterment of our community and nation.

NOMINATED BY:_______________________________________________________

DATE:_______________________________________________________________

Please submit to:
SCMS
Physician Citizen of the Year Nomination, Orange Flag Building
104 S. Freya St., Ste. 114, Spokane, WA 99202-4868
Or fax to: (509) 325-5409

Spokane County Medical Society
MARK YOUR CALENDARS

Watch for more details!

2013 SCMS EVENTS

Mammogram Party
February 27 Wednesday  Inland Imaging Holy Family

Women Physicians’ Retreat
March 15-16 Friday/Saturday  Bozarth Center

Volunteering Abroad
April 11 Thursday  Providence Auditorium

CME with Primary Care Update
May 2 Thursday  Red Lion Inn at the Park

Community of Professionals Bloomsday
May 5 Sunday  To Be Determined

Senior Physicians Golf Tournament
May 17 Friday  Manito Golf Course

Young Physicians Meeting ACP/WSMA
May 19 Sunday  To Be Determined

Community of Professionals River Cruise
August  Spokane River

CME prior to WSMA Annual Meeting
September 27 Friday  The Davenport Hotel
**Welcome Home**

**Winter Packages**

**WINTER PACKAGE #1**
**AT MOUNTAIN LODGE** *
featuring one night in a Standard Room

- 20% OFF on any service or retail purchase at Spa Ssákwa’q’n
- $10 Extra Play Cash • $10 Gas Coupon

**$109.98**

**WINTER PACKAGE #2**
**AT SPA TOWERS** *
featuring one night in a Deluxe Room

- $80 Spa Ssákwa’q’n credit with complimentary day pass for two to enjoy the amenities (valued at $40).
- $50 Extra Play Cash • $10 Gas Coupon

**$299.98**

*Mention offer code WINTER1 or WINTER2 when booking at 1 800 523-2464.

Subject to availability. Offers valid Sun – Thurs through March 15th, 2013.
All stays incur a 7% tribal tax. 24-hour cancellation policy. Must be a Rewards member. Ask how!

---

1 800 523-2464 | CDACASINO.COM | /CDACASINORESORT
25 miles south of Coeur d’Alene at the junction of US-95 and Hwy-58
Rockwood Neurosciences Center

SERVICES / SPECIALTIES (NOT LIMITED TO):

- General Neurology
- Neuromuscular medicine
- Electrodiagnostic medicine
- Cerebrovascular Diseases
- Multiple Sclerosis
- Stroke and TIA
- Parkinsons Disease and related movement disorders
- Deep brain stimulation
- Electroencephalography (EEG) Evoked Potentials
- Cognitive disorders and dementia evaluation
- Central nervous system neuroimmunology
- Electrodiagnosis
- Neurosurgery
- Gamma knife/radiosurgery
- Surgical localization/treatment of medically intractable epilepsy
- Extra/intra-operative functional brain mapping utilizing implanted electrodes
- Brain tumor evaluation and surgery
- Minimally invasive spine surgery
- Intra-operative navigation in spine and brain
- Headache management
- Neuropsychological evaluations
- Psychiatric diagnosis and treatment
- Individual, couples, and family counseling
- Counseling to cope with physical illness, mental illness and developmental disorders
- Trauma, stress and post-traumatic stress counseling

NEUROLOGY PROVIDERS:

Scott E. Carlson, M.D., FAAN
Salil Manek, M.D.
Conrad Nievera, M.D.
Yashma Patel, M.D.
Wade Steeves, M.D.
Jon Ween, M.D.
Erin Baldwin, Ph.D.
Pat Hesselgesser, ARNP
Janette Worley, ARNP

NEUROSURGERY PROVIDERS:

John Demakas, M.D., FAANS
Chris Heller, M.D.
Lynn McClatchey, ARNP
Kathleen White, ARNP

BEHAVIORAL HEALTH PROVIDERS:

Craig Lammers, Ph.D.
Cass Ragan, M.D., CPE
Jeffrey Schack, M.D.
Heather Henriksen, M.A., LMHC
Sarah Kaldor, LMHC
Erika Klossner, LICSW
Karen Mega, LICSW

TO SCHEDULE AN APPOINTMENT OR REFER A PATIENT:

Neurology Center / 509.342.3200
Neurosurgery and Spine Center / 509.755.6735
Behavioral Health Center / 509.342.3480

www.rockwoodclinic.com