N E W S L E T T E R

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AMERICAN SOCIETY OF CRITICAL CARE ANESTHESIOLOGISTS

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President's Message

Task Force Highlights New Year

By Clifford S. Deutschman, M.D.
Philadelphia, Pennsylvania

First, I want to wish each of you a Happy New Year. The past year has been an interesting one for me both professionally and personally. I look forward to a truly outstanding 2004.

There have been a number of truly important occurrences since my last message. These have ramifications for ASCCA and for all anesthesiologist-intensivists.

Anesthesiologists historically have played a key role in establishing critical care as an important clinical subspecialty requiring a specialized fund of knowledge and clinical skills. Over the past few years, however, the role of anesthesiologists in critical care has diminished significantly. ASCCA is committed to reversing this trend because we believe it is essential that anesthesiologists play a key role as the prominence of intensive care medicine in the American health care system increases. ASCCA's mission is to preserve and expand the pivotal role of critical care medicine, as practiced by intensivists in intensive care units, within the scope of practice of anesthesiology. This will be accomplished through education, advocacy and community. As I have articulated previously, recent developments in the healthcare marketplace provide an opportunity and the imperative for expansion of our role in the intensive care unit (ICU).

Recent developments indicate that the American Society of Anesthesiologists (ASA) leadership is acutely aware of the importance of critical care medicine (CCM) to the practice of anesthesiology and wishes to facilitate the goals of ASCCA. First, at the ASA 2003 Annual Meeting, the House of Delegates passed an important resolution that endorses the role of anesthesiologist-intensivists in the ICU and authorizes the formation of a task force to evaluate how to extend critical care activities within the specialty. The charge to this task force is to present a realistic vision of what anesthesiologist-intensivists believe needs to be done to refine and redefine the role of ASA with regard to the practice of CCM. The task force is co-chaired by Gerald A. Maccioli, M.D., Raleigh, North Carolina, as chair of the ASA Committee on Critical Care Medicine and Trauma Medicine, and myself, as ASCCA President. In forming this task force, ASA President Roger W. Litwiller, M.D., appointed a prominent group of anesthesiologists who are also intensivists and who have shown a commitment to the education of anesthesiologist-intensivists, leaders from academic anesthesiology with a background in critical care and a representative from subspecialties in cardiac anesthesiology, neurosurgical anesthesiology and pediatric anesthesiology, where critical care medicine is prominent. Thus members of the task force include: James G. Ramsay, M.D., a cardiac anesthesiologist-intensivist from Emory University, Atlanta, Georgia; Todd Dorman, M.D., F.C.C.M., Director of the CCM Fellowship Program at Johns Hopkins University, Baltimore, Maryland; William E. Hurford, M.D., F.C.C.M., Professor and Chair of Anesthesiology at the University of Cincinnati, Cincinnati, Ohio; former director of the CCM Fellowship at Massachusetts General Hospital, Alex S. Evers, M.D., Professor and

Clifford S. Deutschman, M.D.

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ASCCA

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Web Page

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www.ascca.org

Membership

Membership in ASCCA is open to all anesthesiologists and residents in approved anesthesiology programs. Membership applications may be obtained by writing to **ASCCA**, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

ASCCA Dues

Dues are $150 for active members and $150 for affiliate members. Resident members of ASA are provided joint membership in ASCCA through the Society's affiliation with *Anesthesiology*. Prompt payment of your dues is greatly appreciated by the ASCCA officers and directors. Remember, payment of your dues allows you to enjoy the full privileges of ASCCA membership.

EDITORIAL NOTES

Editorial Policy

The opinions presented are those of the authors only, not of ASCCA. Drug dosages, accuracy and completeness of content are not guaranteed by ASCCA.

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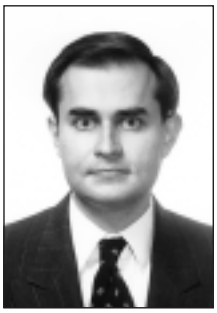
Editorial

Our Own Best Ally

By Michael L. Ault, M.D.
Editor



Michael L. Ault, M.D.

Residency and fellowship interview season have now arrived in full force. Once again it is not only a relief to me but also a deep personal satisfaction to see medical student interest in anesthesiology rise to a new high. Additionally I believe that most critical care medicine fellowship programs also have seen an increase in the number of fellowship applications, and I am hopeful that this swell will continue to grow. We must remember, however, that anesthesiologist-intensivists remain the best advertisement for our unique subspecialty.

…we must be aware of the lifestyle concerns that many trainees and medical students have, and we must use these to our full advantage as anesthesiology-based intensivists.

Anesthesiologists have had a long, steadfast history in the subspecialty of critical care medicine. As society has shifted to a more "lifestyle-oriented" culture, though, we saw the number of critical care medicine fellowship applications decrease. Thus we must be aware of the lifestyle concerns that many trainees and medical students have, and we

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2003 Annual Meeting Review

Critical Care in the Forefront

By Robert A. Royster, M.D.
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The ASCCA 2003 Annual Meeting was held in San Francisco, California, on October 10, preceding the American Society of Anesthesiologists Annual Meeting. Registration and continental breakfast began at 7 a.m. **William E. Hurford, M.D.**, Cincinnati, Ohio, made the opening statements and welcomed **Michael H. Wall, M.D.**, Dallas, Texas, as the moderator for the oral abstracts presentations.

The morning abstracts began on an exciting note with an abstract out of the "Brain Attack Lab" at the University of Louisville, Louisville, Kentucky. **Ozan Akça, M.D.**, presented a study on ischemic preconditioning (IPC), a defense mechanism by which various tissues develop resistance to further ischemia after suffering an initial ischemic insult. The researchers used slices of hippocampus from rat brains, applying them initially to various environments representing respiratory acidosis, metabolic acidosis and control. The brain slices initially exposed to either respiratory or metabolic acidosis environments showed greater recovery of neuronal function following a hypoxic period than did the control groups, suggesting low pH as the mediator of IPC in rat brains rather than high PCO_2 alone.

Conan McCaul, M.D., Dublin, Ireland, was next and presented research on epinephrine use during cardiopulmonary resuscitation (CPR). As cardiac arrest in children is most commonly secondary to asphyxia, these researchers used a rat model, inducing asphyxial cardiac arrest, and subsequently performed CPR using either epinephrine (10 and 30 mcg/kg groups) or saline (control). Dose-dependent diastolic dysfunction (via transthoracic echocardiography), left atrial hypertension and increased mortality were seen in the groups treated with epinephrine. These effects were attenuated in another group by subsequently administering verapamil.

Chad E. Wagner, M.D., Houston, Texas, presented a study on dopamine kinetics in adult patients undergoing cardiopulmonary bypass (CPB). Patients undergoing CPB were placed on "low-dose" dopamine infusions (2 mcg/kg/min), and dopamine levels were measured at various times pre-CPD, during CPB and post-CPB. As expected blood dopamine levels varied widely. However, unexpectedly, dopamine concentrations increased during CPB. The results produced comments from various audience members suggesting similar dissatisfaction with the predictability of this infused inotropic agent.

Ulrich Schmidt, M.D., Boston, Massachusetts, then presented an abstract elucidating his construction of an adenovirus with a cardiomyocyte-specific promoter. This 4xMLC-2v promoter may be useful in myocardial gene therapy in heart failure to produce more site-specific transgene expression.

Robert A. Royster, M.D.

This year's Young Investigator Award was presented by Dr. Wall to **Martina Richtsfeld, M.D.**, Boston, Massachusetts. Dr. Richtsfeld presented a study on long-term pyridostigmine administration using a rat model. This study demonstrated that either higher doses of pyridostigmine or longer administration of the drug will result in a significant decrease in acetylcholine receptor number in the rat model. The study design was applauded as a very elegant one, and members of the audience voiced the desire to see a follow-up of the results (the rats were followed for 27 days). Dr. Richtsfeld replied, however, that the expense of the laboratory and workforce needed to continue this study for a longer period of time would be considerable.

To conclude the first scientific session, **Neal H. Cohen, M.D.**, presented the 2003 Lifetime Achievement Award to **Sten G. Lindahl, M.D., Ph.D.** Dr. Lindahl's research in pulmonary physiology, ventilatory and metabolic responses to anesthesia and his contribution as an editor of several textbooks have made him a respected leader in critical care. Dr. Lindahl presented a short lecture on oxygen sensing, uptake and utilization, beginning with the "history of oxygen" and continuing with the physiology of hypoxia and thermogenesis.

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Critical Care in the Forefront

Neal H. Cohen, M.D., right, presents Sten G. Lindahl, M.D., Ph.D., with the 2003 Lifetime Achievement Award.

The 2003 Young Investigator Award was presented to Martina Richtsfeld, M.D., left, by Michael H. Wall, M.D.

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A coffee break ensued at this point, and attendees were seen leisurely viewing poster presentations on a variety of topics from the perilaryngeal airway to perioperative hypothermia. Of note multiple studies were seen on the use of dexmedetomidine, an alpha-2 agonist administered via infusion for its sedative and analgesic properties, which demonstrated its use in multiple scenarios in the intensive care unit (ICU).

Scientific Session II began with a statement on "the new mission of the ASCCA," presented by ASCCA President **Clifford S. Deutschman, M.D.**, Philadelphia, Pennsylvania. According to Dr. Deutschman, in defining the future mission of our Society, we need to address declining membership, uncertainty regarding what our membership wants from us, declining corporate support, the changes in the marketplace and the shortage of providers as our patient population ages and becomes more sick. To do this, a task force was formed after last year's meeting. Their proposal was put before the board of directors and was further altered to a final revision of the mission statement, which was included in the March 2003-May 2003 ASCCA *Interchange*. Quoting this revision, Dr. Deutschman stated that "the mission of ASCCA is to preserve and expand the pivotal role of critical care medicine as practiced by intensivists in intensive care units within the scope of the current practice of anesthesiology. This will be accomplished through education, advocacy and community… We do have a commitment to research in this Society, but we are coming to the recognition that to do everything that we would like to do is to do it all poorly." Commitment to research will continue, but it will take more of a back seat to these more important goals. Dr. Deutschman stated that:

Clifford S. Deutschman, M.D.

"To achieve its mission, ASCCA will adhere to four guiding principles:

1. Intensivists are an integral part of the modern health care system because they improve the quality and cost effectiveness of patient care.
2. Intensive care medicine is an essential subspecialty of anesthesiology practice because it enhances the overall quality of perioperative care. Anesthesiologists with special training and experience in intensive care medicine improve the quality of postoperative care by advancing our understanding of critical illness. They also contributed to major improvements in intraoperative management and outcomes.
3. Continued participation in critical care medicine is essential to the future of the specialty and to continued improvements in perioperative care.
4. The present numbers of anesthesia intensivists are insufficient to meet current and future needs of patients and practices. Thus the number of trainees needs to be increased."

A series of goals and objectives was created to help advance these principles. These were further discussed, and a more thorough explanation is available in the March 2003-May 2003 newsletter.

Douglas B. Coursin, M.D., Madison, Wisconsin, next spoke about anesthesiologists in the ICU. He referred to anesthesiologist-intensivists as "an endangered species." Dr. Coursin believes this can be attributed to a lack of role models, an "inability to reproduce," a lack of commitment on the part of the overall specialty, a lack of money, lack of a cohesive voice in demanding adequate reimbursement, lack of courage, lack of foresight and lack of leadership. He believes there is a chance to turn the subspecialty around, but a commitment needs to come from the top down, and we need to exploit the talent of

those already within our membership and become acute care specialists. He believes the scope of our parent society needs to be changed, a different type of trainee needs to be attracted and the economical and political outcomes front needs to be pushed.

ASA President **Roger W. Litwiller, M.D.**, Roanoke, Virginia, addressed the assembly next. He voiced the support of ASA for increasing the role of critical care medicine in our specialty. The ASA House of Delegates is developing a resolution for the appointment of a task force to determine how to address this problem. Next year's ASA Annual Meeting will include a two-day critical care medicine track. Dr. Litwiller pointed out the fact that unless we are able to convince Congress to do otherwise, Medicare payments will decrease by 4 percent to 5 percent and will decrease by the same amount for each of the next three to four years. He stressed that if we do not come together as a political force, many of us will be out of business, and our specialty will suffer.


Roger W. Litwiller, M.D.

After breaking for lunch, Scientific Session III began with **Todd Dorman, M.D.**, Baltimore, Maryland, discussing "Safety and Quality in Critical Care." His session urged us all to evaluate closely our care protocols and methods with a goal of "doing no harm," meaning zero harm. In his opinion, there are many things that can be done without increasing cost that can significantly improve patient outcomes. He used the example of elevating the head of the bed to 30 degrees and titrating sedation appropriately to a level where patients can follow commands in order to decrease the incidence of ventilator-associated pneumonia by around 60 percent. He also spoke of instituting strict sterile technique following Centers for Disease Control guidelines when inserting central venous catheters as a way to decrease line infections and bacteremia. Dr. Dorman also advocated a goal-oriented approach to care in the ICU, and his team has instituted a checklist of daily goals to help accomplish this for each patient. He also listed many enormous initiatives to improve quality and safety in the ICU and is confident that hospitals and practitioners will step up to the plate to improve quality and safety in the upcoming years.

Dr. Cohen followed Dr. Dorman by presenting a discussion on promotion of patient safety. Dr. Cohen suggested that we need to critically evaluate what we do and determine whether it can be done better or if it needs to be done at all. In this way, we can identify opportunities for improvement. Dr. Cohen suggests that we need a consistent method to monitor outcomes in our intensive care units. We need to consider the alternatives, in addition to the risks and benefits, to our interactions or procedures in order to minimize complications. He emphasized that the patient safety initiatives we apply to the ICU need to be applied throughout the entire hospital. Through these initiatives, and because of the depth and breadth of our responsibility, the critical care physician may be the key to patient safety throughout the entire hospital. He advocated competence-based evaluations to determine house staff and attending privileges and would like to see critical care anesthesiologists and other intensivists band together to create a multidepartmental database to help evaluate patient safety issues.

Richard C. Prielipp, M.D., Winston-Salem, North Carolina, a member of the ASA Task Force on Emergency Preparedness, spoke next on weapons of mass destruction. He discussed in detail the various chemical weapons that exist in the world today and how we may identify a syndrome that occurs secondary to the use of these agents in order to treat it. Dr. Prielipp finished with a discussion of the nuclear threat that exists today, including the "dirty bomb," which will use radioactive material combined with conventional explosives to intentionally contaminate a large area.


Richard C. Prielipp, M.D.

Continuing the discussion on biological warfare, **Edward George, M.D.**, **Ph.D.**, Boston, Massachusetts, spoke on the response protocols to biological threats. He discussed in detail the operations of a Disaster Medical Assistance Team (DMAT), which would deliver medical assistance in times of crisis. He also discussed the various roles of the Federal Emergency Management Association, the National Disaster Medical System, which oversees the various DMATs, and International Medical Surgical Emergency Response Teams. He outlined several aspects of the Federal Disaster Response Plan and discussed some of the lessons we have learned from the 9/11 terrorist attacks.

After a break, **Bernard Lowe, M.D.**, San Francisco, California, spoke on ethics in critical care research. He talked about how ICU patients differ from other patients for whom informed consent guidelines were created, and he discussed the options of waivered, deferred or surrogate consent in patients who cannot consent for themselves at the time the research is being performed. He suggests that many practices in the ICU are not based on hard data, and we must be able to perform prospective randomized clinical trials in order to know how to best take care of our patients. Dr. Lowe therefore discussed how to inform the surrogate of risks, benefits and alternatives to entering their loved ones into a clinical trial.

Michael Matthay, M.D., San Francisco, discussed several controversial issues relating to the National Institutes of Health/ARDS Net clinical trials and answered many of the allegations forming the basis of the investigation by the Office of Human Research Protection (OHRP). He concluded that although the investigation by OHRP began with good intentions, it was misguided and poorly managed by individuals who did not have the scientific expertise to evaluate clinical trial design. He illustrated how after delaying this extremely valuable clinical trial for an unreasonably prolonged period of time, OHRP was eventually forced to concede that the low tidal volume study was within the realm of ethical medical research. He believes this delay may potentially have caused harm to patients who were not able to benefit from the results of the

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Task Force Highlights New Year

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Chair of Anesthesiology, Washington University, St. Louis, Missouri; W. Andrew Kofke, M.D., a neuroanesthesiologist-intensivist at the University of Pennsylvania in Philadelphia; Jayant K. Deshpande, M.D., a pediatric anesthesiologist-intensivist from Vanderbilt University, Nashville, Tennessee; C. William Hanson, III, M.D., F.C.C.M., Director of Critical Care Medicine at the University of Pennsylvania and Neal H. Cohen, M.D., M.P.H., Professor of Anesthesiology/Perioperative Medicine and Dean of Faculty at University of California-San Francisco, and Immediate Past President of ASCCA. The task force has begun to formulate its proposals. Dr. Maccioli and I are scheduled to present our recommendations to the ASA Board of Directors in June. It is our hope that a resolution that defines how to implement the recommendations can be formulated for consideration by the House of Delegates in October 2004.

A second important opportunity to broaden the footprint of anesthesiologist/intensivists has been created with plans to change the format of the ASA 2004 Annual Meeting and increase the participation of specialty groups.

A second important opportunity to broaden the footprint of anesthesiologist/intensivists has been created with plans to change the format of the ASA 2004 Annual Meeting and increase the participation of specialty groups. In an effort to revitalize the symposium, the program committee has elected to add specialty tracks. One of the first tracks to be included in the program is the Critical Care Track. This will be presented on Saturday and Sunday of the Annual Meeting. A committee chaired by Dr. Cohen is formulating the program. Members include Dr. Dorman and Dr. Maccioli, Andrew Gettinger, M.D., Dartmouth Medical Center, Lebanon, New Hampshire, and Michael F. O'Connor, M.D., from the University of Chicago, Chicago, Illinois. I can tell you that the initial program looks terrific. It consists of Breakfast Panels, a series of Refresher/Plenary Lectures by truly outstanding individuals, both one- and two-hour panels focusing on state-of-the art topics that cover clinical care, research and practice management, point-counterpoint discussions on controversial topics and scientific panels that will include presentation of a number of the abstracts submitted to the Annual Meeting. The final panel will be sponsored by *Anesthesiology*. The format will be unique; promising junior investigators will present their work. This will be followed by a short lecture by each individual's mentor, placing the work in context and highlighting the importance of mentorship and instruction in conducting investigation. We urge all interested researchers to submit their work for this interesting symposium.

Finally, I am pleased and excited to announce that the recipient for the first Annual Research Award in Critical Care Medicine has been identified. The winner is Guido Musch, M.D., from Massachusetts General Hospital. His proposal is titled "Regional Effects of Alveolar Recruiting Strategies on Gas Exchange and Cellular Inflammation in Acute Lung Injury." The award is sponsored by ASCCA, administered by the Foundation for Anesthesia Education and Research (FAER) and financed by a generous, unrestricted grant from Abbott Laboratories. Dr. Musch will receive salary support for two years to allow protected time to conduct his research. We hope the funding of this award will continue on an annual basis, as ASCCA, FAER and Abbott all agree that the need for support of research education in critical care is of paramount importance. Special thanks to Jeffrey R. Balser, M.D., Ph.D., Vanderbilt University, Robert N. Sladen, M.B., Columbia Presbyterian Medical Center, New York, New York, and Yvonne Harter of Abbott for their stellar work in making this award possible.

In finishing, I once again urge each of you to contribute to ASCCA. Volunteer for a committee, submit an abstract to the Annual Meeting and convince others to join. Your contributions are essential. ✧

ASCCA Past President Selected for Prestigious Women in Leadership Program

M. Christine Stock, M.D., 1991 ASCCA President, Chief of Anesthesiology at Northwestern Memorial Hospital and Chair of the Department of Anesthesiology at Northwestern University Feinberg School of Medicine, Chicago, Illinois, was recently selected to participate in the Hedwig Van Ameringen Executive Leadership in Academic Medicine (ELAM) Program for Women. Dr. Stock, a resident of Wilmette, Illinois, is one of only 45 senior women faculty from medical and dental schools in the United States, Puerto Rico and Canada and the only candidate from Illinois who has been selected by ELAM as a Fellow in this competitive program.

Founded in 1993, ELAM is the only in-depth national program that prepares senior women faculty for leadership positions at academic health centers. ELAM's mission is to increase the number of women at academic health centers in leadership positions and their success rate in attaining and remaining in these positions.

While medical schools are attracting increasing numbers of female students,

M. Christine Stock, M.D.

women are still rare in senior academic administrative positions. Currently only 10 of the 126 U.S. allopathic medical schools are headed by women deans. Of these, 25 percent are ELAM alumnae.

"I'm looking forward to starting the program," says Dr. Stock. "I think it will give me a broader picture of the issues and challenges confronting the health care industry, and in turn make me a better department chair."

The ELAM curriculum combines traditional MBA training oriented toward academic health management with personal and professional development focused on leadership development, career advancement, communication, and the use of new information/learning technologies. Program highlights include opportunities to meet with nationally recognized leaders in academic medicine, health care, government and industry and to interact with peers from different disciplines and institutions.

In between the program's three intensive on-site sessions, Fellows complete a variety of independent assignments, including interviews with senior executives to understand the operation and challenges of their institution from other perspectives, and the design and implementation of an action project that addresses an institutional need or goal. ✧

Critical Care in the Forefront

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study. In order to avoid this in the future, Dr. Matthay suggested that "mechanisms must be developed for the OHRP to utilize true experts in a timely fashion that inspires confidence in this potentially valuable government agency that has not yet lived up to what it should be."

Michael J. Breslow, M.D., Baltimore, Maryland, co-founder of VISICU, a company that helps hospitals redesign ICU care delivery systems and provides the technology to do so, spoke on new technologies in critical care practice. Dr. Breslow stressed that the ICU is a data-rich environment and that we are far behind other industries in these areas: data presentation, facilitating communication, decision making, providing information about how well we are doing and leveraging limited human resources. He illustrated some technology that is currently available to improve our use of data in all of these areas and suggested that it only needs to be accessed by hospitals in order to improve patient care.

Gerald A. Maccioli, M.D., Raleigh, North Carolina, closed the final session with a discussion on medicare compliance. He discussed the importance of developing a Medicare compliance program within our current sociopolitical environment in which there are many ways we can be fined, punished or imprisoned for Medicare fraud. Dr. Maccioli outlined the operational elements of an effective Medicare compliance plan, specifically:

Gerald A. Maccioli, M.D.

- Written standards of conduct for employees
- Written policies promoting commitment to compliance and addressing specific areas of potential fraud
- Designation of a chief compliance officer
- Education and training program
- Periodic audit program
- Internal investigation process
- Investigation and remediation of identified problems
- Guidelines for response to requests from outside agencies
- Screening new employees and vendors
- Process for communication
- Policy on response to violations

Following Dr. Maccioli's discussion, a business meeting was held that concluded this year's ASCCA Annual Meeting. Members were free to enjoy a beautiful evening in San Francisco and look forward to next year's meeting in Las Vegas, Nevada ✧

The Malpractice Insurance Crisis: What You Can Do for Your Practice

Christopher R. Jarvis, M.B.A.

and

David B. Mandell, J.D., M.B.A.

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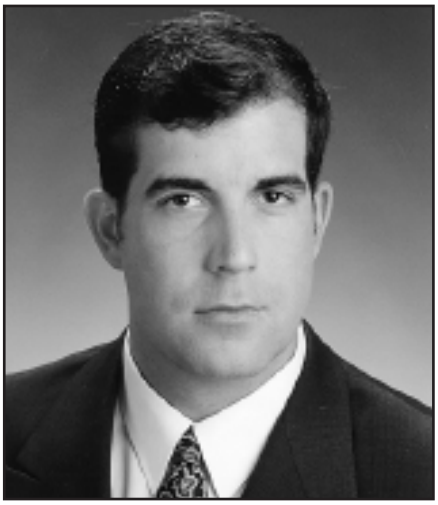

Christopher R. Jarvis, M.B.A.

David B. Mandell, J.D., M.B.A.

As professionals with many physician clients, we routinely are asked by physicians throughout the country to answer questions on a variety of topics. In our combined experiences, however, we have never been as inundated with calls as we have in the last year regarding the malpractice insurance situation. Doctors from all specialties across the nation called us looking for ways to either reduce their malpractice premiums or find alternatives to their traditional carriers.

The question on their minds, and perhaps on yours as well, is the following: What can you do in your practice in response to this malpractice insurance crisis? We outline three strategies every physician should consider:

I. Make Asset Protection a Priority

Newsweek's cover article, "Lawsuit Hell," on December 15 used 10 full pages to discuss the litigation problems in this country and highlighted physicians as the primary targets. Regardless of the state of the malpractice insurance market, physicians should always see asset protection as an important part of any business and personal financial plan. When we use the term "asset protection," we mean shielding the assets of the practice and personal assets from all potential lawsuits, including malpractice claims.

While this has certainly been a priority over the last decade, at no time has it been more important than in the current malpractice insurance crisis. Because premiums have become so expensive, many physicians are considering reducing their coverage from traditional limits to lesser limits. While this may make sense, it is only part of the equation. If you decide to reduce your malpractice insurance coverage, you MUST be simultaneously implementing an asset protection plan to protect all of your practice and family wealth. An ideal solution is one that not only reduces your cost of malpractice insurance but also provides the same level of protection for your assets. It makes no sense to reduce coverage limits because premiums are expensive and then leave your practice's and personal assets exposed to lawsuits and creditors. That is why asset protection is so important.

It makes no sense to reduce coverage limits because premiums are expensive and then leave your practice's and personal assets exposed to lawsuits and creditors. That is why asset protection is so important.

While an in-depth discussion of the tools and strategies that asset protection professionals use is beyond the scope of this article, we will list a number of tactics here. As with insurance planning, however, these strategies and tools must be implemented before there is a problem. That is why one must engage in asset protection planning as early as possible.

Potential Asset Protection Tactics:

1. Shield the practice's most valuable asset, its accounts receivable (AR), through a leveraging or factoring strategy. Often this can create significantly more after-tax retirement wealth in addition to protecting the AR from medical malpractice claims.

   Your options:

   a. Take a loan against the AR and invest the loan proceeds in an asset that grows tax beneficially and is asset-protected. Often this can be achieved by having the practice and the physicians co-invest in a limited liability company (LLC). Depending on how the LLC operating agreement is drafted, significant tax benefits can be enjoyed, giving the physician the opportunity to build retirement wealth beyond his or her pension if the loan terms can be negotiated to a reasonable level. The AR is shielded because of the lender's security interest in the receivables.

b. Sell the AR to a particular type of factoring company. Unlike the "typical" factoring firm that makes money on buying your AR on the cheap, these firms offer a pass-through type of arrangement where the physician can set the purchase discount at whatever he or she wants within reasonable parameters. The AR is shielded because the factoring company's ownership of the receivables.

2. Shield the practice's equipment and/or real estate, if any, by implementing LLCs to own the real estate or equipment, leasing back the assets to the operating practice. Because the practice no longer owns the equipment/real estate, lawsuits against the practice or any of the physicians no longer threaten these assets.
3. Protect personal assets through the use of state and federal exemptions.
4. Protect assets through the use of legal entities such as LLCs, family limited partnerships (FLPs), trusts and "debt shields." Each of these tools can play an important role in an asset protection plan.

Once your practice and personal assets are properly shielded, you gain a tremendous level of flexibility. No longer financially exposed to a malpractice claim, you will now have the ability to lower coverage limits (and the resulting premiums). Further there is evidence that by being protected and having lower coverage, you become less of a lawsuit target in the first place. Simply put, you no longer have a "pot of gold" for the plaintiffs at the end of their lawsuit rainbow.

II. Consider Captive Insurance Companies

A captive insurance company (CIC) is one created by the physician owner(s) to insure their medical practice. This company often may use a third-party "fronting company" to write the initial malpractice policies, which then are reinsured to the physicians' captive. In this way, the profits on the insurance business, as well as the investment on the reserves, are held by a company ultimately owned by the physicians.

In that case, they enjoy a tremendous windfall by recapturing a significant portion of their premium payments (plus compounded investment gains). This is especially so if the captive is created under one of the tax provisions that give extremely beneficial tax treatment to small insurance companies, particularly those created under tax §501(c)(15) or 831(b). In fact the tax benefits are so significant that they merit a case study.

Case Study: "Dr. Steve"

Dr. Steve is a successful physician who was tired of paying what he considered to be exorbitant malpractice premiums. He was especially annoyed because he had not incurred one successful judgment against him in 20 years of practice. He lowered his third-party coverage and made up for it with a policy written from his CIC. He established a CIC individually. Let us take a look at the benefit Dr. Steve enjoyed from his CIC.

Table 1 shows what kind of assets can be built inside a CIC over just a 10-year period for a physician in Steve's situation. As you can see, more than $1.7 million could be accumulated in such a vehicle over the period — quite a substantial asset base — which, of course, Dr. Steve owns. When he wants to close the company and access the funds, there will be a number of options available to him.

If Dr. Steve had just continued to pay his outside insurer, not a dollar of the $1.7 million would be his; the insurance company would have it all.

III. Evaluate Risk-Retention Groups (RRGs)

A risk-retention group is a liability insur-

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Table 1: Dr. Steve and His CIC — Effects on His Practice's Bottom Line

	Before Creating the CIC	Year 1
Malpractice protection	Traditional $1 to $3 million coverage	Reduced coverage plus additional CIC coverage and "defense-only policies"
Practice income (net)	$300,000	$300,000
CIC premium paid	$0	$100,000[a]
Personal income: stock transactions	$75,000	N/A
CIC income: stock transactions	N/A	$75,000
Taxable income	$375,000	$200,000
Federal and state income taxes[b]	$168,750	$90,000
Adjusted after-tax wealth[c]	$206,250	$285,000
Benefit to Steve's bottom line		**$78,750**

[a]Deductible premiums can be as high as $1.2 million per year.

[b]Assumes combined federal and state income taxes of 45 percent.

[c]Exclusive of transaction costs.

Six Tax-Saving Ideas: Plan This Year and Save Next April 15

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and

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As a physician, you work too hard not to make tax planning a priority. That is, of course, unless you enjoy spending 40 percent to 50 percent of your time working for the Internal Revenue Service (IRS). Still, if you are like most physicians, you do not even dedicate one day per month to see how you could reduce your tax liability. The purpose of this article is to show you six ways to save taxes on income and possibly motivate you to spend that day on planning now and save on next year's taxes. Let us examine these ideas now.

1 Get Deductions for Risk Management and Asset Protection Planning

Captive insurance companies (CICs) are great for physicians (and physician groups) looking to make annual tax-deductible contributions of $100,000 to $1,000,000 for asset protection and risk-management programs. The CIC we are discussing here is a legitimate insurance company registered with the IRS for domestic tax treatment, typically based in an offshore jurisdiction such as Bermuda or the British Virgin Islands. Most CICs are established in these countries because of their favorable insurance laws and local tax treatment, although the funds in the CIC can be maintained and managed in the United States. The CIC must always be established with a real insurance purpose, that is, as a facility for transferring risk and protecting assets. You can use a CIC to insure all or portions of your practice's significant risks such as medical malpractice, sexual harassment, wrongful termination, discrimination, worker's compensation, Medicare fraud, loss of license and even health insurance. If structured properly, these companies can be tax-exempt, and the assets inside the companies grow tax-free. There are strategies that allow CIC owners to reduce, if not eliminate, taxation on the withdrawal of these funds if they are never needed to pay claims.

2 Asset-Protect Your Practice's Most Valuable Asset and Reduce Taxes

As a specialist, you are likely very aware of the malpractice liability crisis presently surrounding the practice of medicine. What you may not realize is that a large judgment against any of your partners will likely threaten *all* of your practice's accounts receivable. Typically this is a medical practice's most valuable asset. If you are not comfortable with the idea that you could lose six months of income as a result of one of partner's mistakes, you must seriously consider addressing this issue.

Many physicians have recently implemented a strategy for asset-protecting their receivables. While the details of the options go beyond the scope of this article, it should be mentioned here that at least two of these strategies (financing and enhanced factoring) allow the practice to reduce its income tax burden as well because of deductions generated by the strategy. Thus if asset protection is a concern of yours, in addition to tax reduction, we recommend that you investigate your practice's options in this area. Our free special report on the malpractice crisis discusses these options and can be obtained for free if you subscribe to our newsletter at <www.jarvisandmandell.com>.

3 Share Income With Lower-Income Family Members

Family limited liability companies (FLLCs) and family limited partnerships (FLPs) are used primarily for asset protection. FLLCs and FLPs, however, can save you thousands of dollars each year in income taxes. This is accomplished by what is called "income sharing," that is, spreading the income created by the FLLC or FLP to the limited partners or members who are in lower tax brackets. Since most physicians are in a 40-percent tax bracket and many of them have children (must be over age 14) who are in either a 15-percent or 28-percent tax bracket, the FLLC/FLP can save 12 percent to 25 percent on income earned by FLLC/FLP assets such as mutual funds, rental real estate, stocks and bonds.

4 Gain Tax-Deferral, Asset Protection and Risk Reduction for Your Investment Portfolio

There are two types of annuities: fixed annuities (which pay you a fixed return over a period of time) and variable annuities (which have an underlying stock market investment). If you have assets that you do not intend to use until retirement, there is no reason not to utilize an annuity to defer income taxes. Under realistic assumptions, a $500,000 stock portfolio could generate an annual tax liability of $10,000 to $25,000. An annuity will let you invest funds that would otherwise go to the government and defer taxes on the earnings until you retire when you may be in a lower tax bracket. Additionally some states protect annuities from creditor claims. In the states that do exempt them, annuities are an ideal tool to safeguard wealth.

5 Use Charitable Giving to Reduce Income Taxes — The Charitable Remainder Trust (CRT)

As a society, Americans cherish the right to give to the charitable institutions of their choice. The problem is that many times we do not know how to give or we assume that our family will suffer as a result of our giving. There are many ways you can make charitable gifts while benefiting your family as well. The most common tool for achieving this "win-win" is the charitable remainder trust (CRT). A CRT is an irrevocable trust that makes annual or more frequent payments to you (or to you and a family member), typically, until you die. What remains in the trust then passes to a qualified charity of your choice. A number of advantages may flow from the CRT.

First you will obtain a current income tax deduction for the value of the charity's interest in the trust. The deduction is permitted when the trust is created even though the charity may have to wait until your death to receive anything. Second the CRT is a vehi-

cle that can enhance your investment return. Because the CRT pays no income taxes, the CRT can generally sell an appreciated asset without recognizing any gain. This enables the trustee to reinvest the full amount of the proceeds from a sale and generate larger payments to you for your life. Finally the trust will be eligible for an estate tax deduction if it passes to one or more qualified charities at your death.

6. Eliminate the Hidden 80-Percent to 90-Percent Tax Trap of Retirement Plans

If you die with money in your pension, your family will have to pay income taxes between 40 percent and 45 percent. Then they will be forced to pay estate taxes of 50 percent on those assets. This can eat up 80 percent or more of your pension or IRA!

The capital transformation strategy (CTS) helps reduce these taxes and increases the net estate to your heirs without sacrificing your quality of life during retirement. The CTS is the most powerful strategy for handling this tax trap. Because it is very complex, however, you must find an advisor who is adept with all areas of taxation, the Employee Retirement Income Securities Act, Department of Labor rules and is an expert in life insurance. Only this type of advisor can deftly implement such a strategy. If you have more than $500,000 in a pension plan and you are worth $3 million or more and do not wish to leave 80 percent to 90 percent of your estate to the government, you should seriously consider the CTS.

David B. Mandell, J.D., M.B.A., and Christopher Jarvis, M.B.A., are authors of *The Doctor's Wealth Protection Guide* and have addressed numerous medical societies around the country. Their firm, Jarvis & Mandell, LLC, services clients nationally. They can be reached at (888) 317-9895 or through <www.jarvisandmandell.com>. ✧

"Judge Learned Hand" said: "There is no reason to pay more taxes than the law would provide, there isn't even a patriotic duty to do so." This article gives you a few ideas on how to save taxes for 2004 and beyond. Feel free to contact either of us if you have any questions regarding the above.

As a special benefit to readers of the ASCCA *Interchange*, we are offering a free copy of *The Doctor's Wealth Protection Guide* (plus $7 shipping and handling). You can get your copy by calling (800) 554-7233.

See page 10 for Abstract Submission Cover Letter

Announcing an Easier and Faster Way to Submit Critical Care Abstracts for Presentation at the ASCCA Annual Meeting

ASCCA invites submission of abstracts for presentation at the ASCCA Annual Meeting on October 22, 2004, in Las Vegas, Nevada. Abstracts will be graded competitively on the basis of scientific merit and will be selected for either oral or poster presentations. Abstract presentation at the ASCCA Annual Meeting does not conflict with or preclude presentation at the American Society of Anesthesiologists (ASA) 2004 Annual Meeting.

The Committee on Education has made it easier to submit critical care abstracts for presentation at the ASCCA Annual Meeting, especially if one is submitting an abstract for presentation at the ASA Annual Meeting. To submit an ASCCA abstract, simply copy and paste your ASA abstract into a Word document.

Format the document so that it has one-inch margins all around, print and send it to the ASCCA office with the cover letter that appears on page 10. Each package MUST INCLUDE a diskette or CD of your abstract submission. The abstract submission deadline is April 26, 2004.

For more information or to submit an abstract, contact:

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Cover Letter for 2004 Abstract Submission

PLEASE COPY — This cover letter must be filled out completely and accurately and submitted with each abstract or the abstract will be rejected for technical reasons. All abstracts and completed cover letters must be received by the program chair by **April 26, 2004.**

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1. Title of Abstract: _____

2. Full Name of Author(s):
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4. Session Preference: Oral ☐ Poster ☐ Either ☐

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6. Human Studies: If human subjects were used in the research, the following statement must be signed by the presenting author.
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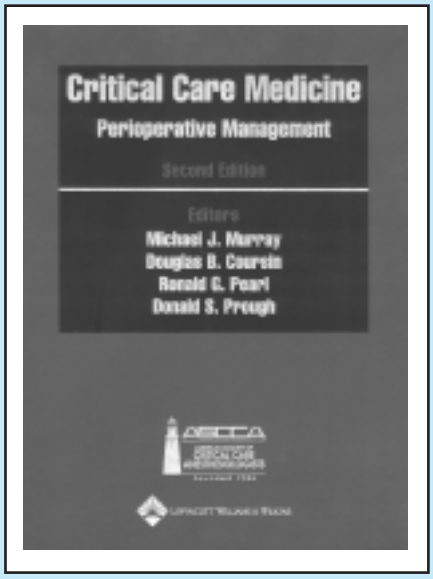
Critical Care Book Review

Critical Care Medicine: Perioperative Management, 2nd Edition
M.J. Murray, D.B. Coursin, R.G. Pearl, D.S. Prough, Eds.
Lippincott Williams & Wilkins, 530 Walnut Street, Philadelphia, PA 19106-3221
U.S.A.: $US149.00; 220x285 mm; pp. 905; ISBN: 0-7817-2968-8

The following review of Critical Care Medicine: Perioperative Management, 2nd Edition *was published in the February 2003 issue of* Anaesthesia and Intensive Care *and was written by P. Older, M.D., of Western Hospital, Melbourne, Australia. It is reprinted here with permission from the Australian Society of Anaesthetists, Ltd.*

This book of some 800 pages and over 100 contributing authors is an outstanding publication covering almost every aspect of intensive care, including organization and staffing, ethics, genomics, informatics, research, procedures, haemodynamics, fluids, pharmacology, physiology, cerebral protection, neurosurgery, cardiology, resuscitation, respiratory medicine, SIRS, renal and hepatic failure, pulmonary embolism, infection management, transplantation, obstetrics, poisoning, burns, advanced imaging and a small section on pediatrics.

The format of the book is quite excellent with each chapter written by experts in their field. There is a good summary at the end of each



chapter under the heading of "Key Points." The book is well bound with good quality paper and has an excellent index, making it very easy to use as a reference source.

The most exciting aspect of this publication is that it is up-to-date, with many of the authors' references being from the late 1990s and even 2001. I was unable to find a single chapter that I reviewed as "out-of-date." The book is understated when its title suggests it is a treatise on Perioperative Management – it is much more than that.

It is invidious to pick out any specific chapter for praise, but appropriately the first chapter in the book is dedicated to Preoperative Assessment. This should be read in conjunction with chapter three. The authors of both these chapters emphasize the importance of determination of exercise tolerance. If that were done with more care in this country, then there would be a big reduction in the current need for emergency postoperative ICU admission.

While there are many other books on critical care medicine, I have not come across one that is both an excellent reference book and a book that is a delight to read. It is a very impressive publication.

I strongly recommend this book to anesthetic departments and intensive care units.

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The Malpractice Insurance Crisis: What You Can Do for Your Practice

Continued from page 9

ance company owned by its members. In the mid-1980s, during the last liability crisis, federal legislation called the Risk Retention Act of 1986 was passed. This act allowed industries of like kind to band together to start their own insurance carrier. RRGs are the product of "hard" insurance markets like today's medical malpractice market. Today, in many states, insurance people and physicians are working together to form RRGs for physicians.

RRGs frequently are able to offer their members coverage while charging less than what commercial insurers charge (or they offer coverage at the same price that a commercial insurer would have charged if one had been available and willing to offer insurance). Further, as a physician-owned company, a medical malpractice RRG is typically able to offer its insureds more control over their professional liability programs.

Conclusion

In response to the medical malpractice insurance crisis, most doctors with whom we speak or consult are frustrated because they are only given alternatives to change policy at the state or federal level. This article provides brief ideas on what type of action might be on an individual or group level to shield assets and reduce the costs of the insurance itself.

Today, in many states, insurance people and physicians are working together to form RRGs for physicians.

As Mr. Jarvis and Mr. Mandell continue their commitment to the financial well-being of physicians, they have created a special report on the malpractice crisis and have made it available for free to subscribers to their newsletter at <www.jarvisandmandell.com>.

To help you better understand asset protection, we have made *The Doctor's Wealth Protection Guide* available for free if you pay the $7 shipping and handling charges.

David B. Mandell, J.D., M.B.A., and Christopher Jarvis, M.B.A., are authors of *The Doctor's Wealth Protection Guide* and *WEALTH PROTECTION: Build & Preserve Your Financial Fortress*. Their firm, Jarvis & Mandell, LLC, services clients throughout the country. They can be reached at (888) 317-9895 or via e-mail at <jarvis@jarvisandmandell.com>. ✧

Table 2: Dr. Steve and His CIC — Building His Tax-Free Nest Egg

	Before Creating the CIC	Year 1	Year 2	End Year 10 (projected)
Annual premium paid to CIC	N/A	$100,000	$100,000	$100,000
CIC income: return on prior reserves	N/A	$10,000*	$21,000	$159,374
CIC reserves	N/A	$110,000	$221,000	**$1,753,117**

*Assumes 10-percent return on investments. The CIC will pay no tax on its earnings.

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Our Own Best Ally

Continued from page 2

must use these to our full advantage as anesthesiology-based intensivists.

Certainly the operating room gives many anesthesiologists a well-defined daily structure that leads to few, if any, responsibilities once the anesthesiologist has left the operating room. Many trainees, however, do not realize the flexibility that a critical care medicine fellowship can add to these duties.

While in the operating room, I am told when to arrive, when to take a break, when to eat lunch, when to make a telephone call and when I may go home. Outside of the operating room, my day is often longer, but I regain much autonomy. I can now decide when I want to make rounds, when to eat lunch, schedule a mid-day meeting or work on a research project in the afternoon for an hour or two. Thus not only do I have a job that I love and has great hours (compared to many primary care physicians), but I have the added advantage of flexibility in my schedule when I play the role of intensivist. I certainly do not want the role of a full-time operating room anesthesiologist or a full-time intensivist because I am now spoiled, and I make a point of letting my trainees know how spoiled I am in my dual role and obligations. I am one of the few anesthesiologists who can have my cake and eat it too.

We anesthesiologists are our own best advertisement for the role of anesthesiology-based intensivists.

We anesthesiologists are our own best advertisement for the role of anesthesiology-based intensivists. Instead of hiding the perks that naturally arise from our situation, it is time to flaunt them. We must show our trainees that not only is the world of intensive care medicine a fascinating place to work, it is a great "lifestyle bonus" to an anesthesiologist. Now is a time for creative advertising, and our society has forced many trainees to raise the question of lifestyle choices in addition to professional obligation. I encourage every one of us to use the concerns voiced by trainees as they approach the end of their training as a great opportunity to introduce them to the world of critical care medicine and its many hidden advantages. We can be our best ally. ✧