

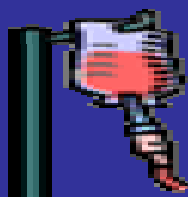


NetCAP E-Newsletter

<<April-June 2004>>

Summer Edition

“Network – A group engaged as a supportive system of sharing information and services.”



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Tarrance Report

How many hospitals use locum tenens anesthesiologists? Is this trend increasing or decreasing? Has the national shortage of anesthesiologists impacted the delivery of anesthesia services by hospitals? The Tarrance Group, a Virginia-based research consulting firm (www.tarrance.com), attempted to address these questions and others in a survey of senior hospital administrators. Their results reported in July 2002, are still germane two years later. Of the 957 hospitals sampled [>100 beds], 327 responses were obtained.

THE TARRANCE GROUP

EXECUTIVE SUMMARY

A majority (51%) of hospitals have had to use locum tenens providers – generally at a very large cost – to supplement their anesthesia groups. Among those hospitals most likely to use locum tenens providers are hospitals that do not have an adequate number of anesthesiologists (66%), hospitals with over 250 beds (54%), and hospitals that use anesthesiologists and CRNAs (56%).

One-half of all administrators (47%) believe that they do not currently have an adequate number of anesthesiologists on staff while nearly three-in-ten administrators (29%) indicate that they expect their hospital to lose anesthesia providers over the course of the next six months.

In response to a question that asked administrators how concerned they were about the hours being worked per week by their anesthesia providers, 68% expressed some level of concern (i.e. on a 10-point scale, 68% of respondents ranked this issue with a score of 6 or higher). More than one-third (34%) of hospitals are subsidizing the clinical practice revenues of their anesthesia providers. Almost one-half of administrators (47%) report that their hospital has had to limit the number of operating rooms in service or the available hours of an operating room due a shortage in anesthesia staff.

One of the more salient findings to be drawn from these data is that the nation's largest hospitals (250+ beds) are more likely to report that they do not have an adequate number of anesthesiologists on staff than smaller hospitals. As a result, shortages in anesthesia coverage are having the greatest impact on patients who rely on the largest – and often busiest – hospitals in America.

Based on the activity on Gaswork.com, and the plethora of staffing agencies that currently are competing for hospitals contracts, the Tarrance report suggests that the “locum tenens” model of work as an “independent contractor anesthesiologist” is likely to increase over the next few years, until supply and demand of anesthesiologists/CRNAs significantly changes.

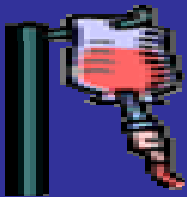
In the Spotlight - Diastology

NetCAP

• Network of Cardiac Anesthesia Professionals

• An e-information network for professionals involved in contract cardiac anesthesia

• NetCAP is sponsored by NCAC, PA



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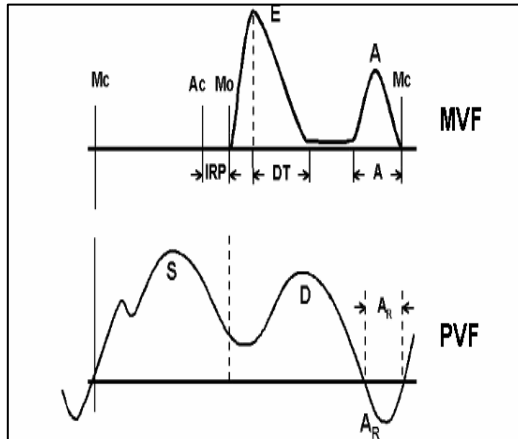
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We're on the Web!
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Ever go to a TEE meeting and find yourself in a lecture on ventricular diastolic function, only to be lulled into a state of profound boredom. Well, this website, <http://www.fac.org.ar/scvc/llave/PDF/roelandi.PDF> features an article by 2 European cardiologists that actually makes diastology quite rationale. It also discusses some of the newer modalities, color M-mode propagation velocity and tissue-doppler imaging with examples of each stage of dysfunction.

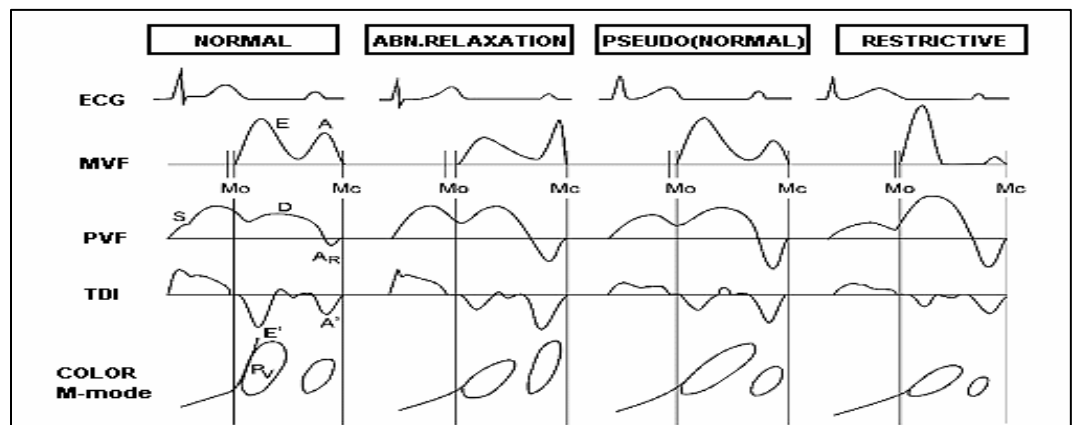
In order to simplify the concept of diastology, 3 progressive stages of LV diastolic dysfunction are described. Stage 1 (abnormal relaxation), Stage 2 (pseudonormal) and Stage 3 (restrictive).



An assessment of LV diastolic function requires measurement of transmitral flow (MVF) and pulmonary vein flow (PVF) using PWD. One has to have a basic working knowledge of what the components of normal waveforms are, i.e. the 'E' and 'A' waves on MVF and the 'A', 'S' and 'D' waves on PVF.

The ratio of the 'E' and 'A' wave height on MVF is commonly used to identify Stage 1 dysfunction. The 'E' is significantly smaller than the 'A' wave. A Vasalva manoeuvre may be used to identify Stage 2 dysfunction - a

normal E/A wave ratio reverts to a Stage 1 pattern with Vasalva. A tall and narrow 'E' wave identifies Stage 3 dysfunction; an 'E' wave deceleration time < 150 msec is commonly used to detect this.



And ...



This Newsletter contains information, views and judgments expressed exclusively by Paul G. Loubser, M.D. Since judgments are subjective in nature, they should be interpreted with some caution. Every effort will be made to be conscientious about reporting accurate and reliable information. Feedback is welcome on any subject matter. The newsletter is also posted on our website.