

Should We Ride the Train or Stay at the Station?

Annual Meeting of the ASA Board of Directors

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The Annual Meeting of the ASA Board of Directors was convened at the Westin O'Hare Hotel near Chicago from August 20-21, 2005. CSA members in attendance representing their specialty colleagues from California included: Edgar Canada, M.D., CSA President; Mark Singleton, M.D., CSA President-Elect; Linda Mason, M.D., CSA Immediate Past President; Kent Garman, M.D., ASA Alternate Director; former CSA Presidents Steven Goldfien, M.D., a member of the ASAPAC Board, and Norman Levin, M.D., Chair of the ASA Committee on Bylaws; Ms. Barbara Baldwin, CSA Chief Executive Officer; and yours truly.

Sixty-eight reports and resolutions from various ASA officers, section leaders, committee and task force chairs, and directors constituted the business of the Board.

P4P—Pay for Performance

Medicare payment for physician services is a major issue in Washington, D.C., this year because the annual update formula, known as the Sustainable Growth Rate or SGR, is projected to result in a 5 percent reduction in physician reimbursement in 2006 and each of the subsequent five years. During the last two years, physicians have enjoyed legislatively mandated, though small (about 2 percent per year), positive updates at a time when negative updates would have occurred under the SGR formula. This year the SGR formula will again dictate changes to physician payment under Medicare, but it will also need to correct for those previously unwarranted increases. Congress and the Center for Medicare and Medicaid Services (CMS) have been unwilling to fix the flawed SGR formula for several years. But this year, they claim to have the answer to our prayers—it is called Pay for Performance. "P4P," as it is known, will provide token increases in physician reimbursement, but only if they meet certain performance improvement criteria. Amazingly, AMA and many specialty organizations, most notably the primary care specialties, have agreed to participate in the P4P folly. Alexander Hannenburg, M.D., ASA Vice-President for Professional Affairs, is preparing ASA and its membership for P4P by proposing quality improvement measures that would be easy for practicing anesthesiologists to satisfy: addressing timeliness of prophylactic antibiotic administration in surgery, maintaining intra-operative patient normothermia, and post-operative pain management.

While this item of information before the Board was for “information only,” I was amazed at the complacency and lack of objection to Pay for Performance. The attitude of some ASA members is that P4P is a done deal—that we need to get on the train before it leaves the station. The last time I heard that analogy was when managed care was heralded as the new paradigm in health care. Medicare has systematically underpaid physicians for years, both because the government does not value our services and as a means to balance federal and state health care budgets. I would welcome any increase in my compensation from Medicare, but I object to any linkage of my compensation to the satisfying of quality performance measures. P4P is the tip of any ugly iceberg, which will expose physicians to more onerous regulations and will most likely be adopted by private payers. It is merely an effort to justify underpayment of doctors. I think that this is one train that we should not get on. Hopefully, the membership will be more outspoken in their objection to P4P at the ASA House of Delegates.

ASA/AANA Facilitated Meetings

During the last two years, the leadership of the ASA and the American Association of Nurse Anesthetists (AANA) have met periodically to attempt to resolve differences and to address some shared concerns with a unified voice. Such meetings have been mediated using a professional facilitator. One positive result was a joint statement on the appropriate use of propofol. Recently, however, the AANA has accused the ASA and its component societies, specifically mentioning California, of using legislative and regulatory means to control CRNAs. At the same time, AANA has pursued an aggressive public relations campaign in the media, on major radio outlets, and via advertising that, according to ASA President Gene Sinclair, is “inflammatory and demeaning to anesthesiologists.” To add fuel to the fire, the ASA Board learned that the AANA is conducting an aggressive lobbying effort against ASA’s attempts to correct the “Anesthesia Teaching Rule,” which has resulted in a 50 percent reduction in payment to academic anesthesiologists when they are supervising two residents concurrently (surgeons covering residents receive full fee while supervising overlapping operations). AANA claims that if the rule were changed for teaching anesthesiologists, it would create “incentives to teach anesthesiologists and discourages nurse anesthesia education by providing twice the reimbursement for—medical residents than for—student nurse anesthetists” and that nurse anesthetist education is already disadvantaged by lack of access to GME funding. This seems to be a matter of comparing apples to oranges, but AANA sees their members as anesthesiologist equivalents. Perhaps a visit to a local ophthalmologist might help correct their shortsightedness, or would they prefer an optometrist?

Despite a resolution from the North Carolina component, which called for the ASA leadership to withdraw from the facilitated meetings with the AANA Board, the ASA Board felt that the Executive Committee needed to maintain some dialogue at their discretion. However, a proposed Joint Statement on Anesthesia Practice, drafted by ASA leadership and AANA, was overwhelmingly rejected by the ASA Board for

containing too many flaws and overstating the role of nurse anesthetists. AANA's recent contrariness did not help matters.

Pulse Oximetry and End-Tidal CO2 Alarms

With encouragement from the Anesthesia Patient Safety Foundation (APSF), the ASA Board of Directors approved two recommendations from the Committee on Standards of Care chaired by former CSA President Jack Moore, M.D. In response to numerous episodes of adverse outcomes when pulse oximeters have been silenced or when alarms for pulse oximeters and/or capnography have been deactivated, two new standards were adopted. Although final approval will require House ratification, the new provisions will state: **“when the pulse oximeter is utilized, the variable pitch tone and the low threshold alarm shall be audible”** and **“when capnography or capnometry is utilized, the alarms shall be audible.”**

The Board also approved language from the Committee on Bylaws, chaired by another former CSA President, Norman Levin, M.D., that would eliminate the Committee on Standards of Care. Because of concern about overlapping responsibilities and lack of consistency in methodology used for determining and promoting standards of practice, the responsibilities of the Committee on Standards will be incorporated into a newly titled Committee on Standards and Practice Parameters.

Practice Parameters

Former ASA President James Ahrens, M.D., presented the report of the Committee on Practice Parameters. Four documents will be submitted to the ASA House of Delegates in October for approval, three of which are new practice parameters and one of which is an updated version. The new proposals are:

- Practice Guidelines for Peri-operative Management of Patients with Obstructive Sleep Apnea.
- Practice Advisory for Peri-operative Visual Loss Associated with Spine Surgery
- Practice Advisory for Intra-operative Awareness and Brain Function Monitoring.

The Advisory on Intra-operative Awareness has garnered the most attention due to the claims of some individuals (equipment vendors) that monitors for depth of anesthesia should be required for all general anesthetics in order to prevent intra-operative awareness under anesthesia. Even analysts on Wall Street have followed this issue closely. In a related report, ASA President Gene Sinclair recommended the allocation of \$500,000 to the Foundation for Anesthesia Education and Research in the form of a restricted grant to “conduct a randomized controlled trial that involves a sufficient number of patients to prove or disprove ... whether brain function monitoring reduces the incidence of awareness under general anesthesia.” The advisory on sleep apnea has also been eagerly anticipated by many ASA members who are seeking guidance on this increasingly more prevalent problem.

The one updated practice parameter is the Practice Guidelines for Blood Transfusion and Adjuvant Therapies. The Board also approved the development of a practice parameter on neuraxial anesthesia. The Guidelines on Obstetrical Anesthesia will be updated.

Credentialing Guidelines

In 2004, the CSA successfully introduced a resolution to the ASA House of Delegates which instructed the ASA to “develop credentialing guidelines specifying the qualifications of individuals who are granted privileges to administer anesthetic drugs to establish a level of moderate or deep sedation.” This issue originated from a CSA task force chaired by CSA President Eddie Canada, M.D., which focused on the appropriate use of propofol. The Committee on Sedation Credentialing Guidelines, chaired by James Hicks, M.D., presented a four-page document for approval. Although the document was well received, the Board referred the guidelines for clarifications on a number of items. If and when approved, this resource will be included in the ASA Manual for Anesthesia Department Organization and Management (the “MADOM”).

In a related report from the Committee on Quality Management and Departmental Administration (QMDA), the Accreditation Association for Ambulatory Health Care (AAAHC) has formally endorsed ASA's statement on the safe use of propofol. Additionally, the American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF) requires that, as a standard for facilities that AAAASF accredits, propofol can be administered only by an anesthesiologist; a CRNA; or an anesthesiology assistant under the supervision of an anesthesiologist. Credit for the adoption of such safety standards goes to those ASA members who have actively participated on the boards of these organizations, especially Jeffrey Apfelbaum, M.D., and former CSA President Thomas Joas, M.D.

Miscellaneous Issues

Other items of interest before the ASA Board included the following:

- ASA annual dues will remain at \$450 for active, \$225 for affiliate, and \$25 for residents
- Monetary support to other organizations such as FAER and APSF will increase by nearly \$500,000 (\$1.5 million to FAER and \$500,000 to APSF)
- The House of Delegates book distributed to ASA delegates and alternate delegates will be organized according to reference committees while retaining the current numbering designations for reports from committees, officers, and directors.
- President-elect Orin (Fred) Guidry, M.D., recommended that the category of educational members for nurse anesthetists be terminated due to lack of interest, there being only seven CRNAs who have joined ASA in this category since its approval in 2003. However, the Board disapproved this action item.

- The Task Force on the Distinguished Service Award, chaired by Mark Warner, M.D., recommended changes to the process of nominating worthy members for this esteemed recognition. The proposal will result in changes to the composition of the DSA committee, a clarification of the eligibility requirements, and a requirement that the committee meet annually for its deliberations.
- Steven Barker, M.D., Ph.D., expressed his frustration in dealing with the leadership of the American College of Emergency Physicians on issues related to airway management and anesthesia in emergency room settings, especially as it relates to the use of propofol by non-anesthesiologists. The issue was referred to the Administrative Council for further action.
- The Committee on Obstetrical Anesthesia chaired by David Birnbach, M.D., reported on ACOG/ASA activity. While ACOG supports ASA's position that labor nurses should be able to adjust dosages on epidural infusion pumps, ACOG has asked ASA to change its guidelines on OB anesthesia, as well as the ASA/ACOG Joint Statement, to reflect their position that it is no longer necessary to have an obstetrician involved in all cases where neuraxial analgesia is provided to a laboring woman. ASA objected to any change, and the issue has been tabled.
- Significant increases in honoraria for the editors of the SEE (Self-Education and Evaluation Program) and ACE (Anesthesiology Continuing Education) were approved. This was in response to changes in the ASA's Travel Reimbursement Policy adopted by the Board in March 2005. Additionally, significant increases in honoraria were approved for editors of the journal *Anesthesiology*. While I support such changes, I believe that other individuals, such as our representatives to the AMA Relative Value Update Committee (RUC), also should be offered honoraria due to their expertise, time away from practice, and immense amount of time in preparation for such representation and liaison activities.
- The Committee on Ethics, chaired by Susan Palmer, M.D., offered a resolution addressing issues that confront anesthesiologists involved in the care of patients presenting for organ donation after cardiac death (DACD). While approving the resolves, the Board felt that the Committee on Ethics as well as the Committee on Transplant Anesthesia should educate members and help members develop guidelines and protocols on this subject.
- The Committee on Occupational Health, chaired by Jonathan Katz, M.D., presented the document titled "Model Department Policy for Drug and Alcohol Testing as Part of a Comprehensive Intervention for Suspected Substance Abuse in Anesthesia Professionals." Although this policy was presented for information only, many members will find it an excellent resource. Former CSA President Stephen Jackson, M.D.,

deserves much credit for the development of this statement, which is nearly identical to the one he successfully championed for adoption by the CSA House of Delegates in 2004.

- The Board approved a resolution which will provide a waiver of dues for one year for ASA members when involved on active duty for at least 90 days in military operations “in support” of actions in Iraq and Afghanistan.

Afternoon Session

The candidates' forum included presentations by members seeking higher office in ASA. Contested elections this year include ASA Secretary Peter Hendricks, M.D., and Jeffrey Apfelbaum, M.D., Chair of QMDA, both seeking the position of ASA First Vice-President (a.k.a. President-Elect-Elect). Additionally, three ASA directors are seeking the job of ASA Assistant Secretary: Arthur Boudreaux, M.D., from Alabama; Murray Kalish, M.D., from Maryland; and Timothy Quill, M.D., from New Hampshire. Each of these individuals made brief presentations and participated in a question and answer format. Mark Lema, M.D., who is running uncontested for ASA President-Elect, also made a brief presentation.

Ronald D. Miller, M.D., from UCSF, presented a very interesting, yet sobering, discussion from the Task Force on Future Paradigms for Anesthesia Practice. Dr. Miller has become a passionate advocate for the ASA to look at the specialty as it will be 20 years from now.

Finally, the members heard a brief overview of state and federal legislative and regulatory issues from ASA's new Director of Governmental and Legal Affairs, Mr. Ronald Szabat, J.D., L.L.M. With the recent signing into law of the Patient Safety Bill, the Society's focus is on the correction of the draconian Medicare teaching rule. In addition, the Society appreciates the opportunity presented to the specialty with the inclusion in the appropriations bill of a reference to “anesthesiology research.” This brief wording creates immense opportunities for desperately needed N.I.H funding in our specialty.

On the state beat, fourteen states have now “opted out” of Medicare's physician supervision requirements, including South Dakota and Wisconsin in 2005. Although Montana “opted in” in March, an outcry from hospital administrators and surgeons in that state, as well as the dissemination of the recently drafted CMS “interpretative guidelines” on the elements of physician supervision, forced Governor Brian Schweitzer to “opt out” again. These guidelines, which were generated by CMS staff without public notice or comment, are not binding, but they infer a very unrealistic standard for what constitutes “immediately available” when the operating practitioner is the one supervising a nurse anesthetist, such as in a rural community.