

Atlanta – A Pleasant Surprise!

The 2005 ASA Annual Meeting

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When it became apparent that the 2005 ASA Annual Meeting could not be held in New Orleans following the tragic and destructive effects on that city by Hurricane Katrina, ASA leadership and staff made extraordinary efforts to ensure that the meeting would indeed be held someplace. Fortunately, the city of Atlanta, Georgia, was able to provide the necessary convention facilities, lecture halls, hotel rooms and other amenities to accommodate the ASA, its members and the various commercial exhibitors. While many individuals were inconvenienced by changes in travel plans, the educational activities, the scientific and commercial exhibits and the House of Delegates meetings were held with few, if any, glitches. Much credit for the success of this meeting goes to then ASA President Gene Sinclair, ASA Executive Director Ronald Bruns and the Park Ridge staff, all of whom understood the importance of preserving what is considered to be the largest and most extensive anesthesia meeting in the world, as well as one of the cornerstone benefits of ASA membership. At last count, 14,305 individuals (5,796 ASA members, 2,336 nonmember physicians, 2,511 spouses and guests, and 3,662 vendors) attended the meeting. Although over 18,000 attended the meeting in Las Vegas in 2004, this number of attendees in Atlanta far exceeded expectations.

The 2005 Annual Meeting was to have been the culmination of a year-long celebration of the 100th anniversary of the ASA. Promoting a theme of “A Century of Advancing Patient Safety,” many celebratory events had been planned to commemorate this event in the New Orleans venue, including a sold-out gala dinner-dance featuring entertainer Jerry Lewis and former CSA and ASA President Peter McDermott as master of ceremonies. Many of these activities have been postponed until the 2006 meeting in Chicago.

Because of the change in venue, the House of Delegates and related meetings needed to be held a day earlier than usual due to the availability of meeting space. Thus the opening session of the House of Delegates and the four reference committees were held on Saturday, October 22; the final House session convened on Tuesday, October 25. The state component and geographic caucuses also met one day earlier than usual, on Friday and Monday afternoons, October 21 and 24. Among the individuals appointed to reference committees

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by Dr. Sinclair were CSA Past President Steven D. Goldfien, M.D., who served on Reference Committee #1, and UCLA Anesthesiology Department Chair Patricia Kapur, M.D., who successfully chaired Reference Committee #2 with great distinction, considering the controversial and complex issues for which its members heard testimony.

Of the 354 voting members of the House, CSA remains the largest delegation with 27 delegates and one director. While there were several issues identified during the first meeting of the California caucus, there was considerable interest in the controversial issue of "Pay for Performance." P4P has been proposed by the Bush administration and some members of Congress as an incentive to America's physicians to secure positive updates in the Medicare fee schedule. ASA leadership has attempted to find ways by which anesthesiologists can benefit from such financial incentives should CMS adopt them. However, delegates from the CSA, appreciating the long-term disadvantages of P4P, adopted a near unanimous position to oppose any linkage of physician payment to quality improvement indicators. During the subsequent meeting of the 14-state Western Caucus, the focus of the meeting was principally on candidate development for ASA officer positions as well as on electronic communications within the caucus. Caucus endorsement of candidates for ASA office will be based on a two-thirds affirmation of those members present, voting by means of a secret ballot. Future communications within the caucus, including dissemination of meeting announcements and minutes, will be done via the Western Caucus listserv. Additionally, a Western Caucus Web Site has been established with the help of Norman Cohen, M.D., of Oregon, which can be visited at: <http://osaonline.org/WC/WesternCaucusWebsite.html>.

Ten resolutions and 194 reports from officers, directors, committees, and task forces constituted the business of the House. Many of these items have been discussed in previous reports from your ASA director as part of the periodic summaries on the meetings of the ASA Board of Directors. Some issues remain controversial or were modified by action of the HOD and thus warrant your attention.

Credentialing Guidelines

This issue originated with a resolution from CSA in 2004 that called for 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.**" In the initial report to the ASA Board in August 2005, the draft guidelines proposed by the ad hoc Committee on Sedation Credentialing Guidelines for Non-anesthesiologists were referred back to that committee for refinement. The revised document presented to the

House generated additional concerns during reference committee testimony, specifically that such guidelines should not address deep sedation. Through the efforts of Dr. Kapur's reference committee, a final revision, "Credentialing Guidelines for Practitioners Who Are Not Anesthesia Professionals to Administer Anesthesia Drugs to Establish a Level of **Moderate Sedation**," was presented to the House. Despite numerous attempts to derail or wordsmith this document on the House floor, delegates recognized the urgent need for a strong statement on moderate sedation and approved it overwhelmingly. The issue of credentialing nonanesthesia-trained practitioners for **deep sedation** privileges remains controversial and was thus referred to a committee of the president's choice. These guidelines on moderate sedation are far from perfect, but they do provide a realistic template for practitioners who need to address such credentialing issues in their practice settings. See the final version at <http://www.asahq.org/publicationsAndServices/credentialing.pdf>.

Standards of Care

Following recommendations that originated from the Anesthesia Patient Safety Foundation, and which were presented by the Committee on Standards of Care, the House adopted revised standards of care, which address the monitoring of patient oxygenation and ventilation. These revisions were proposed to respond to a number of adverse events in which the volume on the pulse oximeter and/or the end-tidal CO₂ alarms was muted. The revised standards now state (new language in italics):

Standard II Oxygenation Methods

Blood oxygenation: During all anesthetics, a quantitative method of assessing oxygenation such as pulse oximetry shall be employed.* *When the pulse oximeter is utilized, the variable pitch pulse tone and the low threshold alarm shall be audible to the anesthesiologist or the anesthesia care team personnel.*** Adequate illumination and exposure of the patient are necessary to assess color.

Ventilation Methods

When an endotracheal tube or laryngeal mask is inserted, its correct positioning must be verified by clinical assessment and by identification of carbon dioxide in the expired gas. Continual end-tidal carbon dioxide analysis, in use from the time of endotracheal tube/laryngeal mask placement, until extubation/removal or initiating transfer to a post-operative care location, shall be performed using a quantitative method such as capnography, capnometry, or mass spectroscopy.* *When capnography or capnometry is utilized, the end tidal CO₂ alarm shall be audible to the anesthesiologist or the anesthesia care team personnel.***

Practice Parameters

Three new practice parameters were adopted by the House of Delegates. They are:

1. Practice Guidelines for Perioperative Management of Patients with Obstructive Sleep Apnea.
2. Practice Advisory for Perioperative Visual Loss Associated with Spine Surgery.
3. Practice Advisory for Intraoperative Awareness and Brain Function Monitoring.

To everyone's surprise, there was little testimony at the reference committee in opposition to the controversial issue of brain function monitoring. Although eagerly awaited by many practitioners, much of the credit for the development of the obstructive sleep apnea guidelines belongs to Jonathan Benumof, M.D., of UCSD, who has long advocated for a more intensive and cautious approach in the management of such patients. These new practice parameters can now be found on the ASA Web Site.

Pay For Performance (P4P)

The issue of P4P was on the agenda as an "information only" item from the Division of Professional Affairs. Despite that fact, there was considerable discussion about the issue. Alexander A. Hannenberg, M.D., ASA Vice President for Professional Affairs, has taken the lead in identifying areas where quality incentive measures could be applicable to anesthesiologists in a P4P model, specifically in perioperative normothermia, timely administration of antibiotics for surgical prophylaxis, and comprehensive pain management. Even private payers seem to be interested in P4P: In 2004, the Blue Cross/Blue Shield Association approached the ASA about the development of P4P criteria for anesthesiologists. Many physicians in this country remain skeptical about the practicalities and long-term benefits of a P4P process. As currently envisioned, it would more likely benefit those practitioners in large, integrated practice groups, especially primary care practitioners, while leaving solo practitioners in the dust. For anesthesiologists, improvements in morbidity and mortality as well as advances in patient safety strategies are already well documented, but would go unrewarded. Many of these concerns were forcefully articulated at Reference Committee #1 by CSA President-Elect Mark Singleton, M.D., and by CSA Director of District 13 and Vice Chair of Practice Affairs Kenneth Pauker, M.D. It is unfortunate that, in light of diminishing reimbursement for physician services under Medicare, physicians and their representative professional organizations have not more forcefully objected to any linkage of physician payment to outcome measures.

ASA/AANA Facilitated Meetings

During the last two years, the leadership of ASA and the leadership of the American Association of Nurse Anesthetists (AANA) have met periodically in professionally facilitated meetings—referred to as the Thoughtbridge process—in the hope of improving communications and supporting patient care issues of mutual concern with a single voice. At its August meeting, the ASA Board of Directors disapproved a resolution authored by Gerald Maccioli, M.D., the ASA director from North Carolina, which recommended that ASA withdraw from this process due to the egregious behavior and unwarranted accusations by AANA (e.g., lobbying against ASA's efforts to improve Medicare reimbursement for anesthesiology academic programs, an aggressive advertising and media campaign, continued state level efforts to eliminate the physician supervision rule, et cetera). The House expressed its ire on this subject by disapproving Board action, and then approved the original resolve, thus terminating this adventure with the AANA. Future dialogue between ASA and AANA leaders, however, will be allowed at the discretion of the Executive Committee.

Reference Committee Qualifications and Appointments

In the past, members of the reference committees have not necessarily been members of the House of Delegates. Reference committees are considered to be working bodies of the House. They are intended to develop consensus positions based on testimony, and thus more efficiently dispense with the business of the House. Some individuals are of the opinion that only voting members of the House should be members of reference committees. In order to clarify this matter, amended Rules of Order, which would establish such qualifications of reference committee membership beginning in 2006, were presented by ASA Speaker Candace Keller, M.D. At the same time, coincidentally, a resolution co-authored by your ASA director and the ASA director from Texas was introduced which would specify that the speaker, rather than the ASA president, appoint the reference committees (similar to CSA, CMA, and AMA traditions). The House seemed divided on both issues, and thus these items were referred to a committee of the President's choice.

ASA Officers For 2006

President	Orin F (Fred) Guidry, M.D. (La.)
President-Elect	Mark J. Lema, M.D., Ph.D. (N.Y.)
First Vice President	Jeffrey L. Apfelbaum, M.D. (Ill.)
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Secretary	Gregory K. Unruh, M.D. (Kan.)
Assistant Secretary	Arthur M. Boudreaux, M.D. (Ala.)
Treasurer	Roger A. Moore, M.D. (N.J.)
Assistant Treasurer	John M. Zerwas, M.D. (Texas)
Speaker	Candace E. Keller, M.D. (Fla.)
Vice Speaker	John P. Abenstein, M.D. (Minn.)

The two new members of the Administrative Council are Jeffrey Apfelbaum, M.D., who defeated former ASA Secretary Peter Hendricks, M.D., and Arthur Boudreaux, M.D., who waged a successful campaign against Murray Kalish, M.D., ASA Director from Maryland, and Timothy Quill, M.D., ASA Director from New Hampshire. These contested elections were conducted fairly, with vigor and openness, lacking any negativity. The ASA is blessed with able leadership, and any of these candidates would have served the Society with distinction.

Distinguished Service Award

This year the ASA Distinguished Service Award was presented to William D. Owens, M.D., of St. Louis, Missouri. Bill has been a contributor to the specialty in many ways as educator, scientist, clinician, advocate, and leader. He served as President of the ASA from 1997-1998, prior to which he also served as President of the American Board of Anesthesiology. This year, the House of Delegates approved the selection of Jerome H. Modell, M.D., a legendary professor and chair of anesthesiology at the University of Florida Gainesville, to be the recipient of the ASA DSA in 2006.

Final Thoughts

First, Atlanta proved to be a good venue for this meeting, contrary to our experience in 1995. The people were friendly, courteous, and most helpful to us conventioners. The weather was great, the convention center seemed more accessible than before, and the restaurants were excellent. Secondly, thanks to the inspiration of Steve Jackson and my wife, Vicki, I found a few moments to visit the Ebenezer Baptist Church in Atlanta, the place where Dr. Martin Luther King, Jr., was pastor and where he is now buried, and to learn more about the unparalleled history of the civil rights movement in the United States, as it evolved in the South during the 1950s and 1960s. It was a profound and moving experience.

Every man must decide whether he will walk in the light of creative altruism or the darkness of destructive selfishness. This is the judgment. Life's most persistent and urgent question is, What are you doing for others?

— Martin Luther King, Jr.