

If You Can't Stand the Heat— Stay Out of Chicago in August!

ASA Board Meeting, August 2003

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The admonition “If you can't stand the heat, stay out of the kitchen” has often been attributed to the late President Harry S. Truman. Although the politics of the ASA bear no resemblance to those of the former politician from Independence, Missouri, the Annual Meeting of the ASA Board of Directors endured the seasonal heat and humidity of the windy city of Chicago during its gathering at the Westin-O'Hare Hotel on August 16-17, 2003. CSA members in attendance representing their specialty colleagues from California included Dr. H. Douglas Roberts, CSA President; Dr. Linda Mason, CSA President-elect, Dr. Kent Garman, ASA Alternate Director; Dr. Patricia Kapur, Chair of the ASA Section on Education and Research; and yours truly.

Fifty-six reports, 38 of which had action items, from various ASA officers, section leaders, committee and task force chairs, and directors were considered. This expanded agenda was substantially larger than previous years, but the Board was still able to resolve its business in a timely manner.

Western Caucus

Members of the Western Caucus met for two hours early Saturday morning, prior to the convening of the Board review committees. Dr. Randy Maydew, Director from New Mexico and Chair of the Candidates Committee, presented some concepts to improve the identification, selection, and support of caucus members seeking officer positions in the ASA. A sample “candidate evaluation form” to rate prospective candidates anonymously was circulated and discussed at length, as was the concept of “caucus endorsement.” These concepts will be refined and presented to the October meeting of the Western Caucus in San Francisco. This year, there will be two members of the Caucus seeking election or re-election: Dr. Bruce Cullen from Washington state, running unopposed for his fourth term as Vice-President for Scientific Affairs, and Dr. John Zerwas, ASA Director from Texas, who is challenging former CSA member Dr. Jan Ehrenwerth, currently ASA Director from Connecticut, for the office of Assistant Treasurer. ASA Treasurer Dr. Orin (Fred) Guidry remains unopposed in his quest for the office of First Vice-President. Other officers running unopposed are ASA Secretary Dr. Peter Hendricks, ASA Assistant Secretary

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Dr. Greg Unruh, ASA Vice-Speaker Dr. John Abenstein, and Dr. Roger Moore, currently the Assistant Treasurer, who intends to inherit the office of ASA Treasurer. Hoping to become the first occupant of the office of Vice-President for Professional Affairs, Dr. Alex Hannenberg, ASA Director from Massachusetts, is also running unopposed.

The reports and issues considered by the Board at the March or August meetings, whether acted upon or accepted for information, will also be presented to the ASA House of Delegates meeting in October 2003. Some of these items are worthy of mention in this report.

Monitored Anesthesia Care (aka MAC)

The Committee on Economics, chaired by Dr. Hannenberg, presented a lengthy report, much of which contained new codes and base unit values included within the ASA Relative Value Guide. Probably the most significant matter, however, was a revision of ASA's Position on Monitored Anesthesia Care. This revision was expected to garner much controversy, but there was none. Although the document has been totally rewritten, the most significant change within this statement is the declaration that "... if the patient loses consciousness and the ability to respond purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation is required." Previous language stated: "... monitored anesthesia care often includes the administration of doses of medications for which the loss of normal protective reflexes or loss of consciousness is likely. Monitored anesthesia care refers to those clinical situations in which the patient remains able to protect the airway for the majority of the procedure. If, for an extended period of time, the patient is rendered unconscious and/or loses normal protective reflexes, then anesthesia care shall be considered a general anesthetic."

The committee has also recommended the formation of a task force to explore the concept of a transition to reimbursement within the RBRVS methodology, that is, the elimination of ASA RVG base units plus time as a basis for payment for anesthesia services. There has been immense pressure from some key members of the AMA's Relative Value Update Committee (RUC) to totally or partially eliminate "time" as a component for anesthesia reimbursement. Although there has been little support within the Committee on Economics for such a substantive change, it was felt that a fresh, non-biased evaluation outside of the committee would be appropriate.

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Expert Witness Testimony

Inspired by the approach used by the American Association of Neurological Surgeons, the ASA continues to move toward the creation of a peer review mechanism for expert witness testimony. At this meeting, changes to ASA's Bylaws, the Guidelines for Expert Witness Qualifications and Testimony, and ASA's Guidelines for the Ethical Practice of Anesthesiology were approved without objection. A report from the treasurer also detailed the potential financial exposure to the Society should an expelled or sanctioned member seek legal redress in the civil courts. Because legal costs and damages could be extensive and since insurance protection is virtually not available, the annual fiscal impact is estimated to be in the range of \$400,000. The establishment of a dedicated reserve fund for this purpose in the amount of \$2,000,000 was suggested.

Standards of Care

Last year, CSA sponsored a resolution to the ASA House of Delegates, which directed the ASA President to designate a committee of his choice to evaluate the use of general anesthesia during spinal manipulation. After considerable discussion, the Committee on Standards of Care recommended that a task force consisting of a broader representation of interests be appointed to address this issue. The Board disapproved this recommendation as many members believe that providing anesthesia for chiropractic manipulation is never justified. Rather than take a position on the subject, some individuals would rather see the subject go away.

In their periodic review of various statements on standards of care, the committee offered a number of changes, some of which were rejected by the Board for being excessive. The Standards for Basic Anesthesia Monitoring are the most explicit requirements for the practicing anesthesiologist, specifying certain kinds of monitoring that "shall" or "must" be used during the administration of anesthesia. However, the suggested addition of the sentence "During regional anesthesia and monitored anesthesia care... the continual monitoring for the presence of expired carbon dioxide is strongly encouraged" was not supported by the Board. While many anesthesiologists use such monitoring, there was not strong support for mandating this for all regional and MAC anesthetics, and thus an ambiguity could result with the words "strongly encouraged."

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Pediatric Anesthesia

The CSA's recently adopted Policy on Pediatric Anesthesia was presented to the ASA Board as an "information only" report. Hopefully, other state component societies will be inspired to adopt similar provisions. There was little comment offered during review committee testimony, the only concern from one member being whether acceptance of this report would constitute an endorsement of CSA's policy. The simple answer is "no."

In a related report, the Committee on Quality Management and Departmental Administration recommended affirmation or revisions to seven existing documents. Chaired by Dr. Jeffrey Apfelbaum, the committee attempted to address the pediatric issue by revising the document titled "The Organization of an Anesthesia Department." Initial attempts to address pediatric anesthesia led to a broader statement which could apply to many types of surgical services within a hospital. The added sentence states: **"This should include the development and maintenance of a written policy defining the peri-operative care of patients that may appropriately be provided in the facility based upon consideration of age, risk categories, proposed procedure, and facility equipment and nursing capabilities."** This new language was approved by the Board.

Bylaws

In an attempt to improve representation of the academic anesthesia community, Bylaw changes were approved which will provide a member on the ASA Board representing the Society of Academic Anesthesiology Chairs (SAAC) as well as the establishment of a Committee on Academic Anesthesiology. The other significant change is the expansion of the Educational Member category, currently open to anesthesiology assistants, to include CRNAs and student CRNAs.

Foundation Support

From year to year, the ASA has demonstrated a continuing financial commitment totaling \$1,850,000 annually to support its three foundations: the Anesthesia Patient Safety Foundation (\$400,000), the Foundation for Anesthesia Education and Research (\$1,050,000), and the Wood-Library-Museum (\$400,000). Much of this money has been funneled into respective endowment funds with the expectation that these foundations would eventually be self-

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supporting. Recently, concern has been raised as to whether the foundations could ever achieve financial independence. There is also the belief that the missions of the foundations serve an important role for the Society as well as for individual anesthesiologists. In a report from the Section on Fiscal Affairs, it was recommended that administrative procedures be developed which would reflect that the foundations should not become independent of the ASA, that the ASA should underwrite the expenses of the foundations as a line item on the annual budget, and that the endowments for each foundation should be allowed to grow, but not be relied upon for long-term survival.

Budget

The budget for the year 2004 was approved even though it projects a \$705,375 deficit. Dues will remain unchanged at \$450 for active members and \$225 for affiliate and educational members. A deficit budget should ordinarily raise concerns, but Board members were reassured by the income and expense statement for the year 2002 that reported a net gain of \$1,291,488.

Propofol

The Committee on Ambulatory Surgical Care reported that, in some practice settings such as gastrointestinal endoscopy suites, propofol is being administered for sedation by non-anesthesia providers, usually by a "sedation nurse" supervised by the procedural physician. In promoting a safe environment for its use, the committee has expressed "... that whenever propofol is used, for general anesthesia or sedation, it should be administered only by persons trained in the administration of general anesthesia. It is important that these persons are not simultaneously involved in the conduct of the surgical or diagnostic procedure." Similar language regarding propofol is contained in the Physicians Desk Reference.

Afternoon Session

Traditionally, following the review committee hearings, two hours in the late afternoon are dedicated to various presentations on relevant subjects, a candidates forum, and a review of current legislative issues. Dr. Jeffrey Balsler of Vanderbilt University Medical School described a very successful program designed to attract and support young academic anesthesiologists in their pursuit of basic or clinical research careers. Dr. Mark Warner of the Mayo Clinic discussed the proposed four-year curriculum for residents in anesthesiology, which would begin in the PGY1 year, has a greater emphasis on training

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in critical care medicine, and calls for fewer months doing surgical anesthesia. The new program has received approval from the American Board of Anesthesiology and the Resident Review Committee. Input from program directors is now being sought. Implementation is anticipated by the year 2008.

In the legislative arena, medical liability reform remains a priority issue for the House of Medicine. HR5, modeled after California's MICRA law, but which differs by providing limited liability protection for pharmaceuticals, medical equipment manufacturers, and health insurance companies, successfully passed the House of Representatives in March. Supporters of the companion Senate bill, S.11, were unable to bring that bill to the Senate floor for a vote. So tort reform on the federal level remains in limbo. Meanwhile, several states, including Arkansas, Idaho, Oklahoma, Texas, and West Virginia, have adopted some version of the MICRA model with caps on non-economic damages in the \$250,000 range.

Physician reimbursement under Medicare, according to the existing flawed methodology, is anticipated to result in a 4.2-4.9% reduction in fees in 2004. Proponents in the House are lobbying for a 1.5% positive increase in 2004 and 2005 to be contained in the Medicare prescription drug and modernization bills.

On the issue of "opt out" of the federal requirement for physician supervision of nurse anesthetists, only the state of Kansas has officially opted out this year. To date, seven states—Iowa, Nebraska, Idaho, Minnesota, New Hampshire, New Mexico, and Kansas—have done so. The states of Kentucky, Wyoming, Missouri, Ohio, and Texas have explicitly stated that they will not opt out. Colorado and Montana have indicated that they intend to exercise the opt-out provision, but they have since become involved in litigation that has prevented any opt-out.