

“Whatever Happens in Vegas, ...”

The ASA Annual Meeting

By R. Lawrence Sullivan, Jr., M.D., ASA Director California

For the first time in nearly 15 years, the ASA Annual Meeting convened in Las Vegas from October 23-27, 2004. With the Las Vegas Hilton Hotel serving as the site for the Annual Meeting of the House of Delegates, close proximity to the adjacent Las Vegas Convention Center provided easy access to lectures, workshops, panels, and the Exhibit Hall. For many attendees, this venue offered not only an excellent educational program, but the irresistible lure of outstanding shows, world-class restaurants, replicas of world landmarks (such as the canals of Venice, the pyramids, and the Eiffel Tower) and innumerable gambling opportunities. As an indication of how popular this venue is to many individuals, the attendance was pegged at 18,849, an ASA record (7,705 members, 1,635 non-member physicians, 3,924 spouses and guests, 3,675 exhibitors, and 1,520 nurse anesthetists, anesthesiologist assistants, or non-physician health professionals).

The vast array of exceptional educational opportunities continues to be the heart and soul of this meeting—refresher course lectures (150), problem based learning discussions (280), panels, clinical forums, workshops (including cadaver and difficult airway sessions), and basic science reviews. This year, two “subspecialty tracks” were offered, each lasting two days and encompassing some of the aforementioned lectures. The subspecialty tracks were in critical care medicine and obstetric anesthesia. As was inaugurated last year, in order to receive CME credits for attending this meeting, registrants needed to submit an attendance verification form and then fill out another form to be submitted at the end of the session attesting to which activities had been attended. On the basis of this information, the appropriate number of CME hours will then be credited to each registrant.

The ASA House of Delegates met in formal sessions on Sunday morning, October 24th, and again on Wednesday morning, October 27th. This year there were 389 members of the House, 348 of whom were voting members (ten officers, 55 directors, 276 delegates, and seven subspecialty delegates) and 41 non-voting members, most of whom are past presidents of the Society. With a growing CSA membership, California’s delegation to the House increased by two to 27, still the largest of all the state components. More importantly, the California delegation demonstrated unusual vigor this year, providing considerable testimony before the various reference committees. In all, 205 reports from officers, directors, section chairs, committees, task forces and foundations, as well as formal resolutions,

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constituted the actionable items of business for the House. Each of these reports were distributed to the members of the House at least two weeks in advance, and they were then open for discussion at one of the reference committees on Sunday afternoon. Any ASA member, not just delegates, is entitled to testify in the reference committee format. Usually, four reference committees, with seven individuals each, are appointed to hear testimony on the issues. They then adjourn to formulate a report recommending what kind of action (e.g., approval, disapproval, amend, refer, et cetera) should be taken by the House on each report. This year, President Roger Litwiller appointed a fifth reference committee to consider the most significant and controversial report: the report from the Task Force to Study Payment Methodology. CSA delegates serving on reference committees this year included Patricia A. Dailey, M.D., and J. Kent Garman, M.D.

On Saturday afternoon, October 23rd, the day prior to the opening of the House of Delegates, delegates from the CSA met in caucus to consider those reports which were expected to be controversial, and to try to achieve a consensus within the delegation. Joining the CSA caucus were other Californians attending the Annual Meeting including alternate delegates, residents, CSA staff, as well as two former ASA and CSA Presidents, John Haddox, M.D., and Peter McDermott, M.D., Ph.D. Immediately following the CSA Caucus, the California delegation met with other state component members of the Western Caucus, one of five geographic caucuses within the ASA—the others being Mid-Atlantic, Midwest, New England, and Southern. The Western Caucus is the largest both in number (fourteen states, 72 delegates, 14 directors—84 voting members) and geographic breadth (from Texas to Montana to the Rockies and the Pacific Ocean). These caucuses met again on Tuesday afternoon, October 26th, to review the recommendations of the reference committees prior to their formal presentation to the House on Wednesday.

Most of the pertinent reports to the House were previously included in the report covering the ASA Annual Meeting of the Board of Directors held in August 2004. However, some items are new or updated pieces of information, and thus warrant a more detailed report.

ASA Centennial. The ASA considers its origins to be the Long Island Society of Anesthetists which was founded in 1905. Embracing a theme of “A Century of Advancing Patient Safety,” the meeting in Las Vegas served as a kickoff for a year long celebration of the ASA’s Centennial. Among the activities are the publication of a book on the history of the ASA coordinated through the Wood Library (available at the 2005 meeting), a videotape/DVD on the history of the ASA, a special traveling exhibit designed for use at state component meetings, a special Commemorative issue of the *ASA Newsletter*, and a gala social event at

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the 2005 ASA Annual Meeting in New Orleans. Additionally, commemorative items such as mugs, pens, polo or dress shirts, and lab coats embellished with the centennial logo can be purchased through ASA’s Centennial Online Store on the ASA Web Site (www.ASAhq.org). The ASA will also use this occasion as a fundraising opportunity for its four foundations (Foundation for Anesthesia Education and Research, Anesthesia Patient Safety Foundation, Wood Library-Museum, and the Anesthesia Memorial Foundation).

Task Force to Study Payment Methodology. In 2003, the House approved a recommendation from the Committee on Economics that authorized the President of the ASA to appoint a task force to “study the relationship of anesthesiology’s payment methodology to the Resource Based Relative Value System (RBRVS).” This potential change in direction is a result of the frustration experienced by ASA in its inability to secure improved reimbursement for anesthesia services from Medicare, especially in light of the increasing use of the RBRVS-based Medicare payment rates and policies by private payers (for example, the anticipated use of RBRVS for Workers’ Compensation claims in California, scheduled to be adopted in 2006). Additionally, representatives from the Centers of Medicare and Medicaid Services (CMS) as well as the AMA’s Specialty Society Relative Value Update Committee (the “RUC”) have implied that ASA’s inability to secure improved payment for anesthesia services is a result of such reimbursement methodology not being fully integrated within RBRVS. An extensive report by the chair of the Task Force, L. Charles (Chuck) Novak, M.D., outlined the history of anesthesia payment methodology, the adoption and implementation of the RBRVS-based Medicare Fee Schedule (MFS) in 1992, the catastrophic reduction of the anesthesia conversion factor from \$19.27 to \$13.94 with the MFS implementation, potential alternatives to the current time-based system, and the impact that any change would have on existing commercial reimbursements, multiple surgical procedures, and academic practices. Although the Task Force did not offer a consensus “recommend,” it did put forth a resolution as a basis for discussion. The payment methodology that would most likely be proposed, when and if a transition to RBRVS should ever be approved, is one that would use a flat fee, non time-based methodology. The 250 codes in the time-based ASA Relative Value Guide (RVG) would be abandoned in favor of an estimated 1,500 codes which would cover most of the 5,000 CPT procedure codes. Any transition to RBRVS would be predicated on maintaining current levels of reimbursement, although many ASA members fear that any change in payment methodology would result in significant losses to anesthesiologists.

Testimony on this issue before the special Reference Committee No. 5 lasted over three hours. Although not hostile, there was overwhelming support for retaining the current time-based system. Many practitioners have had recent success in

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contracting for improved payment, such that Medicare now constitutes a smaller fraction of their reimbursement. Yet, testimony was also heard on the importance of investigating reimbursement alternatives for anesthesiology should health care delivery in this country change drastically. Any such change would presumably adopt the RBRVS methodology. Upon the recommendation of the reference committee, this issue was referred back to an ad hoc committee of the President's choice for further study. A follow-up report is expected at the 2005 House of Delegates. (See a detailed article on anesthesia reimbursement by J. Kent Garman, M.D., M.S., F.A.C.C., on page 34.)

Propofol Use by Non-Anesthesia Trained Persons. There has been great concern among anesthesiologists about the use of propofol by persons (physicians and nurses) not trained in the administration of general anesthetics for the purpose of "sedation" for gastrointestinal endoscopies, cardiac catheterization procedures, or emergency room needs, usually at deep levels of sedation or even transitioning into general anesthesia. As was reported in the previous edition of the *CSA Bulletin*, the ASA Committee on Ambulatory Surgical Care drafted a document titled "Statement on the Safe Use of Propofol." This document was approved by the House without change. It can be found on the ASA Web Site (www.ASAhq.org).

Addressing the related theme of the practice of anesthesiology by non-anesthesiologists, the Committee on Patient Safety and Risk Management, chaired by Steven J. Barker, Ph.D., M.D., of the University of Arizona, expressed the serious concerns of the committee on this issue. It is the committee's intent to explore this issue during the coming year, specifically to determine the extent of this practice, how anesthesia departments are involved in credentialing and in quality assurance activities in such situations, and how such departments remain compliant with JCAHO requirements in this area.

Standards Regarding Ventilation. Current ASA standards require the use of capnography for the intubated, anesthetized patient as well as for the patient in whom a laryngeal mask airway (LMA) has been placed. Over the years, there have been multiple, but unsuccessful, attempts by some ASA members to have this standard of capnography apply when a patient has a regional anesthetic or monitored anesthesia care (MAC). Because the above referenced document on the safe use of propofol by non-anesthesia personnel recommends that the "... monitoring for the presence of exhaled carbon dioxide should be utilized when possible..." it was felt by the Committee on Standards of Care that ASA's Standards for Basic Anesthesia Monitoring should be more consistent with that recommendation. Based on proposed language from that committee, chaired by former CSA President Jack Moore, M.D., as amended by the House, the revised

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standard that addresses the adequacy of ventilation in such patients will now state: “During regional anesthesia and monitored anesthesia care, the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and/or monitoring for the presence of exhaled carbon dioxide.”

Spinal Manipulation under Anesthesia. For two years, this subject has been on ASA’s agenda. In 2003, the House authorized the ASA President to appoint a task force with representation from various committees. Because of the controversial nature of this issue and the difficulty in identifying scientifically valid information on the subject, no conclusions or recommendations have come forth. However, there remains much skepticism about any legitimate medical indications and patient safety regarding spinal manipulation under anesthesia. Both the Task Force to Study Spinal Manipulation under General Anesthesia, as well as the Committee on Standards of Care, recommended that the Committee on Practice Parameters be requested to draft a “Practice Alert” on this procedure. (Under ASA Policy, Practice Parameters include: “practice standards” which are rules or minimums for clinical practice; “practice guidelines” which are “systematically developed recommendations;” “practice advisories” which are “... reports that are intended to assist decision making... but where scientific evidence is insufficient;” and “practice alerts” which are designed to “... facilitate practitioner awareness of a specific problem... .”) It is anticipated that this Practice Alert will be published in the *ASA Newsletter*.

Practice Advisory and Awareness Under Anesthesia. The House of Delegates approved the Practice Advisory for the Perioperative Management of Patients with Cardiac Rhythm Management Devices. This may be found on the ASA Web Site. On the subject of awareness under general anesthesia, a Task Force on Brain Function Monitoring and Intraoperative Awareness, chaired by Jeffrey Apfelbaum, M.D., of the University of Chicago, has been appointed. Because there has been much controversy on this subject, especially the marketing strategies of some commercial vendors whose goal is to have such monitoring mandated for every anesthetic, the ASA has appointed this panel to study the scientific basis for the use of such devices. A report is expected to be submitted to the House in 2005.

Bylaws Changes. Compared to last year’s wholesale revision of the ASA Bylaws, few changes were made at this meeting. Of note was the approval of a permanent Committee on Anesthesiologist Assistant Education and Practice. Attempts to define voting privileges for ASA resident members who have been appointed to an ASA committee was postponed until the Bylaws Committee can clarify voting rights of active and adjunct members serving on ASA Committees.

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ASA Officers for 2005:

President	Eugene P. Sinclair, M.D. (Wisconsin)
President-elect	Orin (Fred) Guidry, M.D. (Louisiana)
First Vice-President	Mark Lema, M. D. (New York)
Vice-President for Scientific Affairs	Charles (Chuck) Otto, M. D. (Arizona)
Vice-President for Professional Affairs	Alexander Hannenber g, M.D. (Mass)
Secretary	Peter Hendricks, M.D. (Alabama)
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Treasurer	Roger Moore, M.D. (New Jersey)
Assistant Treasurer	John Zerwas, M. D. (Texas)
Speaker	Candace Kellar, M. D. (New Mexico)
Vice-Speaker	John Abenstein, M.D. (Minnesota)

The two new members of the Administrative Council are Mark Lema, M.D., who ran unopposed for First Vice-President, and Charles (Chuck) Otto, M.D., who was successful in a very hotly contested election for Vice-President for Scientific Affairs involving two other, equally qualified individuals who have contributed immensely to the Specialty and to the ASA, Arnold Berry, M.D., of Emory University and Roberta Hines, M.D., of Yale.

Distinguished Service Award. This year the ASA Distinguished Service Award was presented to Robert Stoelting, M.D., former ASA Vice-President for Scientific Affairs, former chair of the Department of Anesthesiology at the University of Indiana School of Medicine, and the current President of the Anesthesia Patient Safety Foundation. The House voted to award the 2005 DSA to William D. Owens, M.D., former President of the ASA and the American Board of Anesthesiology.

CSA members who serve as delegates to the ASA House of Delegates spend considerable time preparing for and attending caucuses, reference committees, the House of Delegates, and, for many, ASA committees to which they have been appointed. There remains little time for attending many of the outstanding educational activities. Many thanks to them for their energy and advocacy on behalf of their colleagues and their patients. And as the flight attendant admonished upon landing in Nevada, “Remember! Whatever happens in Vegas, stays in Vegas!”