ASA Annual Meeting, Marc Chagall, and The Blue Angels

San Francisco 2003

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

This year, San Francisco played host to the 2003 ASA Annual Meeting, headquartered at the Marriott Hotel and the adjoining Moscone Convention Center, from October 11-15. Over 17,000 anesthesiologists, assorted spouses, guests, and innumerable exhibitors of anesthesia-related wares flocked to the "City by the Bay" to participate in the largest meeting of its kind in the world. Although San Francisco is renowned for its typical "Indian Summer Weather" in October, the unusually balmy conditions made it difficult for registrants to spend all of their time soaking up CME credits in crowded lecture halls. An additional distraction was the Navy's Fleet Week activities, featuring a parade on the bay of modern warships and a waterfront demonstration of high performance military aircraft, including the Blue Angels, whose afterburners thundered overhead and resounded through the bowels of the Moscone Center. For those more interested in "cultural" activities, the San Francisco Museum of Modern Art (SFMOMA), located across the street from the convention center, was offering a spectacular and extensive exhibit of the works of the famous Russian-French twentieth century impressionist artist Marc Chagall.

Each year, the ASA Annual Meeting provides an opportunity for educational refreshment and scientific stimulation, via lectures on a broad range of anesthesia-related subjects, as well as reports of research activities from American and foreign academic anesthesia institutions. In past years, registrants to the Annual Meeting were automatically given a certificate worth as many as 45 CME credits. No more! Only Superman or Rosie Ruiz could have been at so many places at one time! While electronic verification of attendance at each activity has not been adopted, registrants must now submit an attendance verification form and then fill out an "honor system" 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 is then credited to each registrant.

It is also at this meeting that the ASA's representative body, the House of Delegates, reviews the activities of its officers, the Board, and multiple

committees and task forces during the past year. Reports are presented and often debated in reference committee settings before final adjudication by the House. This year, the number of delegates seated in the House increased by 28 as a reflection of the new composition of the Board of Directors, with each state component now having one director. The ASA House of Delegates thus consists of 333 voting members (9 officers, 52 directors, 265 delegates, and 7 specialty delegates) and 37 non-voting members. Also this year, the CSA was awarded one additional delegate because of its increase in membership, there now being 25 members in the California delegation (24 delegates and one director), still the largest delegation in the House.

Western Caucus. The caucus system in the ASA provides an opportunity to discuss relevant issues to be considered by the House in the hope of generating support from other delegates on particular issues. It also has been a forum to nurture and support candidates for ASA higher office. Because the Western Caucus is the largest caucus both in the number of delegates and in geographic breadth, and because of the immense diversity in modes of practice and political viewpoints, it has been difficult for the Caucus members to develop consensus, especially when supporting officer candidates. Following last year's election debacle, the Western Caucus has now adopted a new mechanism to identify and objectively critique (on an anonymous basis) potential candidates for ASA office, ideally a few years in advance. This new mechanism involves the completion of a "Candidate Evaluation Form" which looks at an individual's qualifications, leadership and communication skills, presence, and potential for "highest" office. The concept of "endorsement" of a candidate by the caucus has also been defined to mean a two-thirds majority of those caucus members voting on a secret ballot.

The House met in formal sessions on Sunday morning, October 12th, and again on Wednesday, October 15th. Two hundred nine reports from the officers, section chairs, committees, and the foundations constituted the business of the House of Delegates. Each item was available for discussion on Sunday afternoon before one of four reference committees to which that item was assigned. *Any ASA member, not just a delegate, is entitled to attend the reference committee hearings and offer comment on any report on the agenda.* Following the conclusion of testimony, each of the seven member reference committees adjourned into "executive session" to compile their consensus reports. The reports of the reference committees were presented to the House at its final session, where all items of business were disposed of

by approval, disapproval, amendment, or referral. While most reports or issues were not contentious or controversial, some of them deserve to be mentioned.

Designation of the Operating Room as a Secure Area. This was the title of an emergency resolution introduced by ASA Delegate Mark Singleton, M.D. Mark has been instrumental in the CSA's agreement with the California Department of Health Services (DHS) on the locked cart issue. This resolution was presented at the last minute because of the reported experience of a Southern California hospital which, during an accreditation survey, was cited for failure to lock anesthesia carts in between surgical cases, thus violating standards adopted by the Center for Medicare and Medicaid Services (CMS). This action was contrary to the understanding reached with DHS. Because the CMS position on locked carts is new, it was felt by Mark and others that it was essential that ASA adopt and promulgate the position that the operating room is a secure environment. Testimony at the reference committee was overwhelmingly in favor of this concept. This position will be developed in depth by the Committee on Quality Management and Departmental Administration, and then referred to the Executive Committee for urgent action. (See the full text of the "ASA Position on Security of Medications in the Operating Room" on p. 30.) *Congratulations to Mark Singleton, M.D., for his persistence and political acumen in developing this important issue.*

Standardization of Pharmaceutical Packaging. Another resolution from California, titled "Standardization of Pharmaceutical Packaging," and authored by ASA Alternate Delegate Johnathan Pregler, M.D., also received support from the ASA House. While there have been similar attempts to achieve such standardization in the past, little has happened. This issue will be sent to a committee of the President's choice, with input to be sought from the Anesthesia Patient Safety Foundation.

Spinal Manipulation under Anesthesia. There have been increased reports of the use of general or sedation anesthesia to facilitate spinal manipulation by chiropractors or osteopathic physicians, especially in California. Last year, the CSA submitted a resolution calling for the ASA "… to evaluate the issue of spinal manipulation under anesthesia, and that practice recommendations … be established. …" The Committee on Standards, to which this issue was assigned, and which was chaired by former CSA

President Jack Moore, M.D., recommended that a task force with broader representation from other committees, such as Professional Liability, Pain, and Patient Safety and Risk Management, be appointed to consider this controversial subject. The ASA Board of Directors, however, decided to disapprove that recommendation, such disapproval (if it were to be upheld by the House) resulting in permanently tabling the matter. After much testimony by concerned members, the reference committee supported the creation of a task force, and, likewise, this recommendation was approved by the House. Expect to hear more on this topic next year.

Expert Witness Testimony. In response to growing concerns regarding the increasing instances of irresponsible and inaccurate expert witness testimony offered by its members, Roger Litwiller, M.D., ASA's newly installed President, has carefully yet deliberately proposed amendments to the Bylaws, the Administrative Procedures, the Guidelines for Expert Witness Qualifications and Testimony, and the Guidelines for the Ethical Practice of Anesthesiology to address this outrageous problem. With House approval, ASA will now establish a program to monitor and respond to such allegations of irresponsible testimony by its members. Noncompliance with the ASA's Expert Witness Testimony Guidelines could result in sanctions being imposed on an accused member, including censure, suspension, or expulsion from the Society. To financially support this endeavor, $200,000 will annually be set aside in each of two funds (total $400,000) which will support the operating costs of this program, and which will provide a fund against potential liability costs.

Noncompliance with the ASA's Expert Witness Testimony Guidelines could result in sanctions being imposed on an accused member, including censure, suspension, or expulsion from the Society.

Monitored Anesthesia Care (MAC). As reported in the previous edition of the *CSA Bulletin*, the Committee on Economics recommended a change to the ASA Position on Monitored Anesthesia Care (which can be found in the ASA Relative Value Guide). See page 28 for the complete text.

There being no objection by the House, this statement now declares, among other things, 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." As surgeons, nurses, and even anesthesiologists have sometimes casually referred to "Big MAC" and "Little MAC" anesthetics, it is important that the critical role that the anesthesiologist plays in ensuring patient safety and comfort is not trivialized or undervalued. Because Medicare and other payers, who often follow Medicare's lead, have repeatedly questioned the appropriateness of "MAC" services, it is important that the definition of general anesthesia versus various sedation techniques be clarified. Likewise, the role of the anesthesiologist when providing sedation anesthesia needs to be differentiated from the "conscious (moderate) sedation" techniques provided by the surgeon or proceduralist.

Anesthesia by Non-Anesthesiologists. Two reports, one from the Committee on Patient Safety and Risk Management, the other from the Committee on Ambulatory Surgical Care, reflect the growing concern about the increasing trend for the administration of general anesthesia by physicians not trained in anesthesiology, usually in acute care settings, such as emergency departments, intensive care units, and diagnostic procedural situations. The ramifications of such practices are many and include credentialing issues, JCAHO standards, oversight responsibilities of anesthesia department chairs, and, most importantly, patient safety. Much of this problem has been driven by the presumed safety of propofol and the improved skills by some other specialists in airway management. However, the list of adverse events continues to grow. The House has directed the ASA President to refer this matter to a committee of his choice.

ACE Program. Most ASA members are quite familiar with the immensely popular Self-Education and Evaluation Program (SEE) to which as many as 5,000 members subscribe each year at a cost of only $200. The focus of this program has been "emerging knowledge," for which 60 hours of Category 1 CME credits are offered. In an effort to address the needs of members facing mandatory re-certification through the American Board of Anesthesiology, the Section on Education and Research, chaired by CSA's Patricia Kapur, M.D., has proposed (and the House has approved) the creation of the Anesthesia Continuing Education Program (ACE). This educational tool will be available beginning in 2004, initially as a paper product, and, eventually, on CD-ROM.

Parity in Medicare Payments. ASA's new Committee on Rural Access to Anesthesia Care, chaired by Mike Schweitzer, Director from Montana, submitted a resolution calling for the ASA to "… support legislation to increase CMS payments to rural physicians and hospitals by adding money to the CMS budget so the rural increases do not decrease urban payments… " There has been broad concern that the Medicare reimbursement methodology discriminates against physicians in rural areas, where physician practice expenses are supposedly less. In fact, this disparity creates a disincentive for physicians in all specialties to serve underserved rural areas. Although the Reference Committee had recommended "referral" of the issue, the members of the House overwhelmingly adopted this resolution, in light of the fact that legislation that would correct this inequity is currently before the Congress. (In December, President Bush signed the Medicare Reform Legislation which contains provisions supporting parity in Medicare for rural physicians.)

ASA Officers for 2004:

President	Roger Litwiller, M.D. (Virginia)
President-elect	Eugene Sinclair, M.D. (Wisconsin)
First Vice-President	Orin (Fred) Guidry, M.D. (Louisiana)
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Speaker	Candace Kellar, M.D. (New Mexico)
Vice-Speaker	John Abenstein, M.D. (Minnesota)

Rebecca Patchin, M.D.—AMA Trustee. During the second session of the House, CSA's Rebecca Patchin was introduced to the assembled delegates. Rebecca was recently successful in her election to the AMA Board of Trustees for a four-year term. (See the July-August 2003 issue of the *Bulletin*.) She is the first physician representing the specialty of anesthesiology to be elected to that prestigious position. With her vast experience in organized medicine, having served on the CSA Board of Directors, as the current Chair of CMA's Council on Legislation, and as

President-elect of the Riverside County Medical Society, Rebecca brings a unique ability to represent the issues impacting anesthesiologists as well as pain specialists.

Distinguished Service Award. This year, the ASA Distinguished Service Award was presented to former ASA President Bernard Wetchler, M.D. The House voted to award the DSA to Robert Stoelting, M.D., in 2004. Dr. Stoelting was Chair of the Department of Anesthesiology at the University of Indiana Medical School, served as Vice-President of Scientific Affairs for the ASA for many years, and currently is President of APSF.

Wright Memorial Lecture. Recognition for greatness in our specialty comes in many ways. Having risen to the pinnacle of his profession, former ASA and CSA President Peter McDermott, M.D., Ph.D., courageously sought new opportunities of stimulation and growth following his career in anesthesiology. Peter recently received his doctorate ("Doctor Doctor McDermott!") in history from the University of California Santa Barbara, and in this process, having become an authority on the seventeenth century English Puritan and colonial administrator in America, Sir Henry Vane (1613-1652). He now is a member of the faculty of California Lutheran University. For those of us who have been lucky enough to hear Peter speak over the years, we all know how fortunate his students are. Peter was honored with the invitation to be the Wright Memorial Lecturer at this year's Annual Meeting. In a presentation titled "Fallacies and Useful Truths: An Overview of History and Science for the Anesthesiologist … or … Lust, Torture and Depravity: The Anatomy of Derangement," Peter was as enlightening, educational, and entertaining as his audience was enthusiastic. Doctor McDermott will remain an inspiration for those of us who seek additional challenges beyond their careers in anesthesiology.

For most of those CSA members who serve as Delegates, the ASA Annual Meeting allows little time for educational activities, what with the many hours spent at caucuses, meetings of the House, reference committee hearings, and innumerable committee meetings. The leadership is aware of this dichotomy and is considering various solutions. In the meantime, we will look for the Blue Angels another time, but I at least did return to San Francisco two weeks later to enjoy the splendors of Marc Chagall.

[**Editor's Note:** I would also like to commend Peter McDermott for his Wright Memorial Lecture lecture as it truly was the most enjoyable and brilliant lecture that I ever have attended—not that I expected any less. Peter's wit is beyond description and we hope to be able to share with our readers some excerpts from his masterpiece in future *Bulletin* issues.]

ASA Position on Monitored Anesthesia Care

Approved by the House of Delegates on October 21, 1986,
and last amended on October 15, 2003

Monitored anesthesia care is a specific anesthesia service for a diagnostic or therapeutic procedure. Indications for monitored anesthesia care include the nature of the procedure, the patient's clinical condition and/or the potential need to convert to a general or regional anesthetic.

Monitored anesthesia care includes all aspects of anesthesia care—a preprocedure visit, intraprocedure care and postprocedure anesthesia management. During monitored anesthesia care, the anesthesiologist provides or medically directs a number of specific services, including but not limited to:

Diagnosis and treatment of clinical problems that occur during the procedure

Support of vital functions

Administration of sedatives, analgesics, hypnotics, anesthetic agents or other medications as necessary for patient safety

Psychological support and physical comfort

Provision of other medical services as needed to complete the procedure safely.

Monitored anesthesia care may include varying levels of sedation, analgesia and anxiolysis as necessary. The provider of monitored anesthesia care must be prepared and qualified to convert to general anesthesia when necessary. **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.**

Monitored anesthesia care is a physician service provided to an individual patient. It should be subject to the same level of reimbursement as general or regional anesthesia. Accordingly, the ASA Relative Value Guide provides for the use of

proper basic procedural units, time units and modifier units as the basis for determining reimbursement.

ASA Position on Monitored Anesthesia Care (Approved by the House of Delegates on October 21, 1986, and last amended on October 15, 2003) is reprinted here with permission of the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, Illinois 60068-2573.

ASA Position on Security of Medications in the Operating Room

Approved by the ASA Executive Committee, October 2003

Preamble

A secure environment of care is needed for medication safety. Medication safety includes the security of oral, sublingual, parenteral, and inhaled drugs used for elective and emergency patient care. A secure area ensures the integrity of anesthesia machines as well as other equipment and materials. Security of medications in the operating room suite is essential for patient safety.

Recommended Policies

1. Access to operating room suites must be strictly limited to authorized persons.

2. All Schedule 3 and 4 narcotic medications must be kept in locked enclosed areas when not under the direct control of an anesthesia professional.

3. Anesthesia professionals must have immediate access to drugs required for emergency patient care. Procedures designed to prevent unauthorized access to such drugs must be consistent with this imperative for patient safety.

4. Anesthesia carts and anesthesia machines may remain unlocked, and non-controlled* medications may be left in or on top of unlocked anesthesia carts or anesthesia machines immediately prior to, during, and immediately following surgical cases in an operating room, so long as there are authorized operating room personnel in the OR suite.

Rationale

A. Because the operating room suite is a limited-access secure location, it is safe practice for anesthesia professionals to leave non-controlled* medications on

the top of their anesthesia carts or anesthesia machines for brief periods (e.g., while going to a nearby holding area to bring a patient into the operating room).

B. At the end of anesthesia cases, when patients are particularly vulnerable, anesthesia professionals dedicate full attention to their patients. This vulnerable period extends from the time the patient emerges from anesthesia until the anesthesia professional transports the patient to a recovery area (e.g., post anesthesia care unit, intensive care unit, et cetera). If drugs are locked up during this vulnerable period, provider access to drugs required for emergency patient care is obstructed. Furthermore, requiring anesthesia professionals to divert attention from patients in order to lock non-controlled* medications in anesthesia carts during the period between emergence from anesthesia and transport of patients out of the operating room jeopardizes patient safety. Therefore, locking non-controlled* medications at this point in the anesthetic should not be required.

C. It is necessary and safe practice for non-controlled* medications to be set up for emergency cases (e.g., in obstetrics and trauma) and made secure in a drawer or cupboard "locked" by a tamper-evident device that can easily be broken by authorized persons. Locks requiring knowledge of a combination or possession of a physical key jeopardize patient safety.

D. It is necessary and safe practice for emergency anesthesia drugs (e.g., dantrolene for the treatment of malignant hyperthermia) to be kept in a dedicated emergency cart or cupboard and made secure ("locked") by a tamper-evident device that can easily be broken by authorized persons. Locks requiring knowledge of a combination or possession of a physical key jeopardize patient safety.

* The term "non-controlled" refers to medications that are not Schedule 3 or 4 narcotics.

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CSA/CMA Legislative Day

The annual CSA/CMA Legislative Day is April 28, 2004, from 7:30 a.m. to 4:30 p.m. CSA members are urged to attend for all or part of the day. The CSA will reimburse 14-day advance coach airfare or mileage to members who are part of the CSA delegation (i.e., not representing a CMA Component Society).

This annual event is a good way to learn the most important issues in medicine in the legislature this year, and to visit your legislator or attend hearings. Please let the CSA office (800-345-3691) know if you are attending so we will know how many tables are needed.

CMA Physician's

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