ASA Interim Board Meeting

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

It seemed ironic to be traveling from the Bay Area, which had been ravaged with a late winter dose of rain, wind and snow, to Chicago, known for harsh winter conditions, but which, though chilly, offered fairly mild weather. Except for one or two issues, such calm conditions set the tone for the Interim Meeting of the ASA Board of Directors, which was held at the Westin O'Hare Hotel on Saturday and Sunday, March 4-5, 2006.

Representing CSA and anesthesiologists in California were CSA President Edgar Canada, M.D., CSA President-Elect Mark Singleton, M.D., ASA Alternate Director Linda Mason, M.D., CSA Treasurer Michael Champeau, M.D., CSA Speaker Linda Hertzberg, M.D., former CSA President Steven Goldfien, M.D., Chair of the ASA Committee on Anesthesiologists Assistant Education and Practice, former CSA President Norman Levin, M.D., Chair of the ASA Committee on Bylaws, former CSA Secretary Patricia Kapur, M.D., Chair of the ASA Scientific Advisory Committee, CSA's CEO Barbara Baldwin, and yours truly. These individuals constituted an uncharacteristically large delegation from one state society. However, because the CSA active and resident members represent nearly 10 percent of the respective membership categories in the ASA, it is important for CSA leaders to have a more visible presence and participation in the political activities and official gatherings of the ASA outside of the Annual Meeting of the House of Delegates.

Western Caucus

Members of the 14 western states constitute the Western Caucus. There has been some concern expressed about adequate time being allotted within the Caucus for discussion of reports during the ASA Annual Meeting. Concern focused on too much time being allowed to candidates for ASA officer positions. Additionally, it was felt that better efficiencies could be adopted in the discussions of reports by using a consent calendar, discussing only extracted items, and having strict time limits.

Looking forward to elections for various ASA offices in October, ASA Treasurer Roger Moore, M.D., of New Jersey will be uncontested in his bid for ASA First Vice-President. ASA Assistant Treasurer John Zerwas, M.D., of Texas will run

for Treasurer and also remains unopposed. Two individuals have declared their candidacy for ASA Assistant Treasurer: Jan Ehrenwerth, M.D., ASA Director from Connecticut, and James Grant, M.D., ASA Director from Michigan. With current ASA First Vice-President Jeffrey Apfelbaum, M.D., moving up as President-Elect in October, there are six other officers, including ASA Vice-President for Scientific Affairs Charles Otto, M.D., of Arizona, who plan to continue in their current positions and who also face no opposition. Of interest is the fact that Dr. Zerwas is running for the lower house of the Texas Legislature. He was the top vote-getter in the Republican primary on March 7, and is expected to win the primary in a run-off on April 11 in a secure Republican district. While the time commitment to the Texas Legislature can be exhaustive, the legislature only meets every two years, and Dr. Zerwas feels that he can continue his commitment as an officer in ASA should he win the election.

Board Reports

Despite there being only 31 items on the agenda, there was copious testimony before the four Board Review Committees on issues of interest. Significant among these items were:

Task Force on House of Delegates Handbook. Chaired by Rodney Osborn, M.D., of Illinois, the Task Force recommended the continuance of a number of changes introduced in 2005 such as the organization of the Handbook by Reference Committee; color coding of reports, and a specific order for board reports; committee, council, and task force reports; and resolutions. The Task Force has recommended that reports for "Information Only" become part of a Speaker's Consent Agenda from which reports can be extracted at the first session of the House, but otherwise testimony on such reports will not be allowed at Reference Committees. Your ASA Director is concerned that such a restricted agenda will not allow adequate opportunity for ASA members who are not members of the House to comment on items of importance to them. Finally, the Task Force recommended that, beginning in August 2006, reports considered at the board meeting be provided only on CD-ROM disks. The Board declared that its members will still be able to request the traditional printed handbook. The transition to an all-electronic format creates many challenges for ASA staff, especially in providing power strips in reference committee meeting rooms.

Credentialing Guidelines for Sedation. In 2005, the ASA House of Delegates approved credentialing guidelines for *moderate* sedation. This document was the result of a resolution from the 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*." Because of concerns about the ramifications of any guidelines addressing *deep* sedation, the 2005 House only approved criteria for *moderate* sedation, and then referred the issue of deep sedation back to the ASA President. In trying to address the issue of *deep* sedation, the Executive Committee presented a document for board approval that, among other things, states: " … that individuals … who are not anesthesia professionals may not recognize that sedation and general anesthesia are on a continuum and thus deliver levels of sedation that are, in fact, general anesthesia without having the training and experience to recognize this state and respond appropriately…" and "…health care organizations should use the same credentialing standards for individuals who are credentialed to administer deep sedation as for those who are credentialed to administer general anesthesia. …" The Board referred this report back to the President with the request that more specific credentialing and privileging criteria be developed for the administration of deep sedation.

House Reference Committee Appointments. At the 2005 ASA House of Delegates, two related issues emerged: the qualifications for appointment to an ASA House of Delegates Reference Committee and who should make such appointments—the ASA President (current practice) or the ASA Speaker (similar to CSA, CMA, and AMA). A task force chaired by former ASA President (and former ASA Speaker) Barry Glazer, M.D., addressed both issues. The Task Force recommended the adoption of the Guidelines for the Appointment of Reference Committees, which have been used by previous ASA presidents but never approved by the House. The guidelines, with some changes proposed by the Task Force, would specify that Reference Committee members need not be members of the House, but should at least have prior House experience; the composition of the Reference Committees reflect the gender, age, geographic, and practice diversity of the membership; a chairperson of a Reference Committee should have previously served on a Reference Committee; Reference Committees shall have seven members; candidates for ASA officer positions not serve on Reference Committees; and the president shall make such appointments, but should also consult with the speaker in making those appointments. While this report was approved by the Board, it must ultimately be adopted by the House. It is your ASA Director's opinion that Reference Committees belong to and are working tools of the House, and thus only voting members of the House should be appointed to them.

Anesthesia Foundation–ASA Hurricane Katrina Disaster Relief. Following the devastation to New Orleans and the Gulf Coast from Hurricane Katrina in late August, the ASA involved itself in two ways. First, the ASA President Gene Sinclair, M.D., established the *Anesthesia Foundation–ASA Hurricane Katrina Disaster Relief Fund* to allow members to designate

contributions to various charities or to the Anesthesia Foundation in the support of anesthesia residents in training who were impacted by the hurricane. A total of $301,243 was collected from 392 donors. Of this amount, $127,743 will have been distributed to designated charities, mostly to the American Red Cross and the Habitat for Humanity. The balance has been directed to the Anesthesia Foundation which has offered grants and low-interest loans to anesthesia residents who have lost their homes and personal belongings.

Amendment of ASA Standards. In a report from the Division of Professional Affairs, it was recommended, and subsequently approved by the Board, that henceforth any new or amended ASA Standards be approved on an "up or down" vote by the House of Delegates, thus avoiding often erroneous "wordsmithing" on the House floor. This provision of the House Rules of Order already applies to the approval of practice parameters and guidelines.

Anesthesiologist Assistants and Regional Anesthesia. The use of anesthesiologist assistants is now codified in twelve states. AAs are intended to be nurse anesthetist equivalents but are regulated by state medical boards rather than nursing boards. They are looked upon as physician assistants to anesthesiologists, and, by definition, require direct supervision by an anesthesiologist. Because of a conflict with the Medical Board in Ohio, the issue was raised whether the use of regional anesthesia by AAs should be regulated by a state medical board or at the discretion of the supervising anesthesiologist. In a report from Steven Goldfien, M.D., Chair of the Committee on AA Education and Practice, it was recommended, and approved by the Board (with some dissension), that "… the performance of regional anesthesia is governed by the ASA Statement on Regional Anesthesia…" and that "… anesthesiologists be given discretion to determine the extent of participation of AAs in the performance of regional anesthesia and invasive monitoring in accordance with their hospital's policies and state's regulations."

Physician Participation in Executions. In February, it was widely reported in the media that two anesthesiologists had been retained to attend the execution of a prisoner at San Quentin for the purpose of assuring a sufficient depth of unconsciousness from thiopental prior to the administration of a lethal dose of pancuronium and potassium chloride. In response to a plethora of comments on the Western Caucus listserv about physician participation in executions, your ASA Director crafted a resolution for the Board addressing this matter, the resolves of which stated:

> **RESOLVED** that the ASA declare its opposition to physician participation in legally authorized executions either by direct action or by performing ancillary functions; and be it further

> **RESOLVED** that the ASA Committee on Ethics be directed to develop amendments to the ASA's Guidelines for the Ethical Practice of Anesthesiology that would specify that it is unethical behavior for an ASA member to participate in a legally authorized execution; and be it further
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> **RESOLVED** that the ASA Committee on Ethics report its recommendations to the ASA House of Delegates at the 2006 Annual Meeting.

The first resolve would merely reaffirm the position that ASA has already stated publicly and placed on the ASA Web Site. The second resolve was intended to have the ASA embrace the AMA Code of Medical Ethics' Current Opinions on Social Policy Issues—Capital Punishment (E-2.06), such "opinion" establishing a strict prohibition of the direct and indirect involvement of physicians in "legally authorized executions." (See the AMA Web Site <http://www.ama_assn.org>.) It was not surprising that there were strong and varied opinions voiced on this subject at the Board Review Committee, most of which related to the role of anesthesiologists as advisors on the use of anesthesia drugs in executions. Your ASA Director was most disappointed that some members do not seem to appreciate that physicians of any specialty are not needed in the execution chamber. There are ample resources for the prison systems that can be found in the literature, from chemists and pharmacologists, and from those who have conducted almost 1,000 such executions over the last 20 years. Anesthesiologists need to remember their sacred trust in preserving life, not terminating it. Worst of all, had the February execution gone forward with two anesthesiologists in attendance, it would have set a precedent which other sentencing judges would likely follow. Because of a lack of consensus on the issue, the resolution was referred to the ASA Committee on Ethics.

Afternoon Session

The afternoon sessions of the Board meeting traditionally include federal and state legislative updates and another subject of interest. Organized by Charles Otto, M.D., the "subject of interest" was titled "Anesthesiology Response to Disaster," a collection of six brief presentations on the Gulf Coast hurricane disaster and the trauma medicine experiences in Iraq.

Hurricane Katrina not only devastated the city of New Orleans, it disrupted two anesthesiology residency programs, Tulane and the Ochsner Clinic, totaling 32 residents and 34 faculties. With the closure of Tulane Hospital, the Tulane anesthesia residents moved to Houston, where the programs there were

able to accommodate them. The Ochsner Clinic has been able to stay open since the hurricane, but the program has been disrupted.

The final panelist presented extremely vivid pictures of the carnage in Iraq. Brian McGlinch, M.D., a military reservist called to active duty at Walter Reed Army Hospital, provided vivid pictures of typical injuries sustained in a war of suicide and car bombs resulting in complex "blast" injuries. A well-synchronized network of field hospitals leading to intermediate care in Bagdad, then Germany, then the U.S., has been effective in salvaging many such injuries using innovative solutions. Anesthesiologists have been key persons in sustaining life in surgical and critical care settings, mostly dealing with issues of massive blood loss.

The legislative update was presented by ASA's Director of Governmental Affairs, Ron Szabat, J.D., and Lisa Percy, J.D., Manager of State Legislative and Regulatory Affairs. At the federal level, ASA's focus this year remains on the Medicare Anesthesia Teaching Rule, which has cost academic departments an average of $400,000 per year in lost revenue; physician payment under Medicare for which Congress has provided another year at 2005 payment rates rather than the 4.4 percent decrease that was expected; positioning the Society for Pay-for-Performance criteria for which it is expected that there will be approximately 140 performance measures for all specialties by the end of 2006; and the Medicare Rural Pass-through discrepancy. Regarding state issues, there are 14 states that have opted out of Medicare's physician supervision of nurse anesthetist rule. More troublesome is the pattern that is developing of rogue nursing boards declaring independent scope of practice for nurse anesthetists, as well as authorizing such physician extenders to practice pain medicine. Hot spots are currently in Louisiana, New York, and California.