President's Page

Address to the CSA House of Delegates

By Edgar D. Canada, M.D., CSA President

Bill Barnaby, CSA Legislative Counsel, presents a resolution to President Edgar D. Canada

Madame Speaker, officers, delegates, friends, and guests, it is a true honor to speak with you today and to look back over the last year that I have served as president of the CSA. It has been a very interesting year for the Society, and I am proud to have been able to serve as president of CSA. Before I start my remarks, I must acknowledge and thank some individuals who have played a significant role in my year as president. My first thanks go to my wife—Linda. Her patience, advice, counsel, and support have been without equal in allowing me to do the things and be in the places that serving in this office requires. Certainly we have benefited by some of the wonderful places that we have had the opportunity to visit. But the cost of that benefit is the juggling of her schedule and placing some aspects of her business on hold. I must also thank my colleagues at the San Diego Children's Hospital Subgroup and members of Anesthesia Service Medical Group who covered the schedule during my absence on CSA business. Another individual who deserves a note of thanks is Dr. James Glassford, a close personal friend who has attended every possible CSA meeting since my installation as president last year.

"Be slow in choosing a friend, slower in changing." —Benjamin Franklin

Many others have been helpful to me over the last year. We all should be proud of our central office staff led by our Chief Executive Officer, Barbara Baldwin.

"Keep thy shop and thy shop will keep thee." —Benjamin Franklin

Additionally, other people important to the success of the CSA include most notably, our legislative counsel, William E. Barnaby, Sr. and William Barnaby, Jr., and our legal counsel, David E. Willett and Phillip J. Goldberg.

I would like to extend a personal thank you to all of the past presidents for their help. One past president whom I especially acknowledge is Rosemarie M. Johnson who served as a mentor to me in my involvement in the CSA as well as the CMA. Two other past presidents whom I must mention are John Hattox,

who encouraged me to get involved, and Tom Cromwell, who took time to participate in the January Retreat of the Board of Directors.

The Executive Committee is a keystone of the leadership of the CSA. I would like to thank each member of the Executive Committee for the efforts they made on behalf of the CSA, especially President-Elect Mark Singleton, who stood in for me at meetings that I was unable to attend, and Immediate Past President Linda Mason, who provided invaluable advice to me. Although I will not mention you specifically by name, each and every member of the Board of Directors played an important role in what the CSA was able to accomplish. For those of you who serve on committees or any other position within the Society, thank you for taking the time to be involved in the work of the Society.

Now before I move on to the issues that have been important to our Society over the last year, let me explain the references to quotations by Benjamin Franklin peppered throughout my speech. 2006 is the tricentennial of the birth of Benjamin Franklin (1706-1790). Benjamin Franklin was an author, diplomat, inventor, physicist, politician, and printer; he published "Poor Richard's Almanack" from 1732 to 1757; and he was the founder and first president of the American Philosophical Society from 1769 to 1790. Just as Franklin played multiple roles in his life, the CSA must play many different roles. Also, one other important anniversary must be noted. 2006 is the sesquicentennial of the California Medical Association. The CMA was founded 150 years ago in Sacramento and is an important partner in our advocacy efforts.

I would like to highlight the important issues for anesthesiologists in California and for the CSA over the last year. These issues include internal reorganization of our Society, scope of practice, adequate and fair compensation for physician services, and physician participation in execution.

Internal reorganization of our Society had three main concerns: 1) House of Delegates efficiency and effectiveness, 2) relevance of the Annual Meeting, and 3) relocation of our CEO. The pivotal question for evaluating all of these concerns is: Are your needs being met? In my speech last year, as president-elect, I asked us to evaluate the efficiency and effectiveness of our current governance process. Our goal should be to seek the governance process and structure that most effectively meet the needs, desires, and preferences of our members.

Changes have been proposed and made to our House of Delegates. Are your needs being met? I also asked that we evaluate the relevance of our Annual Meeting, and that process is ongoing.

In December of 2005, the CSA leadership became aware that our CEO would be relocating, effective in April. In January, the Board of Directors, after thoroughly evaluating the various options, voted unanimously to accept an open-ended trial period of our current CEO relocating to the Midwest. A continual two-way evaluation process is in place, with an interim report scheduled for the September 2006 BOD Meeting.

Scope of practice issues were an important item this year. In August, we filed suit against the Board of Registered Nursing *(CSA v. BRN)* after getting nowhere within the Department of Consumer Affairs regarding complaints over the BRN actions to expand the scope of practice of Certified Registered Nurse Anesthetists, as evidenced by statements made on the BRN Web Site. The BRN statement read in part that "The Board of Registered Nursing has no requirement … for the physician, dentist or podiatrist to supervise the CRNA providing their anesthesia services. Therefore, the CRNA provides anesthesia services under the authority of his or her own license as a licensed independent practitioner when requested to provide anesthesia services…." Additionally, the BRN policy statement declared that "It is within the scope of practice of the CRNA to provide acute and chronic pain management services and emergency procedures both inside and outside the operating room suite." The CSA believes that this statement is an incorrect interpretation of California law. After our suit, the BRN promptly removed the statement from their web site but dragged their feet on our request for discovery regarding the statement. We are suspicious as to how the statement originated. Earlier this month, our motion in Sacramento Superior Court to force the BRN to produce the documents requested in discovery was granted.

Another "scope of practice issue" is the request from the American College of Gastroenterologists to the Federal Drug Administration seeking removal of the warning language on the package insert for propofol. Current language reads in part: "…should only be administered by persons trained in the administration of general anesthesia and not involved in the conduct of the surgical/diagnostic procedure." This is about patient safety. Some gastroenterologists are promoting weekend training courses for nurses. Well, "NAPS LEADS TO RAPS." Translation: Nurse Assisted Propofol Sedation (NAPS) leads to respiratory arrest after propofol sedation. The ASA and CSA submitted comments to the FDA opposing this change. To date, the FDA has not announced any changes to the warning language. However, some health insurance companies have decided not to pay for an anesthesiologist's services for routine colonoscopy. SB 1508 (Bowen) entitled, "Health Care Coverage: Colonoscopies," *might* correct this issue for patients and anesthesiologists, but as currently written *might not*. We are following this bill closely and will work to make it beneficial for patients and anesthesiologists.

Ensuring adequate and fair compensation for physician services was a significant focus of the CSA advocacy efforts, as it has been in the past and will continue to be in the future. The focus was on three items: 1) payment for out-of-network services, 2) reversal of the Medicare Sustainable Growth Rate Formula, and 3) the Medicare anesthesiology-teaching rule. The story regarding the payment for out-of-network services began as we were fighting AB 1321 that was a prohibition against balance billing by hospital-based physicians. I urge you to use the phrase "payment for out-of-network services" or "payment for noncontracted physician services" instead of "balance billing." Words are important, often framing the discussion. The CMA Committee on Medical Services Subcommittee on Balance Billing presented a report to the CMA Board of Trustees in July that recommended that a pilot program for hospital-based physicians be developed. As adoption of this action would have been counter to longstanding House of Delegates policy, the BOT requested feedback from the HOD. The CMA BOT, by adoption of this action, would have addressed a contentious problem, but the proposed solution would have been detrimental to hospital-based physicians. The CSA Executive Committee promptly communicated our concerns about such a solution. Others did so as well. In August, the CMA BOT did a 180-degree turn when it: 1) created the Dispute Resolution Technical Advisory Committee with broad representation and 2) reaffirmed HOD policy opposing any prohibition on "balance billing." I participated in the Dispute Resolution TAC as CSA's representative.

In January, the Dispute Resolution TAC presented to the CMA BOT a consensus statement on a dispute resolution process that was adopted "as principles only for the purposes of further action." The essential elements of the consensus statement was that any pilot project should apply to all physicians, be voluntary, apply only to Emergency Medical Treatment and Labor Act (EMTALA) situations for only HMO patients or their delegated risk-bearing organizations (RBOs), and place minimal limitations on balance billing. Of note over the course of the last year, two important court cases were decided in favor of non-contracted physicians:

1. *Bell v. Blue Cross of California* (filed 7/21/05 CA 2/1)
2. *Prospect Medical Group v. Northridge Emergency Medical Group* (filed 2/17/06 CA 2/3).

In the *Bell* decision, the court ruled that health plans and their delegated RBOs have an obligation to pay noncontracted physicians for the reasonable value of any emergency services those physicians provide to health plan enrollees. In the *Prospect* decision, the court ruled that noncontracted physicians have the right to bill patients for the reasonable value of their services when those fees are not paid by the patient's health plan or its RBO. The court further ruled that the Medicare fee schedule could not be deemed to be the "reasonable rate" for

physician services across the board. Additionally, the court ruled that health plans and RBOs have the right to contest the reasonableness of noncontracted physician's fees.

In late January, the Director of the Department of Managed Health Care informed the CMA that the development of some type of expedited dispute resolution process was a high priority for the DMHC. Earlier this month the CMA BOT's formal response to the DMHC's dispute resolution process proposal notified the DMHC of CMA's strongest opposition to any mandatory processes or proposals that pre-empt a physician's rights under the *Prospect* and *Bell* decisions. Furthermore, the CMA BOT declared that the TAC's consensus statement and evaluation of the DMHC proposal be used in negotiation with the DMHC, but that final policy on this matter shall be developed by the CMA HOD in October. It is both interesting and important to note that the Prospect Medical Group has filed a petition for hearing in the California Supreme Court to overturn the *Prospect* decision, and the DMHC has filed an amicus brief in support of that petition. CMA Legal Counsel believes that it is unlikely that the Supreme Court will accept the case for review.

At the last minute (February 1, 2006) Congress provided a temporary fix for the Medicare Sustainable Growth Rate Formula, which would have resulted in a nearly 5 percent decrease in Medicare payment for physician services. However, this fix was for only one year. In Congress, the adage is "Why seek the long-term solution when you can fix it again, again, and again?" It keeps us coming back. The nonpartisan Medicare Payment Advisory Commission has recommended that the payment for physician services should rise consistent with changes in the cost to deliver care, for example, as measured by the Medicare Economic Index. This was a major advocacy effort of the ASA Legislative Conference a few weeks ago. Efforts are underway to work with the AMA and other specialty societies to achieve this goal.

The Medicare anesthesiology teaching rule provides that payment for anesthesiologists when supervising two residents be cut in half. This type of payment rule does not apply to surgeons or internists. It is estimated that anesthesiology training programs lose $300,000 to $400,000 per program because of this rule. The ASA has worked with the Centers for Medicare and Medicaid Services to correct this, but to no avail. Legislation, "The Medicare Anesthesiology Teaching Funding Restoration Act of 2006," has been introduced in Congress to correct this disparity: H.R. 5246 (Shaw) or H.R. 5348 (Stark). So far, only three out of 52 California Congressional Representatives have signed on to co-sponsor either bill. Please urge your Representative to sign on to co-sponsor this legislation. This is important for

all anesthesiologists, not just those at academic institutions. Viable training programs are essential to the future of our specialty.

Physician participation in executions became an issue rather quickly, and we responded to the concerns of our members, the media, and the public. A statement based on the ethical principles of the ASA and AMA was posted to our web site. Media interviews from both radio and television were responded to by me as well as other members of our Society. The CMA has introduced legislation—AB 1954 (Lieu)—that would prohibit the California Department of Corrections from using physicians to assist with or otherwise participate in executions.

Our active membership has increased and we will finish the year with a positive balance sheet. As you can see, many of the issues that we have to deal with involve the government. We all need to be involved. We need to contribute to our Political Action Committees so that we can do more. There are two reasons that you should contribute:

1. You like what we are doing. **Contribute so that we can do more.**
2. You don't like what we are doing. **Contribute so that you can change what we are doing.**

Make your contribution to GASPAC for the state issues. Make your contribution to ASAPAC for federal issues. It is easy—just go to **http://www.csahq.org** for GASPAC or to **http://www.asahq.org** for ASAPAC. If you prefer not to use the computer, call the CSA office at (800) 345-3691 for assistance.

Thank you for the opportunity to have served. It has been a wonderful ride. I would like to close with a final quote from Benjamin Franklin:

"Energy and persistence conquer all things."

2006 ASA Art Exhibit

The theme category for the 2006 ASA Art Exhibit will be "My Hometown." The Art Exhibit will take place at the ASA Annual Meeting in Chicago, Illinois, October 14-18, 2006. For more information, go to the ASA Web Site at **http://www2.asahq.org/web/miscfiles/06exhibitgl.asp**