President's Page

Address of CSA President-Elect Kenneth Pauker, M.D., to the 2011 House of Delegates

We are honored today by a veritable panoply of distinguished visitors, whose names, in the interest of time, are projected on the screen. That the CSA has attracted such a turnout of ASA leaders from all over the country speaks volumes about how important CSA ideas and participation have become to the ASA. Let's thank each of them for coming to San Jose to be with us.

Now, I'd like to acknowledge those who are most responsible for my standing here today. When I began my involvement with the CSA, I just wanted to participate in the work and have a chance to hang out with the stimulating characters I have come to know at the CSA and ASA, but these folk wanted more from me, and, after a while, bit by bit, I came to the hopeful realization that my ascending the leadership track would be good for the CSA and a stimulating journey for me as well. Steve Goldfien took me aside soon after I first attended a CSA Board of Directors (BOD) meeting and told me to read Sturgis, to study Krause's "Death of the Guilds: Professions, States, and the Advance of Capitalism, 1930 to the Present," and to join the CMA if ever I wanted to become a CSA leader. He challenged me with his ideas, and he involved me in the ASA Committee on Anesthesiologist Assistant Education and Practice, which he chaired. Steve Jackson nurtured my writing and craftily suggested topics for *Bulletin* articles, subjects with meat on the bone, the chewing of which plumped up my comfort with practice affairs and medical politics. I came to appreciate that taking on the task of elucidating complex issues is a process of discovery, and that you wind up understanding them much more deeply, often appreciating hidden subtleties, than from just reading about them or even studying them, and that writing makes you a more articulate speaker. Dan Cole made me believe that my passion and my probing approach to issues were talents that should be deployed in the service of elucidating gnarly issues confronting both the CSA and the ASA. Jim Grant and I just basically bonded years ago. He wrapped me in his warm optimism and clear thinking, encouraged me, and pushed me onward.

And then, there is my Debbie, my beautiful young wife of 30 years, my city girl from Pittsburgh, the mother of my remarkable daughter and son, my confidant and friend. She has her reservations about sharing me with the CSA, but she knows my heart in this and every matter, and she loves me enough to be here

today to demonstrate her support. We all know that one year is really just a flash in time. Thank you in advance, Debbie. I love you.

As I look out upon the faces in this Grand Ballroom, I am proud and honored by the confidence you are showing in my ability to lead this venerable society during this tumultuous time in the history of American medicine.

So here am I, a community anesthesiologist, a reformed internist, on this path less traveled. We all are beset by distracting external considerations that conspire to have us forget what past ASA President Roger Litwiler declared so unequivocally just a few years back, "It's all about the patient, because we have no other reason to exist!"

Common wisdom is that "it takes a village," and we here together are that village. Indeed, it surely will take all of us, playing off each other; sharing perspectives, ideas, and strengths; strategizing; and then acting together, testing perhaps what some might declare to be the legal limits of collective action, to do what needs be done to save our patients and our profession from the "charlatans, poachers, and quacks" who are swirling around us, probing for weaknesses, wrapping themselves in the cloak of the FTC, trumpeting about "practicing to the full extent of their licenses," and hoping to invoke the ill-advised antidiscrimination clauses in PPACA.

The spectrum of issues arrayed before us as anesthesiologists practicing in California is broad and deep, both unique to our state and also as local iterations of a national agenda. Almost everyone is this room has heard of them, but some folks have paid less attention. Please refer to our Web site for my list of 29 important topics on the table for national, state or internal CSA action. These are posted at www.csahq.org and will constitute a continually updated, prioritized list of key issues. Moreover, there soon will be an opportunity for each and every CSA member to comment upon each item, and even to add to the list [see the Web site update on pages 89–90]. For now, I will focus on just five particularly critical issues that will demand attention during my Presidential term, and give you the flavor of how I mean to move you who are the CSA to try to address them.

1. The nurse anesthetist opt-out is a manifestation of an insidious expansion of the scope of practice by advanced practice nurses. The rationale is that this maneuver intends to enhance "access to care," but it seems clear that it would come at a cost of degrading quality. Misinformation and disingenuous distortions of the facts are deployed routinely through multiple vehicles within the media to bolster acceptance by legislators and the public.

Under my leadership, the CSA will develop a robust strategy of enhancing communication about what we as anesthesiologists do, and what makes our

role critical to safe and efficient perioperative, obstetric, pain, and critical care. We will author white papers, confront misinformation with facts clearly explained, wade out into the community to sponsor forums with various community groups, lobby lawmakers and regulators, and deploy lawyers and lobbyists as needed.

2. The recently enacted federal health care insurance reform legislation, the **Patient Protection and Affordable Care Act (PPACA)**, has provisions that, if actually put into play, may well destroy anesthesiology as we know it. To start with, it is an unfunded mandate, largely to be "financed" on the backs of practitioners. This is despite our very low contribution to escalating health care expenditures, which are largely from increased procedures and tests, as well as from pharmaceuticals and changing national demographics—the baby boom maturing into the Medicare boom. Half of the increased "access" in PPACA will be by expanding "insurance coverage" to the uninsured through Medicaid. In California, we have a population of 37 million, with 6 million Medi-Cal enrollees, expected to grow to 9 million under PPACA in 2014, and an anesthesia conversion factor of $14 ($17 for OB), one of the lowest in the nation. At these rates, access is a pipe dream. Moreover, the "nondiscrimination" clause, which bars insurers and others from discriminating against categories of practitioners who render "equivalent" service, introduces a federal civil rights issue into what is properly an issue of scope of practice. And even worse than that, the Independent Payment Advisory Board (IPAB), which ought to be thought of as the "Independent Rate Setting Commission," is populated entirely by all nonclinicians and has been set up to slash Medicare spending in ways that are non-negotiable and not appealable.

Under my leadership, the CSA will work with the ASA to analyze, understand, strategize, and then communicate to our members. There is a long and complex political story here, and ultimately only political action can save our patients from the devastating access problems that IPAB, if rolled out as scheduled, will surely produce.

3. Performance measurement is essential to improving quality. Pay for Performance (P4P) is one potential use of these measurements, and it comes in many flavors, many of which are fraught with unintended consequences. So on the one hand we must measure, and therefore construct appropriate and robust measures for our specialty, report our outcomes to a national clinical outcomes registry, and be benchmarked against each other in various ways. On the other hand, we must resist the inappropriate use of measures using poor data and unadjusted for risk, and be extremely wary of publicly reported outcomes. We all must become experts in understanding how and why measures are constructed, their pitfalls, their pros and cons.

Under my leadership, the CSA will educate its members and other relevant parties on why and what to measure and how to do it. We must educate, communicate, and exchange information with each other as this field continues to evolve. We will enlist the expertise of LPAD and EPD working together to try to bring clarity to a domain where there is now largely confusion and obfuscation.

4. Accountable care organizations (ACOs), proposed as one of the foundations of the coming brave new world of Obamacare, are being pushed as a major new vehicle to improve quality patient care while reducing redundancy and cost. The Center for Medicare and Medicaid Services has just published its rules on how ACOs should work to qualify for federal dollars, but commercial health care systems and hospitals have been strategizing and theorizing about this for quite some time. In some ways, this appears to me like a reinvention of HMOs, except that patients may drop in and drop out at will. Furthermore, there appears to be a shifting of financial risk within the next few years to physicians and the ACO entities, and away from an ultimate financial responsibility by the federal government. ACOs intend to foster competition between groups of doctors and institutions, and strategies being discussed touch upon corporate practice, foundation models, what some would consider kickbacks, and new systems of payment for medical services.

Under my leadership, the CSA will promote sharing of perspectives and approaches, and analyses by various experts, locally, around the state, and nationally. When necessary, we will illuminate what appear to be illegal arrangements. We will share with our members ways to prove the value of our (extended) services, and explore the concept of a potential surgical "home" as this idea and federal legislation to create it continue to be developed.

5. Advocacy—federal, state, and even local—is a cornerstone of advancing our agenda to promote an appreciation for what anesthesiologists do. If we anesthesiologists do not advance our specialty-specific concerns for our patients and our profession, and our suggested solutions, who will? It is not enough to assume that others who are more engaged will do what needs be done and financially support what needs be paid for. To do so, to continue to "punch the clock" and then go home to our families and our interests outside of medicine, is shallow, unprofessional, and ultimately self-defeating during these turbulent times when we all have targets painted on our backs. We are in this together, and we need each other's energy and support. We must start with the doctor-patient relationship, and from that basis move to successively higher levels of political involvement. Sure, engaging marketing professionals may be one way to get some of our message out, but the best and worst public relations derive from our individual relationships with each and every patient and family.

Under my leadership, the CSA will cultivate an army of writers who will prepare white papers, letters to editors, opinion pieces, and scripts for media. We will charge the EPD with developing educational materials beyond its proven expertise in clinical topics, some perhaps related to patient interactions. We will bring the ASA Leadership Spokesman Training Program back to California to train more spokespersons. Now that we have sufficiently developed the infrastructure to support our Web capability, we will refocus on developing content. We will encourage district-level and even group-level political fund-raisers, refine our database of constituents and contributors, find new ways to enhance participation in GASPAC and ASAPAC, and port the ASA CapWiz system to California, to use it for state-specific issues. The latter is just now getting up and running.

Given these kinds of critical issues, what is the purpose of the CSA? What is its mission? Let's take a moment to reacquaint ourselves with our mission.

> *The California Society of Anesthesiologists is a physician organization dedicated to promoting the highest standards of the profession of anesthesiology, to fostering excellence through continuing medical education, and to serving as an advocate for anesthesiologists and their patients.*

This is what the CSA is organized to do, but where would we like to be in a year from now, two years, five years? And what specifically can the CSA do for its members, of sufficient import for each to embrace membership? This is what we could define as the CSA Vision. While we have had sporadic strategic retreats of the BOD every few years, we do not now have a mechanism for ongoing strategic discussion. We do not now have a CSA Vision per se.

I hope to change that by having strategic planning—and therefore, a Vision setting—be a part of every BOD meeting. Between BOD meetings, our Executive Committee has the authority to act, and it does, sometimes meeting each month by teleconference—eight people doing much of the day-to-day and month-to-month decision-making for 4,000-plus members. Our plate is too full of critical issues to have this few people meet this infrequently. The BOD is not—and cannot—be engaged because, even though e-mail discussions are ongoing, it just does not meet often enough to maintain involvement of the district directors who constitute it. And if the Directors are not engaged, how can CSA members in the trenches become more engaged? This is something that must be changed.

Here is my Vision for the CSA. I would like the CSA to be the first and primary resource to which our members turn to become better informed on a broad range of practice affairs issues—white papers, discussions, sample policies—the disseminator of information and advice concerning regulatory requirements

and visits by accreditors, and how best to evolve our practices to survive economically. I want the CSA to be there for our members, to anticipate their needs, and for our members to look to the CSA as their organization that will help them, educate them, and do battle for them. And in return, I would hope that CSA members will give of themselves to the CSA, to share what they know and what they see in order to preserve and advance anesthesiology. I want our members to become more **engaged** and **involved**, beginning at the level of our local districts, with our District Directors and our Delegates and Alternate Delegates stepping up to do this work as a professional responsibility.

The following is a list of ideas to promote engagement and involvement:

- Gather and report information on changing local patterns of clinical practice.
- Coordinate local political action in the service of state or federal issues, including local lobbying.
- Construct a telephone/text chain list to mobilize for urgent action alerts.
- Recruit new CSA/ASA members by visiting nonparticipating groups and making presentations, engaging individual nonmembers and selling CSA membership to each.
- Recruit for GASPAC and ASAPAC by individual visits, presentations, and so forth.
- Participate in local activities sponsored by CMA components.
- Organize town hall forums to educate various lay groups about clinical anesthesia issues, better educating the public in what we anesthesiologists actually do.
- Organize educational meetings intended to stimulate civic engagement beyond just CSA activities—for instance, with the Alzheimer's Foundation, the National Institute of Mental Health, and Global Humanitarian Outreach.
- Organize or participate in rendering clinical care to the uninsured or bringing care to patients in remote locations in California or nationally or internationally through various international programs.
- Organize local site visits for various government officials.
- Organize local dinner meetings for CSA district members, finding funding, speakers and venues.
- Cultivate a liaison with anesthesia residency programs, encouraging residents to visit community practices, and persuading faculty to participate in CME programs in the community.

District Directors need not themselves do all or many of these activities, but each is a service. Each is an educational opportunity. Each enhances the CSA.

So, the flavor of my strategic approach is to address this CSA Vision by enhancing the **engagement** and **involvement** of each and every CSA member. I also am charging a new task force with analyzing the effectiveness of how our BOD functions and recommending how to improve it expeditiously. I also believe in the importance of the HOD, and the importance of involving you, our delegates and alternate delegates, more deeply. Yes, we need to engage and involve all of you good folks beyond just one annual meeting.

And what about lobbying to place CSA members on ASA committees? At the ASA BOD, some years ago, there was a change from a House of Representatives to Senate model. We are 9 percent of ASA membership, and as such need to approximate that percentage of committee chairs and committee members, not the 3 percent or so (by my manual count) that we now enjoy. We know how to get more folks appointed, but it must start by your wanting to be **involved**.

We anticipate a busy and productive year. Many projects have already been set up, some already under way during Dr. Trivedi's term, and some even ongoing from Dr. Hertzberg's year at the helm. We build on what we have already in play and what we have already accomplished. We stand on the shoulders of those who came before us. My plan is to try to stimulate and to expand **engagement** and **involvement** of members at all levels, to make the CSA feel closer and more useful and more user-friendly for its members, to enhance communication, not only disseminating what the CSA leadership thinks members should know about, but also pulling content and priorities and enthusiasm from those who labor in the trenches, at the District level, a real two-way pipeline.

The woods are lovely, dark and deep.
But I have promises to keep,
And miles to go before I sleep,
And miles to go before I sleep.

"Stopping by the Woods on a Snowy Evening"
Robert Frost, 1874–1973

Thank you for being here. Thank you for listening. Thank you in advance for helping me serve you. Together, let's work to reshape our CSA into the kind of professional organization that it can and should be.

Comme disent les Français: Allons-y, mes amis. Nous avons beaucoup à faire.

Summary of the Address of CSA President Narendra Trivedi, M.D., to the 2011 CSA House of Delegates

Just a year ago, I was addressing the House of Delegates with my dreams, hopes and promises, with my vision to take the CSA to next level of excellence. Today, I share with you the highlights of this past year. It has surely been a busy year, and I am proud and happy to say that we have achieved a lot.

History and Current Status of the Nurse Anesthetist Opt-Out in California

The CSA/CMA appeal of former Gov. Arnold Schwarzenegger's (GAS) opt-out action is pending before the California Court of Appeal. Our case is very strong, and we are hopeful for a successful outcome. A summary of the history and recent activity in the opt-out litigation is warranted.

The requirements for an opt-out are that a hospital may be exempted from the requirement for physician supervision of certified nurse anesthetists (CRNAs) if the state (in which that hospital is located) has submitted a letter to the Center for Medicare and Medicaid Services (CMS) that is signed by the governor, *and* has consulted with both of that state's Boards of Medicine and Nursing. Indeed, the letter from the governor must attest that he or she has consulted with those boards about issues related to access to and the quality of anesthesia services in the state, and has concluded that it is in the best interests of the state's citizens to opt out and, *importantly*, that the opt-out is consistent with state law.

We all should note that the California opt-out request was decided behind closed doors within GAS's office and without consultation with—or input from—any professional medical organization. The consultation with the Medical Board was only at the administrative level and not with the full board. Moreover, the letter addressed by the executive director of the board to the governor stated that *California law and regulations require that a nurse anesthetist have physician supervision.* The CSA continues to maintain that independent CRNA practice is contrary to the law of this state despite GAS's action. At no time were issues of access and the quality of anesthesia services in the state addressed, as required by the federal regulation. In short, this action appeared to be a secret end run by GAS's office to use the opt-out process to circumvent what we believe to be state law.

Chronologically, CMS received the GAS letter requesting that California be allowed to opt out of the Medicare physician supervision requirement and subsequently deemed it to be effective July 17, 2009. Following GAS's action, the CSA along with the CMA filed a lawsuit in San Francisco Superior Court, and on October 8, 2010, San Francisco Superior Court Judge Peter Busch denied the CSA/CMA's motion to require GAS to withdraw his action. The judge erroneously concluded that in the absence of a state statute specifically stating that physician supervision is required, the requirement for physician supervision does not exist. He ignored the long history of attorney general opinions, legislative counsel opinions and prior court cases/opinions that concluded otherwise. Over the objections of CSA/CMA legal counsel, Judge Busch adopted the proposed opt-out order drafted by attorneys for the governor and California Association of Nurse Anesthetists (CANA) that was far more overreaching than the points of law addressed in the lawsuit. In late January of this year, the CSA/CMA agreed to appeal that court decision. The appellate law firm Cole Pedroza was engaged as lead counsel. On January 31, 2011, the notice of appeal and writ petition was filed in the First District Court of Appeal. Because the case deals solely with the interpretation of existing state law, the appellate court's review will be "de novo," or entirely new. The CSA/CMA opening brief was filed on April 8, 2011. The current governor, Jerry Brown, and CANA will be filing their response brief on or before July 8, 2011. The CSA then will have at least 20 days to file a reply brief, and amicus briefs will be due 14 days after that final filing.

It is unlikely that there will be any immediate change in anesthesia practice in California hospitals resulting from the opt-out. Physician-supervised anesthesia care is the standard of care in California. It seems unlikely that hospitals would readily take on the liability of independently practicing CRNAs. In the event of an adverse outcome, the hospital, not the surgeon, would be the deep pocket in a lawsuit. The longer term effects of the opt-out remain uncertain and are cause for grave concern for the quality of care that patients may receive in California in the future.

Advocacy

I have spent much of my term meeting with political leaders at the local, state and national levels. While attending the Republican Governors' Association Convention as the ASA representative last November, I met informally with several of the governors to discuss health care issues that affect members of the ASA and CSA, most notably with Gov. Bobby Jindal from Louisiana and Governor-elect Nikki Haley of South Carolina.

As is often said, "all politics is local," and much of my time was also spent meeting with state political leaders. During the year, I met with several U.S. congresspeople to discuss issues affecting anesthesiology in particular and medicine in general. I also organized a fund-raiser for Sacramento congressional candidate Dr. Ami Bera at my residence. I would like to recognize **Drs. Paul Yost, Mark Zakowski** and **Stanley Brauer**, who have worked very hard for the Legislative and Practice Affairs Division. I extend very special thanks as well to **William Barnaby, Junior and Senior,** for their ongoing leadership in advocacy.

Membership

I attended a meeting of the Board of Directors of the Anesthesia Service Medical Group and encouraged every member of this large group to join the CSA and actively participate in CSA activities and advocacy efforts for the profession. My special thanks go to **Dr. Edgar Canada** in this endeavor. I also attended a meeting of Kaiser anesthesiologists at Marino Valley Kaiser Hospital in order to update them on CSA's initiatives and to encourage them to become CSA members. The entire group has agreed to apply for CSA membership; my special thanks go to **Dr. Lawrence Robinson** for his assistance in achieving this goal. I also met with leaders of the Osteopathic Anesthesiologists Society of California, who were enthusiastic about becoming active members of the CSA. During this year, the CSA has continued to see very high membership renewal rates and an overall increase in total members.

Academic Section

The CSA leadership held a meeting with all residency program directors in May. **Dr. Samuel Wald** is to be commended for the work he has done with the program directors. I have invited all academic chairs to take a more active leadership role in CSA activities, and indeed, some academic chairs are working with our new Committee on the Future of Anesthesiology.

Resident Section

This year, for the first time, I have appointed one resident from each residency program to a CSA committee. Having residents serve on CSA committees hopefully will increase both participation and active membership in the CSA once their residency is completed. We currently have 332 active resident members, 42 percent more than the previous year. I am working with Dr. Wald and the residency program directors to plan yearly meetings for all chief residents to meet and discuss issues affecting them. The CSA also will sponsor one resident to attend the ASA Practice Management meeting.

EPD Activities

I attended both the Hawaii fall and winter educational meetings, outstanding events that afforded me the opportunity to meet fellow anesthesiologists from our state and across the country. Special thanks to **Drs. Ronald Pearl, Andrew Patterson** and **Adrian Gelb** for organizing outstanding meetings. In all, these meetings are a reflection of the great leadership by **Dr. Gelb and his EPD team**.

New Era in Electronic Communications

This year has been extremely busy for our communications group. They successfully launched a new Web site, working tirelessly to overcome technical challenges. Following that, they continued to work on Web site enhancement, including social media initiatives and a mobile device interface. I want to thank **Drs. Linda Hertzberg** and **William Feaster** and the CSA staff for all of their great work.

Finance

The CSA has done very well financially in the past 10 years. I feel very fortunate to have been a part of these achievements as Assistant Treasurer, Treasurer and President. We now have a reserve of over $1 million. Please join me in congratulating our Treasurers, my friends **Drs. Peter Sybert** and **William Feaster**, for their leadership and expertise in finance.

"Future of Anesthesiology" Retreat

I would like to reflect on the theme of my presidency, The Future of Anesthesiology, for which we held a CSA Board Retreat in January. The retreat began with a presentation by Dr. Phillip Lumb on future practice models, followed by Dr. Neal Cohen on residents as our future, then Dr. Patricia Kapur on technological and other advances affecting our future. It concluded with Dr. Stan Stead on the economic impact of changes in the future, including compensation. Following this, there was a Board discussion. The Committee on the Future of Anesthesiology will make recommendations at the September 2011 Board of Directors meeting. My special thanks to **Drs. Johnathan Pregler** and **James Moore** for organizing a great retreat. The committee is working to anticipate future practice models and developments with patient care in order to help prepare physicians to meet coming changes in anesthesia practice, especially regarding the role of perioperative physicians.

Summary

As you can see, this has been a very busy year. We have been actively involved in many important issues and achieved great successes. I would like to take this opportunity to thank the CSA Executive Committee, which has consistently provided strong support and guidance, as well as the members of the BOD and Delegates to our House for your trust and support. I am very appreciative and thankful to my partners at Kaiser Permanente, who have always supported my needs.

I have made a few great friends at the CSA over the past 15 years of my involvement with the Society: Dr. Champeau, Dr. Goldfien, Dr. Airola, Dr. Canada, Dr. Mason, Dr. Cole, Dr. Jackson, Dr. Sullivan and a very special friend, Dr. Hertzberg. Thank you all.

And finally, I am so happy to have my family joining us today. My dad has always been there for me. My wife and both sons, Akash and Nick, always supporting, helping, and now at times advising me. Akash is working for Kaiser Permanente and also is a full-time Master's student at USC, while Nick is graduating from UCLA and getting ready for medical school. Thank you both. Very, very special thanks to my wife Trupti, for her love and support, keeping me on track to do the right things in life, and in any responsibilities I have taken in life.

Thank you all for the opportunity to serve you, the CSA, and the specialty of anesthesiology.

Have You Changed Your E-mail Address Lately?

Please send CSA an e-mail with your new e-mail address or go online at the CSA Web Site, www.csahq.org, to update your profile if you wish to receive up-to-date information. The monthly Gasline newsletter is now sent by e-mail only.