2006 ASA Annual Meeting, Chicago

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The annual ASA meeting was held in Chicago, October 14-18, 2006. It was a very well attended meeting, with over 18,400 participants. The CSA delegation was actively involved not only in the California Caucus meetings held on Saturday and Tuesday, but also in the Western Caucus meetings, which were held on the same days. The Western States Caucus of the ASA recognized the many years of service generously given by R. Lawrence Sullivan, Jr., M.D., and acknowledged Dr. Sullivan's tireless work to assist the Western Caucus in its mission by presenting him with a plaque. Dr. Sullivan has served as the ASA Director from California since 1998 and stepped down from that position at the close of the 2006 ASA House of Delegates.

Two sessions of the HOD were held on Sunday and Wednesday morning. In addition, on Sunday afternoon the four reference committees met, each having specific action items that would come from these committees for approval by the HOD on Wednesday morning.

At Reference Committee 1 (Administrative Affairs), the Anesthesia Care Team annual supplemental report stimulated the most discussion, which centered on the term "Qualified Anesthesia Providers" as it appears in the proposed revision of the ASA's Statement on the Anesthesia Care Team. This term defines those members of the Anesthesia Care Team who, by virtue of their training, licensure, and privileges, may provide anesthesia care alone in the operating room. Qualified Anesthesia Providers include anesthesiologists, anesthesiology residents and fellows, anesthesiologist assistants and nurse anesthetists. Nonphysician students, medical students, student nurse anesthetists and perfusionists, as defined in this document, are not qualified anesthesia providers and should not be left alone in the operating room. Anesthesiology residents, however, are physicians who can provide physician services under the supervision of a teaching anesthesiologist, though they often are safely left alone in the operating room. The reference committee drafted an alternative statement that "qualified anesthesia personnel are members of the anesthesia care team capable of delivering anesthesia care as determined by the responsible anesthesiologist." The HOD recommended that the revised Statement on the

Anesthesia Care Team be approved, but the issue of who was a "qualified anesthesia provider" was referred back to the Committee on the Anesthesia Care Team for further refinement.

Another resolution would have placed one resident on each of the reference committees at the Annual Meeting. The HOD upheld the Board of Directors' action to refer for further study. It also referred the issue of insurance coverage for residents receiving treatment for substance abuse. Both of these items will be referred to a committee of the President's choice.

Reference Committee 2 (Professional Affairs) was particularly interesting to California anesthesiologists, as ASA Director Larry Sullivan, M.D., had introduced a resolution about physician participation in executions at the March 2006 Board meeting, which was then referred to the ASA Committee on Ethics. The House of Delegates ratified Board approval of the document titled **"Statement on Physician Nonparticipation in Legally Authorized Executions"** as presented by the Committee on Ethics to the August BOD meeting. It states:

1. Execution by lethal injection has resulted in the incorrect association of capital punishment with the practice of medicine, particularly anesthesiology.
2. Although lethal injection mimics certain technical aspects of the practice of anesthesia, *capital punishment in any form is not the practice of medicine.*
3. Because of ancient and modern principles of medical ethics, legal execution should not necessitate participation by an anesthesiologist or any other physician.
4. ASA continues to agree with the position of the American Medical Association on physician involvement in capital punishment. ASA strongly discourages participation by anesthesiologists in executions.

The Committee on Performance and Outcomes Measurement Report also generated considerable discussion relating to pay for performance. The HOD decided that all performance measures must be evaluated by the CPOM prior to release as an ASA work product, in accordance with ASA administrative procedure 6-XII-B, and be approved by the Executive Committee. These work products will be presented to the HOD.

The majority of the time in Reference Committee 2 was spent over credentialing guidelines for sedation. In 2005, the HOD approved the statement titled "Credentialing Guidelines for Practitioners Who Are Not Anesthesia Professionals to Administer Anesthetic Drugs to Establish a Level of Moderate

Sedation." However, this document created an inconsistency with the "Practice Guidelines for Sedation and Analgesia by Nonanesthesiologists" adopted in 2001. Additionally, the issue of credentialing guidelines for "deep sedation" remained unresolved. The special Committee on Sedation Credentialing Guidelines, reappointed by ASA President Orin F. Guidry, M.D., offered a revision of the 2005 document which was retitled "Statement on Granting Privileges for Administration of Moderate Sedation to Practitioners Who Are Not Anesthesia Professionals." This revision was approved by the HOD. Regarding deep sedation, the reference committee offered two alternatives. Option A, which had been previously approved by the BOD, stated: "Because of the significant risk that patients who receive deep sedation may inadvertently enter a state of general anesthesia, privileges to administer deep sedation should be granted only to practitioners who are qualified to administer general anesthesia or to appropriately supervised anesthesia professionals." However, the reference committee recommended the approval of Option B, which would support the concept that "appropriately trained nonanesthesiologist practitioners (physicians, dentists, podiatrists) can safely administer deep sedation, either personally or while supervising an appropriately trained nonanesthesia professional (e.g., registered nurse, sedation nurse)," and with it the **"Guidelines for Granting Privileges to Nonanesthesiologist Practitioners for Personally Administering Deep Sedation or Supervising Deep Sedation by Individuals Who Are Not Anesthesia Professionals."**

Had the deep sedation guidelines been adopted, anesthesiologists would be called upon to help train our nonanesthesiologist colleagues in the skills required to rescue patients who inadvertently enter a state of general anesthesia. The HOD, in a standing vote count, subsequently approved Option A by a wide margin, thus embracing the position that only anesthesia-trained individuals should be privileged to provide deep sedation.

Reference Committee 3 (Finance) did not include any controversial issues.

From Reference Committee 4 (Scientific Affairs), the HOD adopted a resolution on TEE certification for anesthesiologists stating that "the ASA uniquely or collaboratively develop and implement a program of basic-focused education in perioperative echocardiography" and that "the ASA also uniquely or collaboratively explore a pathway for supporting privileges in basic perioperative echocardiography for anesthesiologists."

One of the other focuses of the meeting was the urgent need for anesthesiology to support the Medicare anesthesiology teaching rule legislative reform and to counter its adoption by private payers. The Texas Society of Anesthesiologists introduced a resolution which noted that United Health Care and Blue Cross/ Blue Shield plans have adopted the current discriminatory Medicare

anesthesiology-teaching rule. A demand was made that they cease and desist in this practice at once, and return to the prior practice of paying 100 percent for each of the two overlapping cases in which a teaching anesthesiologist supervises a resident physician. Another resolve called for the ASA to urge its members to 1) send electronic messages through the ASA Web Site and telephonic messages to Congress before the November elections, demanding that Congress end the discriminatory Medicare anesthesiology teaching rules and 2) that the ASA commend and support the chief sponsors and supporters of the legislation before Congress—HR 5246, HR 5348, and S 2990—that would reverse the 50 percent payment penalty unfairly applied to teaching anesthesiologists.

The CSA Delegation to the 2006 ASA Annual Meeting

The HOD elected Jim Grant as Assistant Treasurer in a contested election with Jan Ehrenwerth. The slate of new officers is as follows:

President	Mark J. Lema, M.D.
President-Elect	Jeffrey L. Apfelbaum, M.D.
Immediate Past President	Orin F. Guidry, M.D.
First Vice-President	Roger A. Moore, M.D.
Vice-President for Scientific Affairs	Charles W. Otto, M.D.
Vice-President for Professional Affairs	Alexander A. Hannenberg, M.D.
Secretary	Gregory K. Unruh, M.D.
Treasurer	John M. Zerwas, M.D.
Assistant Secretary	Arthur M. Boudreaux, M.D.
Assistant Treasurer	James D. Grant, M.D.
Speaker, House of Delegates	Candace E. Keller, M.D., MPH
Vice-Speaker, House of Delegates	John P. Abenstein, M.D.

Chicago was a wonderful venue for social events that were cancelled following the Katrina disaster last year, when the ASA was to have been in New Orleans. The delayed ASA Centennial Celebration went forth with much gusto and culminated Monday night with the ASA Centennial Gala, which was sponsored by the Foundation for Anesthesia Education and Research as an event to raise money for the four ASA foundations (FAER, APSF, WLM and the Anesthesia Foundation). This grand event, held at the Grand Ballroom of the Hyatt Regency Hotel, was sold out and included over 1,500 participants. Presiding as Master of Ceremonies was former ASA President, and California's very special "Doctor-Doctor," Peter McDermott, M.D., Ph.D. It was a great pleasure to be able to share an evening with colleagues in a formal, black-tie event that allowed us to celebrate the illustrious past in anesthesiology, looking back at what anesthesiology has accomplished in the last 100 years. In addition, it gave us a chance to look forward to the next 100 years and theorize where anesthesiology will be at that time. There will be many changes in the practice of anesthesiology, but carrying forward the issue of patient safety into the next century will be most important for the care of our patients in the future.

The ASA meeting provided the opportunity for anesthesiologists to be together, to learn, to share, and to plan the future for the specialty. It reinforced my feeling of how wonderful it is to practice the specialty of anesthesiology, of the exciting things we have to look forward to in the future, as well as to reflect on the achievements we have had in the past 100 years in this specialty. It is a great honor for me to represent the CSA as the Director from California to the ASA.