

PRESIDENT'S UPDATE

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ASA President

“Dr. Patchin has a strong sense of purpose and is passionately committed to organized medicine.”



AMA Elects Anesthesiologist to Board of Trustees

‘We now have a front-row seat in the House of Medicine’

Because we are all members of the “House of Medicine,” we need to be actively involved in the activities and plans that will shape the future for all doctors. We are, of course, physicians first and anesthesiologists second, but we often get caught up in the day-to-day hustle-bustle of our practices and personal lives and think that the rest of medicine will “heal itself.”

I am thrilled to be able to announce to our ASA membership that, for the first time in recent memory, we now have a front-row seat in the House of Medicine with the recent election of “one of our own” to the American Medical Association (AMA) Board of Trustees. Were that not enough, other ASA members were elected to or are retaining places on key councils within AMA’s governance structure.

At the AMA Annual Meeting in Chicago, Illinois, on June 14-19, 2003, the AMA House of Delegates voted in five new members to its Board of Trustees. We are proud to announce that **Rebecca J. Patchin, M.D.**, was one of the five to win a seat on this powerful decision-making entity of AMA. She also is the only female physician currently serving on the AMA board.

Dr. Patchin, of Riverside, California, is a longtime member of the ASA’s Section Council and Delegation to AMA. Her credentials are outstanding, not only as a physician and an anesthesiologist, but as a leader, a team-builder and a person of strong principles.

Dr. Patchin has a strong sense of purpose and is passionately committed to organized medicine. She has been one of the strongest membership recruiters in her state medical society

ever since she was a medical student. That kind of performance and level of involvement are rare. She is an ambassador and a coalition builder. These leadership qualities will not only add to the overall strengths of the AMA Board of Trustees, but will also serve our medical specialty by keeping a close watch on what lies ahead in medical-related politics, educational programs and physician-oriented services.



Rebecca J. Patchin, M.D.

While many helped Dr. Patchin with her yearlong campaign efforts, I would be remiss in not mentioning that her campaign manager was 1999 ASA President **John B. Neeld, Jr., M.D.**, of Atlanta, Georgia. The professional manner in which Dr. Patchin’s campaign was managed and executed was the envy of many others who sought election to various positions. Our Delegation to AMA had but nine votes to cast of the 500-plus votes among the House, so you can imagine the effort necessary to achieve this success.

We are proud of Dr. Patchin, Dr. Neeld, Delegation Chair **Richard R. Johnston, M.D.**, of Eugene, Oregon, and all other delegates and alternate delegates who helped Dr. Patchin become elected to the Board. As alternate delegates, your officers — including **Roger W. Litwiller, M.D.**, **Eugene P. Sinclair, M.D.**, and myself — also campaigned diligently for Dr. Patchin.

As important as a Board seat is, there are many other elected positions that wield great power over the AMA’s policy making and program development. We also now have anesthesiologist representatives in these areas as well.

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AMA is considering adopted a set of core principles for optimal office-based surgery that have been agreed upon by ASA with the American College of Surgeons and others. The report is pending further review by the AMA Board of Trustees.

The AMA Reference Committee agreed that in order to provide optimum patient care, registered nurses need to participate in the management of analgesic modalities.

Elected to the AMA Council on Medical Education was **Claudette E. Dalton, M.D.**, of Earlysville, Virginia. She will serve in this position until June 2007.

Re-elected to the AMA Council on Medical Service, with a term extending to 2007, was **Joseph P. Annis, M.D.**, Austin, Texas. This is Dr. Annis' second term on the council.

Last year, the AMA House of Delegates elected **C. Alvin Head, M.D.**, Boston, Massachusetts, to the Council on Scientific Affairs with a term through June 2006.

Also involved on the AMA councils are **David M. Shapiro, M.D.**, Tallahassee, Florida, on the Council on Long-Range Planning and Development; **Robert Hertzka, M.D.**, San Diego, California, chair of the American Medical Political Action Committee (AMPAC); and ASA Speaker of the House **Candace E. Keller, M.D.**, Santa Fe, New Mexico, who also serves on AMPAC with a seat on the AMA Council on Legislation.

In elections for the AMA Young Physician Section (YPS), **Michael B. Simon, M.D.**, Wappingers Falls, New York, was elected alternate delegate from the YPS to the AMA House of Delegates.

Our specialty should be very proud of the staunch commitment, tireless efforts and personal sacrifices made by our colleagues who realize that by being involved, you can have a direct impact on the direction of medicine, today and for the future.

AMA Reports, Resolutions

Anesthesiology was well-represented in other matters that came before the AMA House of Delegates, although two items of business deserve specific mention.

Office-Based Surgery and Anesthesia: The AMA House considered Board of Trustees Report 23 "Office-Based Surgery Regulation" that outlines a set of core principles for optimal office-based surgery which have been agreed upon by ASA with the American College of Surgeons and other national medical specialty societies, state medical associations, health care accreditation organizations, the Federation of State Medical Boards and the National Patient Safety Foundation.

The report was referred back to the Board and is available on the AMA Web site at: <www.ama-assn.org/ama1/upload/mm/annual03/bot23a03.rtf>. This document also refers to the ASA guidelines on the "Continuum of Depth of Sedation" and the ASA physical status classification system.

"Core Principle #1: Guidelines or regulations for office-based surgery should be developed by states according to levels of anesthesia defined by the American Society

of Anesthesiologists (ASA), excluding local anesthesia or minimal sedation. (American Society of Anesthesiologists. Continuum of depth of sedation. Available at: <www.ASAhq.org/publications_and_services/standards/20.htm>. Accessed February 27, 2003).

"Core Principle #2: Physicians should select patients by criteria, including the ASA Physical Status Classification System and so document. (American Society of Anesthesiologists. ASA physical status classification system. Available at: <www.ASAhq.org/clinical/physicalstatus.htm>. Accessed February 27, 2003)."

Also of particular note to anesthesiologists is proposed Core Principle #10, which states:

"Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia or general anesthesia should have appropriate education and training."

In fact, ASA is currently finalizing several educational modules for nonanesthesiologist physicians who supervise nurse anesthetists. A roster of speakers has been developed, and details of the new program will be announced soon.

Continuous Regional Analgesia for Labor: Resolution 530 "Registered Nurse Participation in Epidural Analgesia" was not a new issue for anesthesiologists, particularly those who practice primarily obstetric anesthesia, but adoption by AMA serves as an affirmation that registered nurses can, and should, continue to be involved appropriately in the administration of continuous regional analgesia for the laboring patient.

A copy of Resolution 530 is available on the AMA Web site at: <www.ama-assn.org/ama1/upload/mm/annual03/e530a03.rtf>.

The recommendation of Reference Committee E (Science and Technology) was as follows:

"Resolution 530 asks that our American Medical Association:

(1) consistent with the American Society of Anesthesiologists position statement adopt the following statement on the administration of epidural analgesia: 'In order to provide optimum patient care, it is essential that registered nurses participate in the management of analgesic modalities. A registered nurse — qualified by education, experience and credentials — who follows a patient-specific protocol written by a qualified physician should be allowed to adjust and discontinue catheter infusions;'

(2) work with the ASA and other necessary stakeholders (e.g., Association of

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Women's Health, Obstetric and Neonatal Nurses) to ensure that patients receive the necessary pain relief during labor and delivery; and

(3) encourage the National League of Nursing Accrediting Commission and the Commission on Collegiate Nursing Education to emphasize education and certificate training programs that assure the necessary clinical skills for labor and delivery nurses to be able to adjust the rate of epidural infusion for patients."

It was noted by the Reference Committee that there was substantial testimony in favor of this resolution. Currently, labor and delivery registered nurses are refusing to take orders from the anesthesiologist to adjust the rate of epidural infusion based on the clinical position of the Association of Women's Health, Obstetric and Neonatal Nurses. "However, the American Society of Anesthesiologists has recently stated that in order to provide optimum patient care, registered nurses need to participate in the management of analgesic modalities. Your Reference Committee agrees with this approach," according to its report.

Part of the Solution?

What became abundantly clear to your Delegation at the AMA Annual Meeting was that the

voice of anesthesiology *IS* being heard, and the House of Medicine is heeding its recommendations. Our strength in the AMA House of Delegates, however, is predicated on the number of ASA members who also belong to AMA.

ASA was prominently mentioned in the address of AMA Executive Vice-President Michael D. Maves, M.D., who quoted from the *ASA NEWSLETTER* about the benefits that AMA can offer:

"According to an article in the American Society of Anesthesiologists member publication last summer by Michael Scott, Director of Governmental and Legal Affairs: 'Few ASA members are aware of the contributions made by AMA, and especially its Washington office, in representing our mutual interests in this city. I have often estimated that these contributions are worth annually about a half-million dollars to the Society and its members.'"

If you are not currently an AMA member, please consider making this a priority within your professional commitments. Beyond the monetary investment in paying dues is the voice that it gives you, the individual physician, to be heard in matters of utmost importance to you and your patients. Please be a part of the solution in helping to strengthen the practice of medicine in this country.

"ASA intends to seek a meeting with Mr. Scully to pursue the possibility of introducing greater flexibility into the anesthesiology teaching rule..."

Federal Legislators Support More Flexible Teaching Rule

Since CMS put into place its new teaching reimbursement rules in the mid-1990s, academic anesthesiologists have been permitted full reimbursement for a case only if they supervised one resident at a time. Prior to that time, most Medicare carriers permitted full reimbursement for each of two concurrent cases involving residents; under the new teaching rules, moreover, the "single case" limitation was not applied to academic surgeons nor, for that matter, to primary care academicians.

In May, I wrote to CMS Administrator Thomas Scully to ask him to look into the matter, and I have been gratified by the support I

have received from a number of federal legislators whose constituencies include major teaching programs. These include Senator Hillary Clinton and Representatives Charles B. Rangel (D) and Michael R. McNulty (D) of New York, Representatives Robert T. Matsui (D) and Xavier Becerra (D) of California, and Representative Stephanie Tubbs Jones of Ohio. I anticipate support from Texas legislators as well.

ASA intends to seek a meeting with Mr. Scully to pursue the possibility of introducing greater flexibility into the anesthesiology teaching rule, perhaps on the same terms as are enjoyed by teaching surgeons.

"...the ASA Washington Office waged a vigorous, and ultimately successful, campaign, to eliminate the 'minutes only' restriction."

ASA Preserves Right to Bill Units on Electronic Claims

As most ASA members know, physicians will be required after October 16 of this year to file all claims for reimbursement by electronic means, using a standard form for professional services (Form 837). When this form was originally being designed, it was proposed that anesthesia time be reportable in minutes only, not in units as many private carriers permit.

Recognizing that many carriers permit fractions of units to be rounded up to a full unit, the ASA Washington Office waged a vigorous, and ultimately successful, campaign to eliminate the "minutes only" restriction. Had the restriction been allowed to take effect, conservative estimates indicate that a loss of \$5,000 per year for each ASA member was prevented.

FIRST-CLASS MAIL

President's Update

"I am currently optimistic that despite the differences in the bills, the conference will find the means within budget limitations to forestall the projected reimbursement cut..."

House Medicare Bill Would Eliminate 2004 Cut

As I write, the House of Representatives is poised to pass Medicare prescription drug legislation that contains a provision guaranteeing physicians at least a 1.5-percent positive update in Medicare reimbursement in 2004 and 2005. Enactment of this provision by Congress would eliminate the 4.2-percent cut for 2004 under the Medicare update formula projected by the Centers for Medicare & Medicaid Services (CMS) last March: its inclusion in the House bill represents a major win for organized medicine, including ASA, which has extensively lobbied for reimbursement relief effective in 2004.

The prescription drug legislation now being debated in the Senate does not attempt to deal with the 4.2-percent projected cut. Instead, it contains a provision that would increase the re-

imbursement of physicians practicing in rural areas by amending the terms of the Fee Schedule — a provision not contained in the House bill. Assuming as is likely that both bodies pass prescription drug bills before the July 4 recess, a conference between the two will be necessary to reconcile not only the differences in approach to the physician update problem but also a host of other issues dealt with in the two bills.

I am currently optimistic that despite the differences in the bills, the conference will find the means within budget limitations to forestall the projected reimbursement cut while at the same time providing for improved reimbursement rates in rural areas.