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CONTENTS

FEATURES

Economics in Anesthesiology: Banking on a Future of Fair Value

Improving the Financial Foundation of Our Specialty 6
Norman A. Cohen, M.D.
Stanley W. Stead, M.D., M.B.A.

Update on Alternate Payment Methodologies Workgroup 8
Karl E. Becker, M.D., M.B.A.
Neal H. Cohen, M.D., M.P.H., M.S.

CPT® & RUC: What Are They and Why Do They Matter? 10
Neal H. Cohen, M.D., M.P.H., M.S.
Tripti C. Kataria, M.D., M.P.H.
Douglas G. Merrill, M.D.

Pay for Performance: an Overview 13
Douglas G. Merrill, M.D.
Steven L. Sween, M.D.
Stanley W. Stead, M.D., M.B.A.

COE and Private Insurers 15
Randall P. Maydew, M.D., M.B.A.
Norman A. Cohen, M.D.

The ASA Relative Value Guide™ and the ASA CROSSWALK® 17
Jan Gillespie-Wagner, M.D.
James P. McMichael, M.D.
Stanley W. Stead, M.D., M.B.A.

ARTICLES

ASA Anesthesia Awareness Registry Now Enrolling Subjects 20

Thanks to Our Sponsors 31

Arthur S. Keats, M.D. — 1923-2007 32
Stephen Slogoff, M.D.

Anesthesiology in the News 33

DEPARTMENTS

From the Crow's Nest 1
Quiet Conversations

Administrative Update 3
James D. Grant, M.D.

Washington Report 4
Rockefeller Introduces Senate Teaching Rule Reform Bill, Congress Continues Work on Broader Medicare Package

Practice Management 21
New Federal Rules on Physician Self-Referral Prohibition

State Beat 24
Wisconsin Medical Examining Board Issues Decision on Scope Law

What's New In … 25
The Anesthesia Foundation

Subspecialty News 26
AHA

Subspecialty News 28
SPA

ASA News 30

Letters to the Editor 34

FAER Report 35
New Blood Making Specialty's Future Look Bright

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Quiet Conversations

November is a month filled with quiet conversations. The House of Delegates has met, deliberated and set forth ASA's agenda for the coming year. Implementation requires effort and communication, often quiet communication between committee members, the chairs and ASA officers. November is a time to reflect upon what we have accomplished and on the road ahead. The month is filled with two holidays — one celebrated with gusto, the other slowly fading into obscurity. Yet it is in the celebrations of November that another form of quiet conversation comes into play — that which takes place between members of extended family. Whether by blood or association, November's holidays are a time to remember those who have sacrificed in our names and put their lives on the line for us. It is a time to be thankful not only to our veterans but to all our leaders and to ASA and all of our organizations that work toward making and regulating anesthesiology.

Douglas R. Bacon, M.D., Editor

One of the lasting quiet conversations I have had was with a veteran. He was in his late 70s and had arrived in the operating room where the anesthesia and operating room teams were going about the pre-induction rituals in the heart room. The monitors were on, an I.V. in place, and the anesthesia team was preparing to put an arterial line when the patient was asked, "Are you scared?" The reply: "Hell no — you're not trying to kill me like those Nazis on D-Day." It was a poignant reminder of what this man had done for all of us in the room. He had laid his life on the line that we might enjoy freedom.

That same year, the film "Saving Private Ryan" came out. As VA physicians, we were encouraged to see the movie, and as an added inducement, continuing medical education credit was available for those who answered some questions about the content presented. For me, the movie's ending moved me beyond words. In it, Private Ryan, now a grandfather kneeling at the grave of the captain who saved his life, asked his wife whether he was worthy of the ultimate sacrifice the captain had made for him. Survivor's guilt was something that often lurked below the surface of the patients we cared for at the VA.

On November 11, we celebrate Veterans' Day. Originally known as Armistice Day, the holiday commemorated the end of the mass slaughter known as World War I. In 1954, President Eisenhower, in recognition of the contributions of World War II and Korean War veterans, changed the name to Veterans' Day — set to honor those who have or are serving in the armed forces.[1] In the United States today, unfortunately, this holiday has come to mean a day off from school and sales at the local stores more than a solemn commemoration of those who serve or served to protect the freedoms that we enjoy. At my current place of employment, we work on the holiday despite the fact that two of our founders were brigadier generals in World War I and that there were two hospitals whose staff were supplied by our institution in Word War II.

Another World War II veteran, Bob Curran, wrote a column for many years that covered local stories of interest and a weekly "mailbag" in *The Buffalo Evening News*, the paper of my youth. I will never forget the ending to his Veterans' Day column — "May the words cleave to the roof of my mouth if I ever use the word courage to describe an act in a game boys play." Mr. Curran had seen the worst of life in some ways, as a foot soldier during the Battle of Bulge. His description of a burning tank, with injured men screaming inside, was a recurring piece in his writing, and I suspect it haunted his dreams. I hope Mr. Curran would agree with the assessment that true leadership requires courage, not as dramatic or intense as the life and death decisions of the battlefield, but in some instances as dramatic and long-lasting.

> ***"Rather than taking the popular or easy course, it will take quiet conversations, built upon trust combined with wisdom, to do the right thing, which will be of mutual benefit in the end."***

Over the course of the past year, it has become apparent that there was a need for a major overhaul in the administrative structure of ASA. The triumvirate of President Mark J. Lema, M.D., Ph.D., President-Elect Jeffrey L. Apfelbaum, M.D., and First Vice-President Roger A.

Moore, M.D., tackled this problem without reservation. It would have been easy to ignore the problem, to continue business as usual rather than engage experts to study the function and needs of our "home" office, our Washington Office, the membership and the strategic plan and make the necessary changes that will allow ASA to prosper in the 21st century. With this decision, there are and will continue to be growing pains and difficult issues, such as those concerning office space and parking at the Park Ridge office. These issues and more will need to be dealt with through quiet conversations and respectful deliberation.

One thorny space problem uncovered in the reorganization of the ASA Headquarters Office centers around the Wood Library-Museum of Anesthesiology (WLM), which is housed within the headquarters building and is the only ASA foundation with significant special needs. The George and Ramona Bause gallery exhibits some of the most interesting artifacts in the WLM collection. It also covers a quarter of the first floor of the building. ASA has generously supported WLM for many, many years and was thrilled to have such a wonderful space in which to display the collection WLM Trustees have worked so hard to collect and preserve. If this space is needed to further the mission of ASA, what will happen to the displays? With good leadership, which has already been proven on the ASA side, and the fortitude to trust each other, there is no doubt that the WLM will emerge stronger and better able to serve the needs of ASA members and the general public. Neither side can afford to be motivated by self interest or assume anything but the highest values in the other. Rather than taking the popular or easy course, it will take quiet conversations, built upon trust combined with wisdom, to do the right thing, which will be of mutual benefit in the end.

The strong, decisive leadership that the Executive Committee has demonstrated is something for which all of ASA should be grateful. The United States is among a handful of nations that set aside a day to give thanks for blessings received in the course of a year. The other November holiday is Thanksgiving. Stemming from the harvest traditions of England and the peace between the Wampanoag Indians and the pilgrims, the holiday evolved over time, with the State of New York celebrating an official day of Thanksgiving in 1817. Abraham Lincoln declared the last Thursday in November as a day of thanksgiving. Franklin Roosevelt declared the fourth Thursday in November a federal holiday, Thanksgiving Day, in 1939, and Congress agreed in 1941.[2]

As my extended family gathers in Rochester, I look forward to quiet conversations with everyone. My two eldest sons return home from college, and I am sure to be introduced to new ideas and concepts taught to them. It will be wonderful to have my mother to talk to, and my sister and brother-in-law, whose easy company is a far too infrequent blessing. As an anesthesiologist, I remain grateful for the strength of our Society and for the dedicated and determined leadership shown by our elected officers. Our Washington Office staff members remain tireless in their effort to further our cause on Capitol Hill, and they continue to monitor situations in many states. Our headquarters staff, while slowly expanding and evolving, remains the very best of any specialty society in the Untied States.

Indeed, we anesthesiologists are richly blessed. Take time this November to count your blessings, and engage in quiet conversations with your patients, colleagues and family.

— D.R.B.

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We are ONE

James D. Grant, M.D., Assistant Treasurer

"People who work together will win, whether it be against complex football defenses, or the problems of modern society."

— Vince Lombardi

James D. Grant, M.D.

Two years ago, the American Medical Association (AMA) began its campaign with the theme "Together We Are Stronger." How true do those words become apparent every day? We could do amazing things in so many aspects of our professional lives if we worked together for common goals. Does that mean we have to agree on everything from the get-go? Of course not. But in the end, we need to agree to disagree, come up with a united plan and move our agenda forward… together. Those with whom we don't necessarily see eye-to-eye on many issues would like to see nothing more than a House of Medicine that is divided instead of focused on moving our Society and our profession forward.

Last month I was invited as a guest to a place few physicians have ever explored before — the Board of Trustees of the Michigan Health & Hospital Association. After a weekend of collegial dialogue, we knew that we never would agree on everything, but we did come to a consensus. We concluded that we are together on 90 percent of our issues and that we would leave those few that were contentious "in the parking lot" and move forward together as a united team… the physicians… the hospitals and, yes… even the health plans. The end result was the effectiveness of ONE.

"The way a team plays as a whole determines its success," Babe Ruth once said. "You may have the greatest bunch of individual stars in the world, but if they don't play together, the club won't be worth a dime."

How true is this? Do you remember after 9/11 how there were no longer Republicans and Democrats, but everyone was an American? The partisan bickering of the past that had held this country hostage for so many years was gone. We worked together, because at that time, we all were attacked. In some ways, this country was never stronger. Those attacking the United States probably cringed at the idea of all of us working together — as one — to fight the attacks on our people. By working together, as a nation of ONE, our accomplishments could be endless.

All of these principles hold true for our specialty. Think about so many of our activities. If every ASA member gave just $50 per year to our Foundation for Anesthesia Education and Research, that would be $2,250,000 additional dollars into its coffers to sustain our specialty and to reach new horizons in research. How about $50 a year to the Anesthesia Patient Safety Foundation, another $2,250,000 to the world leader in patient safety studies? I am pretty sure that when you go out for a dinner for two on a Saturday night, you spend more than that! Can you imagine the strength if each and every member of ASA gave just $100 to our ASA Political Action Committee (ASAPAC)? ASAPAC's receipts would be more than $4.5 million — just think about the impact that would have. Better yet, think about American physicians. Most recent reports are that there are about 950,000 physicians practicing in the United States. If each physician gave $50 (the equivalent of about a dozen caramel macchiatos) to the American Medical Association's AMPAC, it would have receipts of $47 million, which would make it clearly the largest political action committee in America — and would likely be the greatest voice in Washington.

Last August at the ASA Board of Directors meeting in Chicago, there was discussion about plans to increase ASA's contribution to our foundations. At one point, someone stood up and referred to academic anesthesiologists and private practice anesthesiologists as "us and them." "Us and them?!" I was taken aback. Then there was a side discussion that ASAPAC was for "private practice issues." Pretty confident that this was not a common thought by anesthesiologists in any of the different practice models, it was still baffling. What is the one thing that our Washington Office and our ASAPAC have worked so hard for over the past few years? The "Teaching Rule," the fight to change the way that the Centers for Medicare & Medicaid Services pays for

Continued on page 5

Rockefeller Introduces Senate Teaching Rule Reform Bill, Congress Continues Work on Broader Medicare Package

Ronald Szabat, J.D., LL.M.
Executive Vice-President – External Affairs and General Counsel

At the behest of ASA, and with strong, coordinated encouragement by leaders in the West Virginia component society, Sen. John D. "Jay" Rockefeller IV (D-WV) has introduced S. 2056, the "Medicare Anesthesiology Teaching Funding Restoration Act of 2007." Sen. Rockefeller serves as Chairman of the Health Subcommittee of the powerful Senate Finance Committee and has been at the forefront of valiant efforts to ensure reauthorization of the Children's Health Insurance Program (CHIP).

The bipartisan bill, introduced jointly by Sen. Jon Kyl (R-AZ), third ranking member of the Senate Republicans, and a strong group of 13 other senators, many from the Senate Finance Committee, would restore full Medicare payment to academic anesthesiology programs, all of which have been uniquely short-changed 50 percent by the infamous Medicare anesthesiology teaching rule. The current teaching rule as it applies to teaching anesthesiologists is costing an average of more than $400,000 per program nationally and has led to the closure of 28 programs since its inception. All of this has occurred as student nurse anesthesia programs continue opening at a rapid pace.

In his Congressional Record remarks upon introduction, Sen. Rockefeller stated that "no other medical specialty or nonphysician providers were affected by this policy change. In fact, payments to nonanesthesiology teaching physicians continue to be paid using the conventional Medicare Physician Fee Schedule. All teaching physicians, except anesthesiologists, can collect the full Medicare fee for working with one resident and also collect an additional full Medicare fee for working with a second resident on an overlapping case as long as the teaching physician is present during the 'critical and key' portions of each procedure and is immediately available to return to a case when not physically present."

Sen. Rockefeller also stressed that in his home state, where there is only one academic anesthesiology program, at West Virginia University in Morgantown, "this program is losing nearly $700,000 per year because of this unfair Medicare payment policy." Sen. Rockefeller added that "when you take into account the fact that many private insurance companies follow Medicare's lead on reimbursement, the final dollar impact is even greater." Accordingly, "other departments within the medical school are being called upon to subsidize these losses instead of using their resources to advance important research initiatives or recruit highly qualified faculty," Sen. Rockefeller observed.

In his rationale for a national legislative solution to the problem facing academic anesthesiology, Sen. Rockefeller summarized the threat to the Medicare program. "This is not just a West Virginia problem," he warned. "This is a national problem with severe implications in every community. Academic anesthesiology programs treat the sickest of the sick, patients with multiple diagnoses, unusual conditions and/or in need of highly complex and sophisticated surgeries." The Senate Finance Health Subcommittee Chairman further

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warned that "the arbitrary Medicare payment reductions for teaching anesthesiologists could mean that patients of all ages and in all communities could see increased anesthesiology shortages in operating rooms, pain clinics, the military, critical care units, labor and delivery rooms, and emergency rooms," without action to reverse the Medicare anesthesiology teaching rule.

In equally strong remarks upon introduction, Sen. Kyl, after noting the severe health care shortages facing Arizona, stated emphatically that, "under this bill [S.2056], the clear winners are patients. Restoring funding helps preserve patient access to safe, quality health care and alleviate growing health professional shortages."

Currently ASA has launched a major grassroots initiative to add Senate support for the measure. The bill mirrors H.R. 2053, the Medicare anesthesiology teaching payment reform legislation introduced in the House by Rep. Xavier Becerra (D-CA), who sits on the House Ways and Means Committee. The House bill currently has almost 100 cosponsors.

As was the case in 2006, the fate of the Medicare anesthesiology teaching rule reform bills likely will rise or fall this year with broader efforts to reverse Medicare sustainable growth rate (SGR) cuts in 2008 and beyond as part of an omnibus health package. ASA continues to work effectively with a broad range of medical specialty organizations and the American Medical Association to advance multi-year, positive updates for all of Medicare that are fully offset from a federal budgetary standpoint. Efforts to extend CHIP, which sunseted on October 1, 2007, and was recently extended on a stop-gap basis, are associated with these efforts.

With so much at stake affecting the health care of both children and seniors in 2007 and beyond, ASA has continued to call on Congress to fairly fund all such programs. In addition, our battle to reform the Medicare anesthesiology teaching rule continues as we seek to ensure a supply of anesthesiologists into the future.

For up-to-the-date information on how you can help take ASA's message to Congress, please visit www.ASAhq.org/government.htm#alerts.

"With so much at stake affecting the health care of both children and seniors in 2007 and beyond, ASA has continued to call on Congress to fairly fund all such programs."

Administrative Update: We are ONE

Continued from page 3

teaching anesthesiologists in our academic programs. We will be successful on this issue because of the united strength of our entire anesthesiology community fighting together for what is right. Resident education and the solvency of our programs are vital for the growth of our academic departments as well as our private practices. Without successful and flourishing residencies, private practitioners will have no one to join their practices — they will be stifled and unable to expand and build.

We are not the "Academic Society of Anesthesiologists" or "Community Society of Anesthesiologists," we are the AMERICAN Society of Anesthesiologists. We can, will, must and do work together for the needs of our specialty. Together we are so much stronger, together we will be heard with one articulate voice. If we want to debate, let's do it with collegiality, professionalism and respect and then come out of the room with one united message.

We are ONE.

Improving the Financial Foundation of Our Specialty

Norman A. Cohen, M.D., Chair
Section on Professional Practice

Stanley W. Stead, M.D., M.B.A., Chair
Committee on Economics

ASA has nearly 100 committees, subcommittees and task forces whose volunteer members attend to the diverse needs and interests of our Society. One of these committees, the Committee on Economics (COE), focuses on an issue important to every practicing anesthesiologist — ensuring fair payment from all payers for our services while minimizing burdensome administrative barriers to receiving such payment.

The ASA Bylaws direct COE to "review and disseminate information" on the economics of anesthesiology practice; to analyze "public and private payer" plans; to advise ASA leadership, the Board of Directors, the House of Delegates and other committees on economic issues; and to serve as a resource to the state component societies.[1] To accomplish these "many missions,"[2] COE represents the ASA membership on the American Medical Association's Current Procedural Terminology (CPT®) Advisory Committee and the AMA/Specialty Society Relative Value Scale Update Committee (RUC). COE also has helped to place committee members on private insurer national advisory committees and has established liaisons with all the major anesthesiology subspecialty organizations. In addition, the committee has helped to place ASA members on important governmental advisory committees such as the Practicing Physicians Advisory Council and the Medicare Evidence Development & Coverage Advisory Committee.

> "Much of the work of the COE involves the development and valuation of procedure codes to describe the work we do every day."

COE is responsible for creating and annually updating two very important ASA publications, the Relative Value Guide™ and the ASA CROSSWALK®. These coding

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resources help all anesthesiologists to bill correctly for professional services. Working with counsel in the ASA Washington Office, members of COE also help to evaluate applications from those who wish to license the use of this valuable intellectual property in non-ASA publications and commercial products.

Much of the work of COE involves the development and valuation of procedure codes to describe the work we do every day. Through our participation at CPT and RUC, we have been very successful in ensuring that new or evolving diagnostic and therapeutic services do have procedure codes with reasonable values to describe the anesthetic care we offer. We also are looking to the future,[3] preparing for possible major changes in the health care payment system and those arising from the pay-for-performance movement.

Many members of COE, both past and present, have worked tirelessly for many years to achieve improved payment from the Medicare program. This year our representatives to RUC convinced that body and the Centers for Medicare & Medicaid Services (CMS) that Medicare grossly undervalues the work we do. In July, CMS proposed increasing Medicare's anesthesia conversion factor substantially. We anticipate that Medicare will announce its final decision on this proposed increase around the time this issue of the *NEWSLETTER* arrives in your mailbox. Stay tuned!

The hardworking and talented members of COE come from a broad variety of practice types and represent all regions of the country. We have active participation by our resident members as well. This issue of the *NEWSLETTER* features several articles written by members of COE that highlight our efforts to preserve and strengthen the financial underpinnings of our profession on your behalf.

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Update on Alternate Payment Methodologies Workgroup

Karl E. Becker, M.D., M.B.A.
Neal H. Cohen, M.D., M.P.H., M.S.
Committee on Economics

For more than 40 years, the ASA Relative Value Guide™ (RVG) has stood the test of time as a reasonable and consistent billing methodology for anesthesiologists. The system evolved based on changes in the method of payment for anesthesia services, from direct payments for anesthesiologists' services by hospitals to fee-for-service payments using a flat-fee methodology as a percentage of the surgeon's fee to the current relative value system using base and time units. The ASA RVG is currently accepted by all insurers and by the Centers for Medicare & Medicaid Services (CMS).

When the Medicare Physician Fee Schedule was implemented in 1992, payment methodology for anesthesia was not incorporated into the resource-based relative value scale (RBRVS); for all other specialties, it was. At that time, however, the Medicare anesthesia conversion factor (CF) was reduced by 29 percent from a national average CF of $19.27 to $13.68. This low CF has persisted, and in 2007 the national unadjusted Medicare CF is $16.19. Fortunately, due to the tremendous work of the ASA Committee on Economics and the Current Procedural Terminology (CPT®)/Specialty Society Relative Value Scale Update Committee (RUC) team, CMS (the agency that administers the Medicare program) has finally recognized the undervaluation of our services and has proposed to increase the anesthesia CF to about $20 per unit. Note that adjusting the CF of $13.68 in 1992 by the average consumer price index over the last 15 years would produce a conversion factor of about $20 per unit. We are now keeping up with inflation — a marked improvement!

Still, a huge discrepancy between the Medicare CF and private payer CF remains. The General Accounting Office (GAO), in a recent study called "Medicare and Private Payment Differences for Anesthesia Services" (GAO 07-463 www.gao.gov/new.items/d07463.pdf), found that the average Medicare CF in 2004 was *33 percent* of the CF for private payers; this does not come as a surprise to anesthesiologists. For other specialties, however, Medicare payment is approximately 80 percent of private payers. Something is seriously wrong here.

To complicate matters further, health care expenditures continue to increase at an unsustainable rate. The Medicare and uninsured populations continue to grow, the State Children's Health Insurance Program is expanding, and calls for universal health care are increasing. Health care availability and affordability are now major political concerns. At the same time, many anesthesiologists have entered into service contracts with hospitals

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and ambulatory surgery centers to provide payment for services that are not covered by health insurance, including call (availability) coverage and administrative responsibilities. Without these contracts and this additional payment, anesthesiologists' incomes would most certainly fall. With the pending Medicare meltdown (see: Savings T. Medicare meltdown. *Wall Street Journal.* 2007; May 9), how long will these contracts be maintained? These issues are of critical importance to the future of the specialty.

What can we do about the payment discrepancies? Some have suggested that the unique method for payment of anesthesia services — time-based methodology — is accounting for the lack of equity in anesthesia payments. Is time the problem? Under RBRVS, the surgeon receives a single payment for an individual procedure, no matter how long it takes, while the anesthesiologist's payment is based on time. Anesthesiologists have always argued that this time-based system is appropriate, since we do not control time, the surgeon does. In reality, it is both the surgeon and the patient who control time. No matter how fast that surgeon is, a difficult and complicated patient will require more time under the care of the anesthesiologist. Despite the desire to maintain time-based payment for anesthesia services, anesthesia time does not have a lot of support with the rest of organized medicine. While there are some codes (e.g., critical care, evaluation and management [E/M] and moderate sedation) that include a time component, time is not a separate component of the 6,000+ other CPT codes. So the common position is that since they do not have it, why should we? As a result, the question that is continually raised is whether we will be able to retain anesthesia time in the future as payment methodologies change.

At the same moment that anesthesia time is being debated, some in organized medicine have advocated a change in payment to a single payment to providers for a particular episode of care (episode case rate payments), a blended payment based on both fee-for-service and episode case rate payments or an expansion of pay for performance (Davis K, Guterman S. Rewarding excellence and efficiency in Medicare payments. *The Milbank Quarterly.* 2007; 85(3):449-468. Blackwell Publishing). Other payment methodologies also are being considered. What they will mean for anesthesia payment in the future remains unknown.

In response to these challenges, your ASA has been proactive. We do not know if anesthesia time as a separate payment element will last into the future, but we have been preparing for the possibility that it will not. In 2003 the ASA House of Delegates authorized the president to appoint a task force (TF) to study the relationship of anesthesiology's payment methodology to the RBRVS and to answer the question, "Would a change to RBRVS methodology offer a chance for improved payment?" The TF produced a focused study of the RVG versus the RBRVS methodology for anesthesia and studied the ramifications of integration into the RBRVS under Medicare. The TF looked at four RBRVS models: flat fee based on an expanded anesthesia code set; time-based using existing core expanded anesthesia code sets; flat fee based on surgical CPT codes and average time; and a building block method using E/M plus intraservice value. All of these models could work, but they all had some problems. In the flat fee and average time models, academic practices would suffer (since their cases are longer and more complex) as would anesthesiologists working with slower surgeons. In the other models that were considered, numerous new codes

Continued on page 23

"Some have suggested that the unique method for payment of anesthesia services

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CPT® & RUC: What Are They and Why Do They Matter?

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Douglas G. Merrill, M.D.
Committee on Economics

Valuing Physician Services

Describing and valuing physician services in the U.S. health care system is a two-step process: first creating a code at the Current Procedural Terminology (CPT®) Panel and then defining a value for the service within the Resource-Based Relative Value Scale (RBRVS). CPT is wholly owned by the American Medical Association (AMA), and the Centers for Medicare & Medicaid Services (CMS) maintain the RBRVS. An important AMA-sponsored committee, the AMA/Specialty Society Relative Value Scale Update Committee (RUC) is the primary avenue for physicians and other health care professionals to help CMS value the code by establishing physician work, practice expense and professional liability costs for each RBRVS service. Getting the right values for each code is important, not only for Medicare payment but because RBRVS has become the most common payment system in this country.

CPT Coding

CPT is a coding system that allows the reporting of professional activities, supplies and equipment associated with a specific clinical service. CPT was originally developed in 1966 by AMA and was adopted by the Health Care Finance Administration (HCFA) — now known as CMS — as the method for describing physician services in the 1980s. In 2000, as part of the Health Insurance Portability and Accountability Act, CPT became the required coding system for use in all health care transaction reporting. AMA continues to maintain CPT and manage the entire process for editing, creating or deleting codes. The

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process allows any specialty or individual to propose new codes or challenge the definitions or need for existing codes. The clinical service codes, Level 1, are five-digit codes that may be reported with two-digit modifiers. CMS has developed the Healthcare Common Procedure Coding System (HCPCS) Level II codes for reporting product, supply and other non-CPT services that are provided to patients. These are codes made up of a letter (A-S and V) followed by four digits, with two character modifiers.[1] HCPCS Level II codes can be modified by CMS via a process that is outlined on its Web site at www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/2007_alpha.pdf.

The CMS rules for use of CPT in billing are explicit in their requirement that as many codes be used (with various modifiers) as are needed to accurately describe a service — *without "unbundling."* Unbundling refers to the process of breaking down a service into its component parts and charging for them separately in an attempt to boost payment. Such activity is considered abuse of the Medicare Trust and could lead to prosecution. Each service is described by a single code, while additional codes may be used to describe services that might have been provided concomitant to the first service, unless those codes are not allowed to be reported simultaneously (i.e., are "bundled").

RBRVS and RUC

Once a service is properly coded, the payment for the service by Medicare is determined based on the relative value of the service compared to other clinical services. In 1992, Medicare altered the way it pays for most physician services. Instead of paying physicians based on charges, HCFA established a standardized payment schedule based on a resource-based relative value scale, or RBRVS. Under the RBRVS system, CMS determines payments by estimating the resource costs needed to provide the clinical service. CMS uses "relative value units," or RVUs, to compare the relative amount of resources used for an individual service compared to all other services on the Medicare Fee Schedule. The resources include three components: physician work, practice expense (PE) and professional liability (malpractice) (PLI) costs, each expressed in RVUs. Payment is calculated by multiplying the combined RVUs for a service by a conversion factor, a monetary amount that is determined annually by CMS. CMS determines the code-specific RVU values based in large part on recommendations received from the RUC. The RUC makes recommendations to CMS for all three resource elements for almost every code published in CPT. For practice expenses, a standing subcommittee of the RUC known as the Practice Expense Review Committee, or PERC, considers expense items proposed by specialty societies and recommends to RUC the values for direct practice expense items, which are clinical labor time, equipment and supplies. While the RUC makes recommendations on time, type of equipment and number and type of supply items used, CMS determines the cost assigned to each of these items, converting the total into a PE RVU value, using a very complex formula. In the final determination of payment, there is the additional factor of the geographic practice cost index that adjusts the payment to account for geographic differences in costs.

> " … the process is driven by evidence, and the demand for proof of efficacy or work valuation requires that members of the specialty participate in the surveys that determine what practice expense and work valuations actually are … "

In addition to defining values for new codes, the RUC provides a reassessment of all previously valued codes through a five-year update process. Both specialty societies and CMS can nominate services felt to have incorrect work values for review. Not surprisingly, specialties prefer to bring codes forward in the five-year review that are felt to be undervalued, while CMS typically brings forward codes thought to be overvalued.

The recommendations of the RUC are forwarded to CMS, which makes final value determinations. As a result of the processes established by the RUC, AMA and specialty societies, the recommendations of the RUC have, in the great majority of cases, been accepted by CMS, recognizing that "organized medicine" has established the relative valuation of services. Nonetheless it is the responsibility of CMS to maintain values in the RBRVS. In the end RUC is only an advisory body, albeit a very influential one.

Role of ASA in Valuing Clinical Services

Specialty societies such as ASA play a major role in advising CMS by providing advisors to the CPT, RUC and its subcommittees. Specialties that have large Medicare case volumes (including ASA) have permanent membership on the RUC, with smaller specialties having the opportunity to be elected to one of three rotating two-year RUC seats. Every specialty that has a seat in the AMA House of Delegates has an advisor at CPT and the RUC who serves as an advocate for their specialty. This advocacy includes presenting codes to CPT, recommending values to the RUC for work and practice expense and commenting on the presentations of other specialties. Each member of the CPT Editorial Panel and the RUC serves in the role of an expert in coding (CPT) or in valuation (RUC). Procedural rules prevent the panel and committee members from advocating on behalf of their specialties, unlike the role of the advisers. As a result, participation in this process by ASA representatives is critical to the proper valuation of nonanesthesia clin-

ical services provided by anesthesiologists (notably evaluation and management, critical care and pain management codes). Although anesthesia services use a different system for determining payment (base + time rather than work + PE + PLI), CPT is responsible for creating anesthesia codes, and the RUC recommends base values to CMS.

AMA appoints the physician members of the CPT Editorial Panel, and these CPT panel members are subject to term limits. While the workings of the committees may seem arcane, they employ a scrupulous methodology that strives to be fair to all while requiring a scientific approach to the valuation of services. The CPT panel will entertain testimony from any entity that might wish to see a change in the CPT coding (adding, altering or deleting a code). The RUC hears testimony only from physician or allied health professional specialty society representatives in determining valuation. The overriding principle is that CMS reimbursement valuations must be "budget neutral" so that any increased payment for one CPT code — usually thereby favoring one or a few specialties — often means a potential commensurate downgrading of other code valuations. CMS actually mandates that any alterations in valuation may not cause physician fee schedule payments to vary overall by more than $20 million from that which would have ensued had the changes not been made.[2]

Thus the process is driven by evidence, and the demand for proof of efficacy or work valuation requires that members of the specialty participate in the surveys that determine what practice expense and work valuations actually are [see "The Survey Process" below].

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1. American Medical Association. Physicians' Current Procedural Terminology. Chicago: American Medical Association; 2005:10-15.
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The Survey Process:

Why It Is So Critical to Proper Valuation of Codes?

When a specialty society earns Current Procedural Terminology (CPT®) approval for a new or revised code, the next step is to determine a work value, usually at the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC). In most cases, the RUC process requires that the specialty conduct a survey of providers who have experience with the clinical service and can provide an assessment of the relative value of the physician work involved.

The RUC has a well-defined process for developing work relative values. After CPT approves a new or changed code, each specialty society is asked to indicate if it has a "level of interest" in determining valuation for the service. When a specialty, such as ASA, receives this invitation, it has one of several options:

1. Survey the members to obtain data on the amount of physician work involved in providing the service;
2. Comment on recommendations developed by other societies; or
3. Take no action.

For codes that are frequently performed by anesthesiologists, ASA usually selects option number 1. It is critical that anesthesia providers who provide the service participate in the survey process, since this familiarity is essential to accurately determining the value of physician work.

The survey process is straightforward but requires careful consideration in providing reliable and credible data for the RUC. AMA staff prepares the survey instrument based on specific RUC-approved language and instructions. In some cases, such as the survey form used for anesthesia codes, the RUC has approved a special survey document to satisfy individual requirements. Specialties request that physicians completing a survey compare the work of the new or revised service to that of an established reference service of widely accepted value. A list of 15 to 30 potential references accompanies the survey.

After the survey period ends, the specialty society committee reviews the results and prepares value recommendations and supporting rationales for the RUC. When two or more specialty societies are involved in developing recommendations, the RUC encourages coordination of the survey process and joint development of recommendations.

The specialty(ies) then presents its recommendations to the RUC and is required to defend every aspect of the proposed valuation. As a result, the more surveys that are submitted and the more detailed the information provided by the physicians completing the surveys, the greater the credibility of the information. After presentation of recommendations, the RUC votes on the specialty's recommendation. A two-thirds majority is necessary for approval. The RUC forwards its recommendations to the Centers for Medicare & Medicaid Services (CMS), which has final authority for maintaining the Medicare fee schedule and the resource-based relative value scale. CMS historically has accepted more than 95 percent of the RUC's work value recommendations.

Pay for Performance: P4P an Overview

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Pay for performance (P4P) programs propose to link payment rates to evidence of achievement of specific quality care indicators. This initiative grew out of the 1999 Institute of Medicine (IOM) report *To Err Is Human* and the resultant paradigms of care improvement embraced by the Leapfrog Group, the Institute for Healthcare Improvement (IHI) and others. Advocates for P4P believe that it will improve quality of care.[1] Furthermore, this strategy is seen as a means of saving money as it rewards efficiency and substitutes payment for quality in place of payment linked solely to volume of services provided.[2] This type of program has been extant in some private payer arrangements, and primary care has now seen the initiation of these policies by federal and state payers as well. The Integrated Healthcare Association (IHA) began its P4P program in 2001.[3] Other payers have begun "pay for participation" programs in which practitioners and facilities can receive payment by simply sharing outcome data rather than by hitting a particular quality "mark."[4] This has culminated with Medicare's Physician Quality Reporting Initiative (PQRI), which began on July 1, 2007.

The incentives that have been discussed usually range from 1 percent to 5 percent of a physician's total revenue.[5] Providing more money has increased quality in specific markets, but pay for performance is very early in its evaluation.[6] One of the lessons learned at IHA is that larger amounts of payment will induce more rapid and widespread compliance with the program objectives. As a result, it has instituted an increase in its bonus program that will reach as high as 10 percent by the end of the decade, up from an initial 1.5 per-

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cent. Some postulate that incentives as high as 20 percent will be necessary to effect quality improvement. It must be remembered that these are "holdbacks" and that the rewards of these programs will be extracted from the payments of those who do not meet P4P targets or have none.[7] In the case of PQRI, Medicare offers physicians a bonus payment of up to 1.5 percent of their 2007 charges (subject to a cap) for reporting on a designated set of 74 quality measures.[8]

Specialty societies have been invited to provide recommendations for appropriate measures of quality to be used in the production of P4P programs by the Centers for Medicare & Medicaid Services (CMS). Coordinated through the American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI), AMA has invested more than $5 million in development of 140 measures,[9] the first half of which became part of Medicare's 2007 PQRI system on July 1, 2007.[10] Medicare is required by law to have measures adopted or endorsed by a consensus organization such as the AQA Alliance (formally the Ambulatory Care Quality Alliance) or the National Quality Forum. This has slowed the approval process.

Measures for P4P can be *outcome* — assess the quality of care to the extent that health care services influence the likelihood of the desired outcome; *process* — assess adherence to recommendations for clinical practice based upon evidence or consensus; or *structural* — describe the capability of the professional rather than care provided or results achieved (e.g., a nurse/patient ratio is a structural measure).[11] The types of measures advocated for use in P4P programs should generally meet the following 10 criteria: [12]

- **High volume:** the diagnoses involved must be relatively common.
- **Gravity:** the conditions that are to be affected must be significant.
- **Empirical evidence:** process and structural measures may rest upon empirical evidence, but outcome measures require the more rigorous test of randomized, controlled trials in the peer-reviewed literature.
- **Gap:** there must be evidence that a significant difference exists between the current practice and the best practice.
- **Probability:** there must be likelihood that the intervention being promulgated will improve the outcomes as desired.
- **Reliability:** the measure (or "metric") is consistent when measured by various observers, at various points in time, and in various settings.
- **Validity:** the metric is proven to actually measure its intended endpoint, and it is clearly defined so as not to be left open to interpretation by various stakeholders.
- **Feasibility:** there must be a way to efficiently obtain the measurement.
- **Acceptance/approval:** the metric should have been identified by such quality measurement organizations as the National Quality Forum, the AMA PCPI, the National Committee on Quality Assurance or by CMS itself.
- **Applicability in several settings:** there must be utility of the metric in many practice settings, ideally ranging from the single-practitioner office to major medical centers.

The ASA Administrative Council, directors and members of the committees on Performance and Outcomes Measurement, Economics, Critical Care Medicine, Pain Medicine, and Ambulatory Surgical Care have all been active in the process of evaluating quality measurements to meet the above criteria. This will be an area of dynamic activity for some time to come and will continue to deserve this high level of ASA organizational attention. Members are encouraged to report any activity in this regard among private payers to the chairs of these committees or to ASA Vice-President for Professional Affairs Robert E. Johnstone, M.D.

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COE and Private Insurers

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The ASA Committee on Economics (COE) strives for enhanced benefit for our members by seeking fair payment with minimal hassles from all payers, both public and private. The role of COE has evolved with the maturation of the medical market. The history of COE's interactions with private insurers is linked to the evolution of government payment methods and policies, most notably the resource-based relative value scale (RBRVS) and the Medicare payment rules, both national and carrier-specific. Discussions with insurers can be initiated by either the insurer or COE on behalf of membership. The discussions are generally a matter of *policy* or *process*. The majority of the interactions of COE with private insurers are questions of payment *policy*. Questions also arise in the specifics of the payment *process*. Primarily through the efforts of the ASA Washington Office and ASA's Coding and Reimbursement Manager Sharon Merrick, CCS-P, COE has often educated insurers, practice managers, professional coders and physi-

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cians in issues concerning *correct coding, modifiers, crosswalk* and *time*. These initiatives usually start with an ASA member's request for help. In reviewing the history of COE with public and private payers, a number of recurrent issues are illustrated to remind us that *the more things change, the more they stay the same.*

In the 1970s, the U.S. Department of Justice sued ASA, claiming that publication of the Relative Value Guide™ (RVG) resulted in illegal price-fixing. Despite ASA's successful resolution of this lawsuit, the experience created great concern about ASA's antitrust exposure for both leadership and staff and has colored ASA's relations with payers since that time. As a result, there was little exchange of information between private insurers and ASA and COE for many years.

Under the leadership of Steven "Butch" Thomas, M.D. (chair, 1988-1996), COE focused on the development of RBRVS and the retention of separate anesthesia time as the predominant payment issues facing ASA. To paraphrase Dr. Thomas, "private insurers were not the Monoliths they are today, and the main issues were coding." Early discussions with Medicare took place at this time concerning the medical necessity of monitored anesthesia care (MAC) services. Some initial contacts with the private sector occurred with individual Blue Cross/Blue Shield entities concerning issues of obstetric billing. These questions of best methods for obstetric billing ultimately led to the development of the current obstetric billing options found in the RVG. An additional issue embraced by COE under Dr. Thomas was an attempt to have the ASA House of Delegates (HOD) adopt a policy to endorse the separate payment for postoperative pain services by the same anesthesiologist providing operative anesthesia services.

During the tenure of L. Charles Novak, M.D., as COE chair (1997-2000), the antitrust concerns continued to dominate COE's interactions with private insurers; however, at that time, Dr. Novak initiated discussions with a medical director from a major insurer. This initial relationship has developed into one of mutual respect with the exchange of information valuable to both parties and, by extension, to ASA's membership. While the early antitrust concerns persist and consideration of fees remains off the table, the dialogue with private insurers has matured to allow constructive discussions in many areas.

Questions often arise during the development of carrier payment polices. Private payers *develop* payment policies as an *internal process,* while the *external* target of these policies are providers. The level of provider input to private insurer payment policy is highly variable and depends upon the insurer making a request for comment or information. An early example of ASA playing a role in payment policy development occurred during the tenure of Alexander A. Hannenberg, M.D., COE chair from 2001-03, and concerned a question of medical necessity for MAC. Specifically, ASA/COE received a request for a comment on the use of separate anesthesiology services for sedation during trigger-point injections.

COE serves as the clearinghouse for questions of payment policy for ASA. Current examples of payment policy challenges earning COE attention include anesthesia services for GI endoscopy, postoperative pain procedures and fluoroscopic guidance for spinal injections. Where official ASA policy as codified by HOD action is available, this is utilized as the primary resource. COE has asked for approval of position statements on payment for postoperative pain procedures and fluoroscopic guidance for spinal injections at the ASA 2007 Annual Meeting in San Francisco. Other formal ASA policies initiated by past COE recommendation include statements opposing bundling of payments for invasive monitoring procedures and transesophageal echocardiography into payments for anesthesia service as well as statements defining MAC and differentiating MAC from sedation services.

The delicate nature of discussions with private insurers is appreciated at all levels of ASA/COE. Individual members of COE, by virtue of expertise in coding and billing in a specific area of anesthesia services, may offer opinions and interpretations when requested. These are accompanied by a disclaimer that these opinions are not necessarily those of ASA, except for those specifically repeating ASA HOD-approved statements. These individual discussions often provide information about insurer payment policy that may be applicable to a broader cross-section of the membership.

Private insurer payment policy has tracked the evolution of government payment rules since insurers can more easily hide behind the government's actions compared to homegrown initiatives. The recent wave of mergers and acquisitions has consolidated private insurers into fewer, but much larger, companies that increasingly adopt government payment policies advantageous to their business interests. This is evidenced by the broad adoption of RBRVS and the private insurer implementation of Medicare-like teaching payment reductions in some markets. The resources dedicated to governmental payment policies have had great impact on the private insurer market, and the development of private and public payment policies has reflected maturation in the general health care market. Future challenges in payment policy will include implementation of pay-for-performance programs and focusing increased attention on medical necessity for anesthesia services, including those supporting GI endoscopy.

The opportunity for education, exchange of information and playing a role in the development of payment policies has predicated the interaction of COE with private insurers. *What you do not know, you cannot influence.*

THE ASA RELATIVE VALUE GUIDE™ AND THE ASA CROSSWALK®

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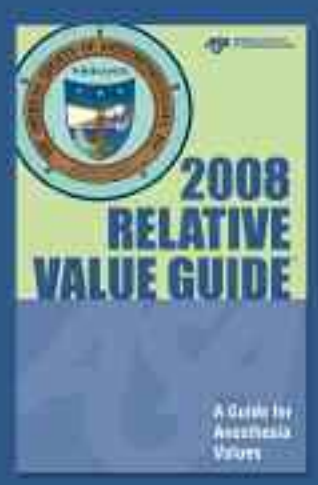
The ASA Relative Value Guide™ (RVG) and the ASA CROSSWALK® are among the most visible and important publications directed toward the economic aspects of the practice of anesthesiology.

RVG

The American Medical Association publishes the Current Procedural Terminology (CPT®) code book. CPT is updated annually and contains codes that describe professional services provided by all physicians and other qualified health care professionals. The RVG, also updated annually, lists the CPT codes that are of interest to anesthesiologists, including all anesthesia codes (CPT codes 00100-01999) as well as codes to describe consultative, diagnostic and therapeutic procedures that are commonly performed by anesthesiologists, and codes for modifiers used in reporting anesthesia services, including:

- Evaluation and Management Services
- Pain Management
- Intravascular Catheterization Procedures
- Transesophageal Echocardiography
- Pulmonary Function Testing
- Neurological Monitoring Procedures
- Other

The RVG's value extends beyond the code listings. It includes italicized "coding comments" that offer guidance from the ASA Committee on Economics on the correct use of specific codes. An



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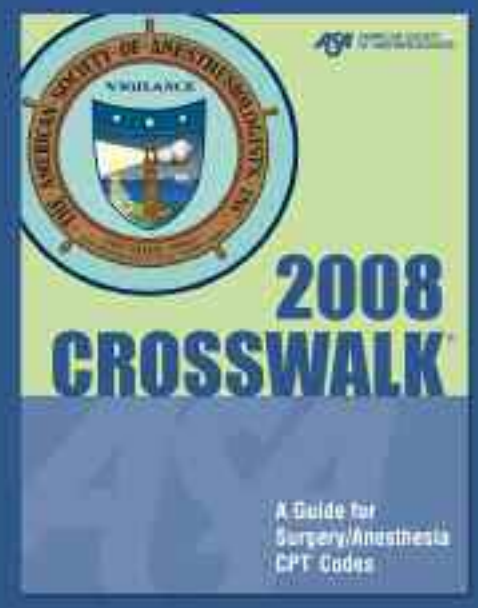


example of a "coding comment" is found in the entry for code 01830:

> **01830** 3+TM Anesthesia for open or surgical arthroscopic/endoscopic procedures on distal radius, distal ulna, wrist, or hand joints; not otherwise specified.
>
> *Includes open procedures on radial and ulnar shaft and bones of the hand.*

An important part of the RVG is the "Summary of Changes" section. In this section, there are convenient and concise summaries of new, revised or deleted codes, including new or revised coding comments along with any base unit value changes from the previous year. These changes also are noted in the body of the RVG.

The RVG also includes official ASA statements, as approved by the House of Delegates, on issues relevant to coding and payment. The 2007 edition includes:

- Position on Monitored Anesthesia Care
- Distinguishing Monitored Anesthesia Care (MAC) From Moderate Sedation/Analgesia (Conscious Sedation)
- Statement on Intravascular Catheterization Procedures
- Statement on Transesophageal Echocardiography

The RVG was developed in response to the desire to have a rational and consistent methodology to value and report anesthesia services to payers, both public and private. In the 1950s, Joseph H. Failing, M.D., and other California anesthesiologists developed the original California Relative Value Study. In 1962, the ASA House of Delegates adopted the first RVG based on the California RVS. Since 1970, the RVG has been reviewed and revised annually. For his efforts, Dr. Failing received the ASA Distinguished Service Award in 1966.

It is important to note that the RVG is not a fee schedule, but rather is a resource for anesthesiologists and can be used to facilitate determination of professional charges. In the 1970s, several medical organizations, including ASA, came under the scrutiny of the Federal Trade Commission (FTC), which charged that publications such as the RVG represented conspiracies to fix prices. All of the other organizations ultimately agreed to consent orders, the terms of which included the cessation of publishing their guides. The FTC did not specifically "go after" the ASA RVG, but the Justice Department brought suit against ASA in 1975 on the grounds that the RVG represented price fixing and was, therefore, a violation of the Sherman Antitrust Act. The case went to trial in federal court in New York City in December 1978. ASA's legal counsel at the time, John Lansdale, Esq., developed the legal strategy to fight the case. Several prominent members of ASA testified in the six-day trial, and ASA prevailed. The ASA Lansdale Public Policy Fellowship recognizes Mr. Lansdale's contribution by pro-

viding recipients a year's study on legislative process and national health care policy.

CROSSWALK®

The CROSSWALK links CPT diagnostic and therapeutic procedure codes to appropriate anesthesia codes. When there are multiple anesthesia codes that could link to a procedure code, the CROSSWALK will offer alternative anesthesia codes along with guidance on how to select the most appropriate code. In addition the CROSSWALK provides coding comments and guidance for coding selection. Below are examples of CROSSWALK entries (including coding comment in italics).

The CROSSWALK was originally created and developed by Stanley W. Stead, M.D., M.B.A., and the rights to the publication were given to ASA. It was first published in 1994 and is updated each year. Dr. Stead continues to serve as editor of CROSSWALK. He and a group of four experienced members of the Committee on Economics meet annually to review the accuracy and appropriateness of the code links, making the CROSSWALK a dynamic and evolving document.

The Reverse CROSSWALK™ was first offered in 2003. This product is indexed by anesthesia code and links the anesthesia code to all appropriate procedure codes.

The RVG and CROSSWALK are published in both print and electronic format. The Reverse CROSSWALK is currently available only on CD. Thanks to the efforts of Sharon Merrick, CCS-P, ASA's Coding and Reimbursement Manager, who provides ASA staff support for the Committee on Economics, the updated publications are routinely available in the fall of the year allowing anesthesiologists to report their services with the appropriate existing, revised or new codes as required beginning on January 1 of each year.

Sample CROSSWALK Entries

20600 **01820** 3+TM Anesthesia for all closed procedures on radius, ulna, wrist, or hand bones.
Arthrocentesis, aspiration and/or injection; small joint or bursa (e.g., fingers, toes).
Alternate(s): 01462, 01470, 01810

Selection of either the primary anesthesia code of one of the alternates is determined by the site of the surgical procedure.

31628 **00520** 6+TM Anesthesia for closed chest procedures;
(including bronchoscopy) not otherwise specified.
Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; with transbronchial lung biopsy(s), single lobe.
Alternate(s): 00326

Consider patient age when selecting anesthesia code.

38381 **00541** 15+TM Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); utilizing one lung ventilation.
Suture and/or ligation or thoracic duct; thoracic approach.
Alternate(s): 00540

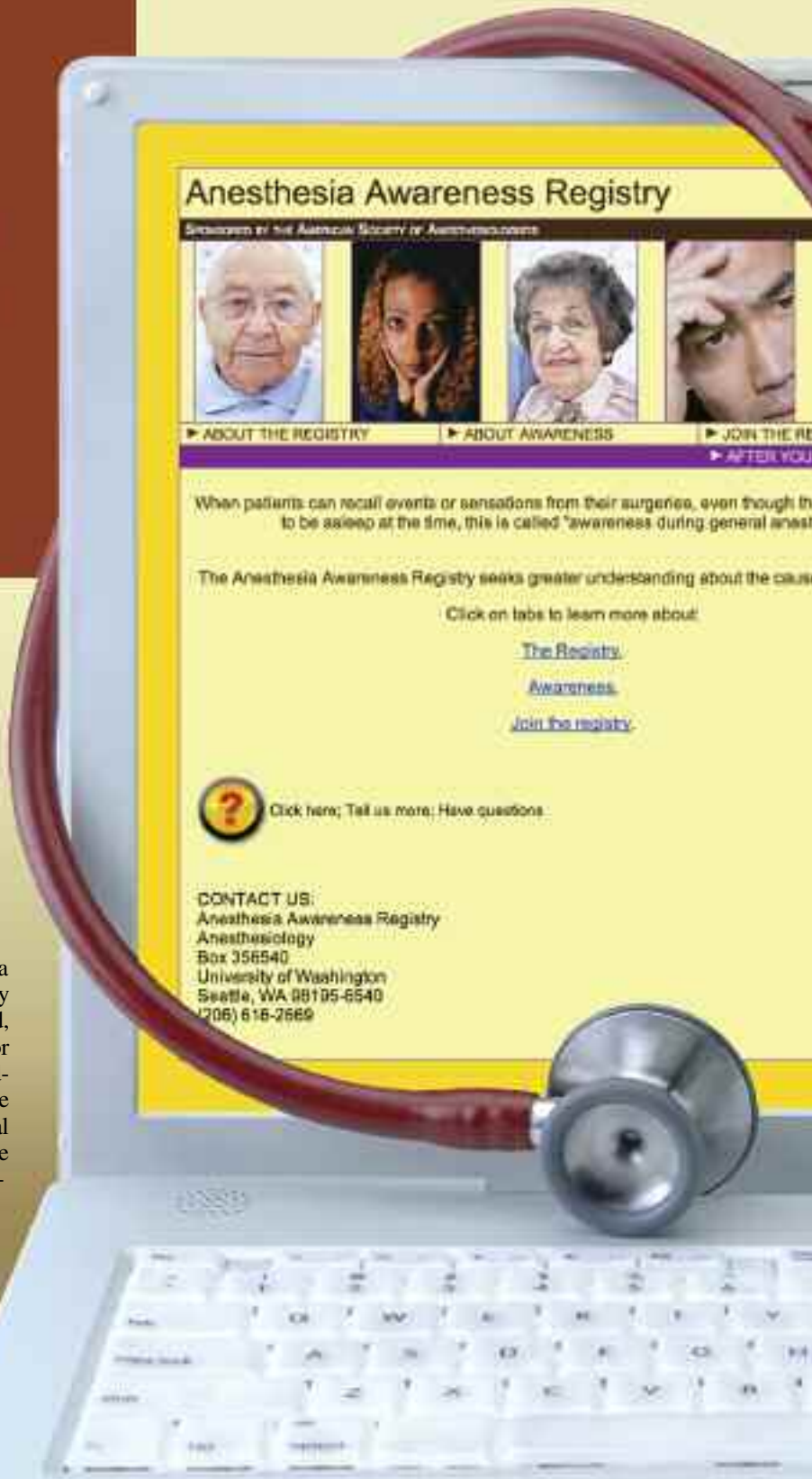
Consider single or double lung ventilation when selecting anesthesia code.

49324 **00840** 6+TM Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy; not otherwise specified.
Laparoscopy, surgical, with insertion of intraperitoneal cannula or catheter, permanent.
Alternate(s): 00790

Report 00790 if catheter placed above umbilicus.

ASA Anesthesia Awareness Registry

Now Enrolling Subjects



The Anesthesia Awareness Registry database is now enrolling subjects. The ASA Committee on Professional Liability initiated the development of the database in order to learn more about patients' experiences of awareness during general anesthesia. The project will provide information on patients' understanding of intraoperative awareness and provide a patient perspective on how anesthesiologists might intervene when a patient has experienced awareness during general anesthesia.

Patients who enroll in the Anesthesia Awareness Registry will complete a survey about their experiences and, if requested, submit copies of their medical records for data abstraction and analysis. Limited funding is available to reimburse patients for the costs of obtaining copies of their medical records. The registry has a federal certificate of confidentiality protecting those who participate.

ASA members wishing to provide information to their patients about the project can obtain a patient information sheet about the Anesthesia Awareness Registry at the project Web site www.AwareDB.org. Enrollment packets also are available directly to patients from the Web site.

New Federal Rules on Physician Self-Referral Prohibition (Stark Law, Phase III)

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Committee on Economics

On September 5, 2007, the Centers for Medicare & Medicaid Services (CMS) published the long-awaited third phase of its final rulemaking (the Phase III rule) regarding the federal physician self-referral prohibition, known as the "Stark Law." The amendments reflected in the Phase III rule go into effect on December 4, 2007.[1] Phase III contains many technical changes and subtle details, along with substantive changes that will require physicians and their counsel to re-evaluate and likely restructure their relationships with "designated health service" (DHS) organizations in the immediate future.

Phase III is a final rule wholly separate from the self-referral provisions contained in the recent Proposed CY 2008 Medicare Physician Fee Schedule (the "Fee Schedule Rule").[2] Confusingly, Phase III requirements significantly differ from and in some topics directly conflict with the Fee Schedule Rule, particularly as providers attempt to comply with the "strict liability" statute. In addition, commentary in the Phase III rule reveals that CMS may be considering yet another future rulemaking to address further issues raised by stakeholders. This brief article serves to point out key Phase III changes that may apply to anesthesiologists practicing in surgical anesthesia, critical care and pain medicine.

Anesthesiologist Referrals to DHS Still Not Excluded

Three years ago, ASA requested confirmation from CMS that anesthesiologists do not refer patients to DHS organizations by providing surgical anesthesia services under the Stark Law and regulations. ASA specifically asked that CMS confirm that anesthesiologists do not refer patients for inpatient or outpatient hospital services when they provide surgical anesthesia services and asked CMS to specifically address the case of freestanding outpatient facilities. CMS *declined* to make this change. In the commentary in Phase III, CMS noted that the consultation exclusion granted to pathologists, radiologists and radiation oncologists is statutory and that CMS lacks the authority to extend it. Furthermore CMS was not persuaded that any special regulatory exception is warranted for "DHS referrals made by an anesthesiologist to an entity with which he or she (or his or her immediate family member) has a financial relationship."[3]

Elimination of Safe Harbor Method for Establishing Fair Market Value of Personal Services

Many anesthesiology practices receiving support from hospitals and other entities have relied upon a "fair market value" (FMV) to establish an appropriate level of support (stipends). Previously, under Phase II rule, FMV was considered by CMS to be a "safe harbor" for establishing compensation for physicians' personal services. Typically compensation was based on the average of the "50th percentile national compensation level for physicians in the same specialty,"[4] using at least four of six specified salary surveys, and dividing the result by 2,000 hours to establish an hourly rate. Phase III eliminates this "safe harbor" method. CMS acknowledges, however, that "references to multiple, objective and independently published salary surveys remain a prudent practice for evaluating fair market value." CMS emphasized that FMV is essential to many Stark Law exceptions and "the appropriate method for determining fair market value for purpose of the physician self referral law will depend on the nature of the transaction, its location and other factors."[4] The abolition of the "safe harbor" provision means that each compensation agreement between physicians and DHS will need to take into account the particular nature and environment of the agreement. Rather than relying on a particular valuation methodology, "ultimately, fair market value is determined based on facts and circumstances."[5]

FMV Exception

Until now, FMV exceptions currently applied only to FMV compensation paid to a physician or group for items or services by a DHS. Phase III now extends the exemptions for payments made by a physician or group of physicians to a DHS hospital or health entity.[6] Office space rent is under additional scrutiny as are equipment leases of less than one year. For physician payments to a DHS to qualify as FMV

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exceptions, agreements must satisfy the more stringent requirements of §411.357(a), requiring a written agreement and stated term length. In the 2008 proposed fee schedule rule, CMS proposes to amend the office space and equipment rental exceptions to exclude per unit of service or "click" rental payments.[2] CMS is seeking more transparency in physician payment to health entity arrangements.

Group Practice Compensation

Physician compensation within group practices receives more flexible treatment than individual physicians under the Stark Law. Generally, in the case of group practices, members of a group practice cannot be compensated in any way that directly or indirectly relates to the volume or value of their referrals for a DHS. Physicians may, however, be paid a share of group profits or bonuses based upon services personally performed or "incident to" as long as the determination of the bonus or profit share is not directly related to the volume or value of physician referrals. "Incident to" services are defined as those services performed by ancillary personnel under supervision of a qualified Medicare provider. "Incident to" does not include medical direction of nurse anesthetists.

Phase III now defines "incident to" services to mean those services that meet the requirements of section 1861(s)(2)(A) of the Social Security Act, the "incident to" billing rule in §410.26, and the relevant manual provisions,"[5] thus allowing a productivity bonus for supplies, including drugs, as long as they qualify and are billed on an "incident to" basis. For example, pain physicians in a group practice may receive a productivity bonus for supplies (including drugs), assuming that they properly qualify and are billed on an "incident to" basis. Note that "incident to" services cannot be billed in a hospital setting.

The "Stand in the Shoes" Provision Converts Indirect Compensation to Direct

Physician practices have used their medical groups as an intermediary to accept payments from a DHS to individual physicians and remain in compliance with Stark regulation. Previously if a health entity had a financial relationship with a physician's medical practice, this was not regarded as a direct compensation arrangement with the individual physician. Rather, if there were a chain of financial relationships involving at least one additional entity interposed between the physician and the health entity, it was considered a potential indirect compensation agreement. This may no longer be valid; instead, a new test is used in analyzing financial relationships.

Phase III introduced a new definition ("stand in the shoes") of their "physician organization" in analyzing financial relationships. Under section §411.354, "a physician is deemed to 'stand in the shoes' of his or her own physician organization." If the only intervening entity between the physician and the DHS is the "physician organization," the financial relationships that were indirect may now be considered direct. In the case of an anesthesiology group, an office lease between the hospital and the anesthesiology group now must comply with the lease exception, rather than rely upon the indirect compensation exception. Moreover, when a medical director agreement exists between the hospital and the anesthesiology group, it must comply with the personal services or FMV exception. In the case of academic medical centers, the academic medical center exemption may apply. Fortunately CMS does not require change to any current indirect compensation arrangements entered into prior to September 5, 2007.[7] They may remain in effect during the original term or the current renewal term.

Academic Medical Center (AMC)

AMCs may face additional regulatory burden under Phase III. There are three principal changes effecting AMCs: first, compensation from each academic medical center need not separately satisfy an FMV test, but the compensation paid to all AMC components must be applied on an aggregate (medical school and faculty practice plans); second, in determining whether the majority of its medical staff are faculty members, the hospital may include or exclude certain types of privileges (e.g., courtesy), but the criteria must be uniform; and lastly, compensation between AMC components and faculty members may not take into account referrals or other business generated for any AMC component.

Physician Recruitment

Hospitals frequently provide recruitment support to anesthesiology groups. Under Stark Phase II, payments made by hospitals intended to induce physicians to relocate their medical practice to the geographic areas served by the hospital in order to become a member of the medical staff are permitted. Phase III now requires that the recruited physician move the practice from outside the geographic service area to a location inside the service area of at least 25 miles or utilize a more complex calculation of how the physician's revenues are derived.[8] More liberal allowances are made for rural hospitals. Payments made to an existing physician group for recruitment continue to be protected if the hospital payments take into account only the incremental costs associated with the recruited physician. Phase III now recognizes medical groups' imposition on noncompete clauses and other practice restrictions for group members as long as they are "reasonable."[8] CMS notes that state law may be an important source of guidance in this area.

Retention Payments in Underserved Areas

Hospitals have made "retention payments" to induce anesthesiologists to continue to practice in a particular area, particularly when the anesthesiologist was being recruited by

another hospital. Currently payments from a hospital to a physician with the intention to retain the physician in the facility service area are permitted in underserved areas. Phase III expands the criteria of an underserved area to be met if at least 75 percent of the physician's patients reside in a "medically underserved area" or are members of a medically underserved population.[9] In addition, Phase III permits retention payments to be made to physicians in the absence of a written recruitment offer from a competing location as long as the offer is *bona fide* under certain constraints.[6]

Professional Courtesy

In the past, CMS required that DHS entities notify the applicable insurer when there was a reduction of the coinsurance obligation (professional courtesy) to physicians or their immediate family members. Phase III has deleted this requirement that the DHS entity notify an insurer when the professional courtesy was extended. In addition, CMS clarified this ruling, noting that it only applies to entities with formal medical staffs (hospitals) with written professional courtesy policy approved by the governing body.[10] Physician-to-physician professional courtesy is unlikely to be prohibited unless the recipient physician is a source of DHS referrals to the physician extending the courtesy.[10]

Conclusion

The Phase III regulations further implement the federal physician self-referral statute (Stark Law). While the provision provided some changes to the actual text of the Stark Law and the commentary provided significant clarification statements by CMS, it also provided insight into the way enforcement authorities may interpret the statute.

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2. Proposed Revisions to Payment Policies Under the Physician Fee Schedule, and Other Part B payment Policies for CY 2008, 72 *Federal Register*, 38122-38395 (July 12, 2007)
3. Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase III), 72 *Federal Register*, 51021 (September 5, 2007).
4. Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase III), 72 *Federal Register*, 51015 (September 5, 2007).
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8. Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase III), 72 *Federal Register*, 51048 (September 5, 2007).
9. Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase III), 72 *Federal Register*, 51096 (September 5, 2007).
10. Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase III), 72 *Federal Register*, 51064 (September 5, 2007).

Update on Alternate Payment Methodologies Workgroup

Continued from page 9

would be required to determine values based on the complexity of the case and type of anesthesia. In all of the models, adjustments would have to be made for multiple surgical procedures. The TF concluded: Time may last forever, but anesthesia time units probably will not; all the models for integrating anesthesia into the RBRVS either do not show much improvement or are unduly complex and unfair to some; we should keep time as long as possible; and ASA must be prepared with viable alternatives when and if we lose anesthesia time units. The findings of the TF were presented at the 2004 ASA Annual Meeting.

The ASA Committee on Economics (COE) continues to study health care literature regarding payment methodologies, to explore new methods of paying for our services, and continues the work of the original TF through the COE Workgroup on Payment. Recently COE involved the Certificate in Business Administration (CBA) Program in the Alternative Payment Methodology Project. We hope the additional input and brainstorming of the CBA candidates will bring the additional insight and creativity necessary to develop an alternative payment methodology that will protect all anesthesiologists' incomes in a fair and equitable manner.

Wisconsin Medical Examining Board Issues Decision on Scope Law

Lisa Percy, J.D.
Manager, State Legislative & Regulatory Issues

As reported in previous "State Beat" articles, the **Wisconsin** Society of Anesthesiologists (WSA) challenged the validity of Governor James Doyle's opt-out of the federal requirement that physicians supervise the administration of anesthesia. WSA believed that the governor violated two of the three procedural requirements to seek exemption from the federal physician supervision requirement: consultation with the state medical board and that the opt-out must be consistent with state law.

The Wisconsin Department of Regulation & Licensing (DRL) submitted a memorandum to Governor Doyle supporting an opt-out; however, there has not been any evidence to indicate that the governor consulted with the medical board. There also has been lack of any evidence that DRL discussed with or consulted the medical board before issuing its recommendation. Moreover, WSA and ASA believed that the governor would be required to amend state law to allow for collaboration or independent practice before opting out of the federal supervision requirement. Therefore, WSA sought a declaratory ruling from the medical board that anesthesia is the practice of medicine and to affirm that Wisconsin law required physician supervision of nurse anesthetists.

Subsequent to filing WSA's petition, the Wisconsin Association of Nurse Anesthetists (WANA) sought a declaratory judgment from the nursing board that the administration of anesthesia by a nurse anesthetist is part of the practice of professional nursing and can be undertaken by a nurse anesthetist independent of a physician.

An administrative law judge (ALJ) took the issue under consideration and issued proposed recommendations and an order to the medical board regarding WSA's petition. The medical board, however, was not required to adopt the ALJ's recommendations.

First, the ALJ recommended that the administration of anesthesia is part of the practice of medicine and surgery and is part of the practice of professional nursing. Second, the ALJ distinguished the scope of practice of a nurse anesthetist versus a nurse anesthetist who holds a certificate to prescribe (advanced practice nurse prescriber) [CRNA/APNP]). The ALJ concluded that a CRNA/APNP who administers anesthesia is not required to have a license as a physician or be supervised by a physician. CRNA/APNPs work in a collaborative relationship with a physician. However, nurse anesthetists who are not certified as APNPs and who administer anesthesia must be directed, supervised and inspected by a physician.

"CRNA/APNPs work in a collaborative relationship with a physician. However, nurse anesthetists who are not certified as APNPs and who administer anesthesia must be directed, supervised and inspected by a physician."

WSA submitted written objections to the ALJ and appealed the proposed recommendation. WSA argued that collaboration for CRNA/APNPs only extends to prescribing; they must still be supervised when they administer anesthesia. Moreover, WSA objected to the ALJ's recommendation that the administration of anesthesia is part of the practice of nursing. In addition to the nurses, the podiatrists and podiatric board supported the ALJ's proposed recommendations.

Ultimately, the medical board rejected WSA's arguments and followed the ALJ's recommendations. After the medical board issued its decision, WANA asked the Wisconsin Board of Nursing to adopt the medical board's decision. A decision on the petition has not yet been made.

The **Indiana** Medical Licensing Board voted 6 to zero (with one abstention) to adopt the proposed office-based surgery regulations. Details of the rule are found in the September "State Beat" www.ASAhq.org/Newsletters/2007/09-07/stateBeat09_07.html.

Next, the rule will be reviewed by the Indiana Attorney General's office. The attorney general will review the rule for form and must act within 45 days of the medical board's action. After review by the attorney general's office, the rule will be sent to the governor for signature.

Lisa Percy, J.D., manages state affairs for ASA in its Washington, D.C., office.

The Anesthesia Foundation: More Than 50 Years of Serving

William D. Owens, M.D., President
John R. Moyers, M.D., Secretary

This year, the Anesthesia Foundation celebrates more than 50 years of accomplishments in satisfying its missions. The purposes of the Anesthesia Foundation are to provide financial help to anesthesia residents in the form of low-interest loans and to stimulate innovation in educational endeavors through books and multimedia presentations. The Anesthesia Foundation was originally founded by the leadership of ASA as a memorial to several of the founding fathers of the organization.

Since 1956, the Anesthesia Foundation has depended primarily upon gifts from individuals (mostly anesthesiologists) and anesthesia societies. Many of the gifts are given as memorial gifts, keeping with the original name "The Anesthesia Memorial Foundation." The only money obtained from ASA was a loan of $5,000 at the onset of the Foundation. This loan was later "written off" so that, in fact, it became a gift from the Society. The Foundation generates other income from temporary investments and from the interest the young physicians pay on their loans. Most of the assets of the Foundation are committed to the loan program. A very small part of the assets are earmarked to honor excellence and innovation in books or multimedia projects. A monetary award is made for this prestigious accomplishment every four years.

— William D. Owens, M.D., President

Currently the Foundation loans amounts of up to $6,000 per year to a resident who demonstrates financial need. The number of loans is now set at 12 per year, but as the Foundation's assets grow, the number of loans granted will increase. No doubt there is a need for more loans judging by the number of applications annually. In 2007, there has been an infusion of some monies from the ASA 100th anniversary celebration in Chicago in 2006. The members of the Anesthesia Foundation Board of Trustees thank all who helped to support its missions through gifts directly to the Foundation and for those who supported the ASA Gala celebration.

The assets of the Anesthesia Foundation now exceed $1.5 million, and, as stated earlier, most of this amount is designated for loans with the remainder held in reserve for emergencies. An example of "an emergency" would be the granting of gifts of money to the residents who were unfavorably impacted by Hurricane Katrina in New Orleans in 2005. No other medical society or foundation supported its residents in any manner similar to that provided by the Anesthesia Foundation and ASA and its members.

The Anesthesia Foundation Board of Trustees is 12 in number, and all trustees (except for one public member) are members of ASA. Each trustee serves without pay or reimbursement. Each may serve up to three four-year terms. These individuals are nominated by the ASA president and must be approved by the ASA Board of Directors.

Continued on page 29

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AHA: Building a Better Future by Looking Back

Doris K. Cope, M.D., Immediate Past President
Anesthesia History Association

Our specialty of anesthesiology has a uniquely American birth among all of the specialties of medicine. The first well-known use of ether for a surgical procedure was performed by Crawford W. Long, M.D., on March 30, 1842. The public demonstration of surgical anesthesia by William T.G. Morton on October 16, 1846, also occurred in the United States, and this event's significance quickly spread throughout the entire world. Without modern anesthesia, the majority of surgical advances would just not have been possible.

Anesthesiology did not, however, spring fully formed from Zeus' head. There were a series of intellectual and cultural milestones that marked the way in the development of our professional heritage. These important discoveries, people, places and ideas are not only fascinating to contemplate but are key in understanding where we have been in the context of history and where we may be going. Anesthesiologists who are interested in medical history have formed a specialty society, the Anesthesia History Association (AHA), which is celebrating its silver anniversary this year.

Interest in forming such a group was inspired by the First International Symposium on Modern Anesthesia History, held in Rotterdam, Holland, in 1982. Later that year, meeting at the ASA Annual Meeting in Las Vegas, Nevada, under the leadership of Roderick L. Calverley, M.D., and Selma H. Calmes, M.D., with the support of 47 participants, AHA was founded.

This Society has been continuously active for the past 25 years, fostering the study and teaching of the history of our medical specialty. The organization currently meets twice a year — in the spring and during the ASA Annual Meeting. The spring meeting, sometimes held in conjunction with the American Association for the History of Medicine and at other times as a stand-alone meeting, has combined resident presentations, senior remembrances and original research often with accompanying historical tours. Memorable events have included: a walking tour of Frank Lloyd Wright's designs in Oak Park, Illinois; Civil War battlefields and redoubts in Nashville, Tennessee; and an upcoming meeting, "The Gilded Age and the Great Industrialists," to be held next May in Pittsburgh, Pennsylvania. The fall AHA dinner meeting, traditionally on the Monday night of the ASA Annual Meeting, has featured dinner presentations with diverse topics such as "The Wounding, Amputation, and Death of Thomas Jonathan 'Stonewall' Jackson: An Anesthetic Insight," "Ambroise Paré and War and Trauma Surgery in the Renaissance," "Anesthesia, but no Curare: Anesthesia Practice During the Korean War," "Clinical Problems of War: An Australian Family Memoir: 1899-1946," "Ethereal Pursuits: In Search of Anesthesia's Treasures," "History of Conjoined Twins," and "Things I Thought I Knew: A Revisionist View of Anesthesia, History and Professionalism."

Even more exciting has been the international cross-fertilization with other anesthesia history societies in

1993 ASA President Peter L. McDermott, M.D., Ph.D., addresses the audience at the AHA Annual Meeting.

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Great Britain, Germany and Spain, among others. There is even a nascent Society for Anesthesia History with the beginnings of a museum in Beijing, China. This worldwide movement has sponsored seven International Symposia on the History of Anaesthesia in Rotterdam, The Netherlands (1982); London, United Kingdom (1987); Atlanta, Georgia, (1992); Hamburg, Germany (1996); Santiago de Campostela, Spain (2001); Cambridge, United Kingdom (2005); and Crete, Greece (2009).

The U.S. society and Emory University co-sponsored the Third Symposium, held in Atlanta, Georgia, on March 27-31, 1992, where the sesquicentennial of Dr. Crawford Long's use of ether vapor to produce surgical anesthesia was celebrated. Collaborative efforts with the History of Anaesthesia Society of Great Britain have resulted in stimulating gatherings such as "Ralph M. Waters, M.D., and Professionalism in Anesthesiology: A Celebration of 75 Years," and jointly sponsored conferences such as the bicentenary of Sir Humphrey Davy's experiments with nitrous oxide, held in Bristol, England, on May 13-15, 1999. The lively interactions and collaborations formed at these and other similar meetings have been marked by true collegiality and lasting friendships.

Preservation of this scholarship has been entrusted to the *Bulletin of Anesthesia History*, jointly sponsored by AHA and the Wood Library-Museum of Anesthesiology (WLM). The first newsletter was published in December 1982 and has grown to a peer-reviewed journal published quarterly. The annual Resident Essay Award, begun by Doris K. Cope, M.D., with the support and encouragement of C. Ronald Stephen, M.D., has directed many anesthesia trainees into the study of medical history. A memorial foundation in Dr. Stephen's honor funds the cash awards to the winning residents. Many of these young scholars have been awarded subsequent WLM fellowships and now hold leadership positions in academia, private practice and in organizations such as AHA and WLM.

The current officers of AHA are:

- Immediate Past President: Doris K. Cope M.D.
- President: Douglas R. Bacon, M.D., M.A.
- Vice-President: William D. Owens, M.D.
- Treasurer: David B. Waisel, M.D.
- Secretary: Mark G. Mandabach, M.D.
- Editor-in-Chief, *Bulletin of Anesthesia History*
  Doris K. Cope, M.D.

The current AHA Council members are:

- Councilor: N. Martin Giesecke, M.D.
- Councilor: Mark E. Schroeder, M.D.
- Councilor: Bradley K. Smith, M.D.
- Councilor: Sandra L. Kopp, M.D.
- Councilor: David C. Mackey, M.D
- Councilor: Jason L. McKeown, M.D.

AHA is a formal 501(3)c nonprofit corporation registered in the state of Illinois. To join AHA, please contact Deborah Bloomberg, AHA Meeting Coordinator, at (412) 784-5343 or bloombergdj@upmc.edu for details.

For those residents with an investigative bent, AHA awards the annual C. Ronald Stephen Resident Essay Award. Interested residents may submit a 1,000-3,000 word essay related to the history of anesthesia, pain medicine or critical care. The first-, second- and third-place winners receive a monetary prize of $500, $200 and $100, respectively. The finalists are announced at the AHA's annual dinner meeting and will present their essays at the annual spring meeting, where the winners are selected.

To enter, essays should be sent to:

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While looking forward is the essence of scientific thought and development of our specialty, looking backward also provides a context for understanding and the opportunity to pass on our heritage to our successors.

AHA President Douglas R. Bacon, M.D., M.A. (right) and former Editor-in-Chief of Anesthesiology *Michael M. Todd, M.D. Dr. Todd was awarded honorary membership in AHA for his efforts in promoting the history of anesthesia.*

SPA at Age 21

Jayant K. Deshpande, M.D., M.P.H., President

The Society for Pediatric Anesthesia (SPA) is proud to be completing its 21st year as an organization dedicated to the advancement of the practice of pediatric perioperative care, with the threefold mission of promoting patient care, education and research. During these formative years, SPA has grown substantially in both its size and contributions to the specialty of anesthesiology. Current membership totals more than 4,400, including practicing anesthesiologists and resident members.

The Society's activities are designed to meet the academic and professional needs of all practitioners who care for children. SPA hosts two scientific and educational sessions each year: the Fall Meeting in October preceding the ASA Annual Meeting and the three-day winter/spring meeting in partnership with the Section on Anesthesiology of the American Academy of Pediatrics (AAP). SPA members have devoted their efforts to providing educational offerings that bridge the science and practice of both pediatrics and anesthesiology and seek to improve the perioperative care of children. The most recent winter meeting, Pediatric Anesthesiology 2007, was held in Phoenix, Arizona, and was attended by nearly 500 registrants. The featured scientific sessions included "Developmental Pathology of the Infant Airway," "Genetics and the Pediatric Anesthesiologist," "Syndromes, Associations and Sequences," and "New Horizons in Paediatric Anaesthesia: Ultrasound," with each session providing research updates and implications for the clinician. The day prior, the new Congenital Cardiac Anesthesia Society (CCAS) www.pedsanesthesia.org/ccas held its inaugural scientific and educational meeting, which proved to be an overwhelming success. Attended by well over 250 registrants, the meeting featured excellent presentations and discussions by leaders in pediatric cardiac anesthesiology.

Advocacy for children's care and overall health is a major part of the SPA mission, a mission shared by our colleagues in the Section on Anesthesiology of AAP. The educational offerings of SPA include discussions on current health care needs of children and on the role of physicians and health care professionals in improving child health. The winter meeting includes the annual AAP Advocacy Lecture, which this year focused on poverty and its effects on the distribution of health care to poor children.

The Society also supports efforts to advance the practice of pediatric perioperative medicine around the globe, collaborating with sister societies of pediatric anesthesia in other countries. This year's Fall Meeting in San Francisco, for instance, is a joint meeting presented in concert with the Association of Paediatric Anaesthetists of Great Britain and Ireland, focusing on "Pediatric Anesthesia Developments and Outcomes." The SPA Committee for International Education and Service, or SPACIES, is a venue for discussion and dissemination of information to anesthesiologists interested in clinical service and educational opportunities in underserved areas of the world. SPA actively supports learning opportunities in pediatric anesthesia in developing countries in the form of fellowships through the World Federation of Societies of Anaesthesiologists. Fellowship recipients have been able to dedicate six to 12 months in training in Vellore, India, to expand their knowledge and practice of pediatric anesthesia.

Looking ahead, our next Winter Meeting, Pediatric Anesthesiology 2008, will be held in San Diego, California, from April 3-6, 2008. The program will offer a cornucopia of educational opportunities. CCAS also will host its second annual meeting on Thursday of the meeting week, which will provide updates on the science and art of the perioperative care of children with congenital heart disease. Attendees may, alternatively, elect to take the course in pediatric advanced life support (PALS) and update their PALS certification on the Thursday before the main meeting begins. A broad range of workshops, refresher courses and problem-based learning and discussions complete the educational offerings. SPA and the Malignant Hyperthermia

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Association of the United States are co-hosting a one-day symposium with experts in malignant hyperthermia (MH) to examine data regarding the relationship of MH and identifiable syndromes. Details of the upcoming meetings can be found on the SPA Web site www.pedsanesthesia.org.

The *SPA Newsletter* and online educational offerings at www.pedsanesthesia.org complement the semi-annual meetings of the Society. The newsletter is published three times a year and contains articles on the Society's activities, reviews of important articles from various medical journals and expert debates on controversial topics. Members also may access ongoing continuing medical education (CME) opportunities on our Web site, where we provide new CME content each month.

SPA continues to co-sponsor a yearly pediatric anesthesiology young investigator award with the Foundation for Anesthesia Education and Research. The Society also is actively pursuing continuing quality improvement initiatives. The Pediatric Regional Anesthesia Network is a coalition of members sharing their institutions' experiences through a registry of data and outcomes for regional anesthesia in children. The "Wake Up Safe" initiative has been working on a process by which we can learn from adverse events and near-miss situations in order to develop recommendations for preventing future adverse events.

SPA is proud to work so closely with ASA. Leaders and members of SPA actively participate in ASA committees in order to promote and advance the practice of anesthesiology. SPA members also are honored to regularly contribute to the educational programs and scientific sessions of the ASA Annual Meeting. This year the Annual Meeting includes numerous lectures and workshops related to pediatric anesthesia.

The Society for Pediatric Anesthesia and its members continue to work diligently to improve the perioperative care of children through our activities in research and education and by fostering a culture of inclusiveness and involvement for all practitioners of pediatric perioperative care. I am privileged to be able to work with great colleagues and represent the members of the Society.

The Anesthesia Foundation: More Than 50 Years of Serving

Continued from page 25

We would like to welcome a new member of the Board of Trustees, Charles W. Otto, M.D., who was approved by the Board in August. Dr. Otto replaces Thomas G. Johans, M.D., who decided not to seek an additional term. This year we also must recognize with sadness the passing of a long-time member of the Board of Trustees and member of the Anesthesia Foundation Advisory Committee, Jess B. Weiss, M.D.

We would personally like to invite each and every one of you to support the Anesthesia Foundation by sending a gift this year or by placing the Foundation on the list of charities that will be supported by your estate. Our administrative expenses are less than 1.5 percent of our assets. I can assure you that the need is there and that the Foundation will use that support to help others in need.

Subspecialty Recertification: ABA Exams in Critical Care Medicine and Pain Medicine

The American Board of Anesthesiology (ABA) will administer examinations for recertification in the subspecialties of critical care medicine and pain medicine via computer at more than 350 test centers from September 20 to October 4, 2008 (except Sundays). ABA will inform candidates of the test sites when the list is available. Physicians previously certified in critical care medicine or pain medicine by ABA may apply to recertify in the subspecialty. After January 15, 2008, applicants may use the ABA Web site www.theABA.org to submit their application for a subspecialty recertification examination electronically.

The standard application deadline is **March 15, 2008**. ABA will consider late applications received by **March 31, 2008**. Applications received after the late deadline will not be considered. ABA will make a decision about an applicant's qualifications for subspecialty examination by May 15, 2008.

Subspecialty Certification: ASA Exams in Critical Care Medicine and Pain Medicine

The American Board of Anesthesiology (ABA) will administer examinations for certification in the subspecialties of critical care medicine and pain medicine via computer at more than 350 test centers on Saturday, September 13, 2008. ABA will inform candidates of the test sites when the list is available.

All applicants for subspecialty certification must satisfactorily complete one year of training in a critical care medicine program accredited by the Residency Review Committee for Anesthesiology or in a pain medicine program accredited by the Accreditation Council for Graduate Medical Education by September 30, 2008. They also must be certified in anesthesiology by ABA or scheduled for ABA oral examination in 2008. After January 15, 2008, applicants may use the ABA Web site www.theABA.org to submit their application for a subspecialty certification examination electronically.

The standard application deadline is **March 15, 2008**. ABA will consider late applications received by **March 31, 2008**. Applications received after the late deadline will not be considered. ABA will make a decision about an applicant's qualifications for subspecialty examination by May 15, 2008.

ASA Welcomes New Director of Communications

On September 10, 2007, ASA welcomed Dawn M. Glossa, M.S., as Director of Communications. Dawn joins ASA at a productive and exciting time as the Organizational Improvement Initiative, now under way, helps to better position ASA as the foremost authority on anesthesiology-related education and policy and attempts to solidify ASA's position as the world's leading patient safety advocate.

Dawn M. Glossa

Dawn brings to ASA more than a decade of marketing and advocacy experience in nonprofit and for-profit organizations. She served as Marketing Coordinator, Marketing Manager and eventually Director of Public Relations and Communications at Sinai Health System in Chicago before being offered the position of Vice-President of Marketing and Communications at ChildServ, a child welfare agency that has served the Chicagoland area since 1894.

She is a graduate of Eastern Michigan University (B.A.), DePaul University (M.S., Public Administration) and Northwestern University's Kellogg School of Management in the Executive Education Program-Fundraising and Marketing. Her thesis at DePaul was titled "Marketing in Hospital Settings."

As the ASA Organizational Improvement Initiative picks up steam, Dawn is eager to join a burgeoning ASA staff whose collective goal is to realize the Initiative's objectives over the next two to three years. "I feel lucky to be joining the ASA staff at this crucial juncture in the Society's history," she said. "ASA is already one of the most respected medical specialty organizations in medicine, but it is only going to get better in the next few years. With a stronger and more focused presence in Washington and beyond, we will be able to better serve our members and their patients as never before."

Dawn lives in Oak Park, Illinois, with her husband Duane and their two sons.

2008 Membership Dues Announced

The ASA membership dues for 2008 (unchanged from 2007) will be as follows:

Active	$450
Affiliate	$225
Educational	$225
Resident	$25
Educational (student)	$25
Medical Student	$10

This information is being provided for those who wish to renew their membership in December. The 2008 dues statements will be mailed to the membership in December 2007. Members may also renew their dues online through the "Members Only" section of the ASA Web site www.ASAhq.org.

Dues payments are deductible by members as an ordinary and necessary business expense; in the case of membership dues paid to a section 501(c)(6) organization such as ASA, this means the "business expense" deduction will be denied to the extent that membership dues are spent by the organization on lobbying.

At the time of the distribution of the dues statements for the coming year, ASA is required (in order to avoid paying a proxy tax) to provide members with an estimate of what the nondeductible lobbying percentage will be for that year. For 2008 the percentage of dues related to lobbying is 9 percent. Therefore 9 percent of dues paid to ASA in 2008 will be disallowed as a deduction. This percentage also will be included on your 2008 dues statement.

Anesthesiology groups paying association membership dues on behalf of an employee (e.g., resident, anesthesiologist assistant) should bear in mind that they must include in the employee's taxable income on Form W-2 that portion of the association's dues that the association reports to the Internal Revenue Service as attributable to lobbying expenses.

Thanks to Our Sponsors

ASA gratefully acknowledges the following sponsors of the 2007 Annual Meeting in San Francisco, California. This support in funding various unrestricted contributions allows the ASA Annual Meeting to continue as the premier anesthesiology meeting in the world.

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Arthur S. Keats, M.D. — 1923-2007

Stephen Slogoff, M.D.

Arthur S. Keats, M.D., died on August 28, 2007. He was truly "A Man for All Seasons" who was a gift to our specialty and brought us great honor from the rest of medicine.

Dr. Keats graduated from Rutgers with a B.S. in 1943 and received his M.D. from the University of Pennsylvania three years later. His residency at the Massachusetts General Hospital from 1948-1951 was remarkable for the lifelong mutual admiration he developed with his mentor, Henry K. Beecher, M.D., and his colleague and friend, Mike Laver, M.D. After a year of practice in Zurich, Switzerland, he became the chief of anesthesia at the Mary Imogene Bassett Hospital in Cooperstown, New York. When surgeon Michael DeBakey, M.D., asked Dr. Henry Beecher in 1954 for a candidate to become the first chair of anesthesiology at Baylor College of Medicine, he received only one name. Arthur held that position from 1955-1974, after which he moved full time to the young and exciting frontier of cardiovascular surgery — the Texas Heart Institute (THI) — with his colleague and friend Denton Cooley, M.D. He was chief of cardiovascular anesthesia at THI until his retirement in 2005.

Arthur S. Keats. M.D.

During his long and illustrious career, Arthur Keats excelled in a variety of endeavors. What few people know is that he was a brilliant clinical anesthesiologist who, with Dr. Cooley in the 1950s and '60s, created and published some of the most important concepts in pediatric cardiovascular anesthesia and surgery. For more than 30 years, Dr. Keats, in collaboration with his colleague Jane Telford, M.D., and others, was one of the most prolific investigators in the area of pain management and, specifically, the clinical pharmacology of opioids and opioid antagonists. As a consequence of these efforts, Dr. Keats was named to the National Institutes of Health Surgical Study Section and the editorial boards of the *Journal of Pharmacology and Experimental Therapeutics* (1970-88) and *Anesthesiology* (1963-73; editor-in-chief, 1970-73.) His editorship of *Anesthesiology* was marked by numerous innovations that continue to serve us today. In his last year at Baylor, he also served as President of the Association of University Anesthetists (now the Association of University Anesthesiologists).

The early 1970s were home to another phase of Dr. Keats' career. In 1967, he was elected to a 12-year directorship of the American Board of Anesthesiology (ABA) and almost immediately became the dominant force for modernization of the examination system. Soon after, he was asked by ABA and ASA to become the first chair of the ASA-ABA Joint Council on In-Training Examinations. Residents and ABA candidates still benefit from his prodigious and remarkable contributions to their education and certification. Scores of question writers and examiners also have profited from his gentle support, robust wit and red pen.

I joined Arthur's faculty at Baylor on the day that Dr. DeBakey decided that their relationship had come to an end, a common practice for Dr. DeBakey. As you now know, Arthur held almost every important nonelected position in our specialty at the time. At our first meeting, I expected to see a god-like figure. Instead he was a bear of a man at 5'8", 250 pounds, and he almost broke my hand while shaking it with hands that had black dirt under their nails. I soon learned that he had just come in from a 4 a.m. bird hunt, an almost daily ritual during bird hunting or fishing season. When I started on July 1, 1974, he asked me if I wanted to stay at Baylor or join him at THI; it was the easiest decision of my life. Over the next 20 years, we collaborated on more than 40 articles that changed the way people looked at cardiovascular anesthesia and challenged some of the most powerful myths in our specialty. He truly relished the latter group!

In 1983, Dr. Keats gave what was to become one of the most memorable and quoted ASA Emery A. Rovenstine Memorial Lectures. In it, he challenged anesthesiologists to become part of the greater medical community and report their findings outside of our parochial journals. A year later,

Stephen Slogoff, M.D., is Dean Emeritus, Stritch School of Medicine, Loyola University Chicago, Maywood, Illinois.

Continued on page 36

ANESTHESIOLOGY IN THE NEWS

Transfusion-Free Care

Norman A. Smyke, M.D., was featured in the December 1 2006, issue of *The Columbus Dispatch* for his efforts to develop a program at Grant Medical Center in Columbus, Ohio, to conserve blood throughout the hospital and provide transfusion-free care upon patient request. Aryeh Shander, M.D., also commented on the possibilities of health care without transfusions.

Anesthesiologists on Track at Grand Prix

A June 5 article in *The Gazette* (Montreal, Canada) featured Pierre Fiset, M.D., as one of two doctors in charge of the trackside hospital at Circuit Gilles Ville-nueve during the Grand Prix competition in Canada. Dr. Fiset commented that as experts at emergency intervention, anesthesiologists are great resources for treatment needed during races.

New Anesthesia Service Director in Monterey

A June 11 piece in *The Monterey County Herald* (Monterey, California) announced that Navidad Medical Center named James E. Spitler, M.D., as anesthesia service director. Dr. Spitler has been a member of the Navidad medical staff since 2005.

Anesthesia Greats Remembered in Boston

The June 16 *Boston Globe* followed Elliott V. Miller, M.D., and a group of Boston area medical residents on an annual tour of the graves of Bostonians whose experiments with ether revolutionized surgery. The graves of Charles Frederick Heywood, Augustus A. Gould, William T.G. Morton, Charles Bulfinch and Henry Jacob Bigelow were visited on the tour.

Dr. Palmer Next Director at McKenzie-Willamette

The Register-Guard (Eugene, Oregon) reported on June 12 that Susan K. Palmer, M.D., of the Oregon Anesthesiology Group has been appointed anesthesiology medical director at McKenzie-Willamette Medical Center in Springfield, Oregon.

Twin Billing in Utah

Daniel Evans, M.D., was highlighted in a June 20 *Salt Lake Tribune* (Salt Lake City, Utah) article as the anesthesiologist during the successful 6.5-hour separation surgery of conjoined twins Allyson and Avery Clark at Primary Children's Medical Center.

Illinois State President on 'Retail' Anesthesia

Rodney C. Osborn, M.D., president of the Illinois State Medical Society, was quoted in a June 21 *Chicago Sun-Times* article focused on the growing number of retail clinics staffed by nurse practitioners that are opening in large retail stores. The Illinois State Medical Society is backing a bill that would impose tighter regulations on the retail clinics.

The ASA Communications Department is interested in hearing from members who have been quoted in the media. To let us know that you have been interviewed, or for assistance with media relations, contact Donna Habich d.habich@ASAhq.org or Brittny Dziadula b.dziadula@ASAhq.org in the ASA Communications Department or call (847) 825-5586.

Sticky Issue on August *NEWSLETTER* Cover

First of all, thank you for all the helpful information communicated via the *ASA NEWSLETTER*.

I am writing in response to the cover photo featured in the August 2007 issue. The photo shows the administration of medication through an "interlink" I.V. port using a needle. If we are to teach "bright physicians all that our specialty has to offer," shouldn't we be teaching them proper I.V. administration techniques? I have twice gone through the testing process after accidental needle sticks (this occurred prior to our hospitals approving the use of needle-free I.V. sets). "Recommendations for Infection Control for the Practice of Anesthesiology," published by ASA, recommends the "use of 'needle less'" systems (e.g., stopcocks, one-way valves, etc.) or shielded needle products that prevent injury. Needles, when needed, should only be used for withdrawing medication from vials. Even "blunt" needles are a risk for practitioners. The continued used of needles is dangerous to both anesthesiologists and patients alike.

The average risk of acquiring HIV infection after an accidental parenteral exposure (needlestick or cut) to blood from a known HIV-infected patient is estimated to be 0.3 percent.

The risk of HBV transmission to a nonimmune HCW after a percutaneous exposure to HBV-infected blood ranges from 6 percent to 37 percent. In its July 2007 issue, the *New England Journal of Medicine* reported a study where 99 percent of all surgical residents had received a needlestick during their training. What percentage of our anesthesia residents are needlessly exposed to accidental needlesticks?

Modern I.V. administration sets have provided us with the opportunity to abandon our archaic ways. We should embrace that opportunity and in the process make our practice safer for both patients and anesthesia providers.

Ramon Guerrero, M.D.
Plano, Texas

Anesthesia Goes to the Movies: Two Classics

Two classic films open fascinating windows on anesthesiology, each in its own unique way. Now out on DVD, they will delight and entertain anesthesiologists and their friends and families.

The thrilling murder mystery "Green for Danger" (1946) is based on the novel by Christianna Brand. Brand was a member of the Detection Club of mystery writers whose rules (for instance, no concealed clues) ensured the reader a fair chance at guessing the solution. "Green for Danger" stars the compelling and droll Alastair Sim, with Trevor Howard portraying the lonely anaesthetist.

ASA members will particularly enjoy the anaesthetist's equipment as well as his sparring with the skirt-chasing surgeon.

In "The Great Moment" (1944), comedic director Preston Sturges brings to life the freewheeling events leading to the discovery of ether anesthesia. Joel McCrea's W. T. G. Morton is one of a cast of characters whose commitment to pain relief is outdone only by their idiosyncrasies. Anesthesiologists will thrill to the renowned ether dome pronouncements as spoken by McCrea and by Harry Carey, who plays Massachusetts General surgeon John Collins Warren.

Historical, but never dull, accurate in detail, these movie classics entertain as they renew pride in our profession.

Ronald M. Meyer, M.D.
Harriet S. Meyer
Wilmette, Illinois

The views and opinions expressed in the "Letters to the Editor" are those of the authors and do not necessarily reflect the views of ASA or the NEWSLETTER Editorial Board. Letters submitted for consideration should not exceed 300 words in length. The Editor has the authority to accept or reject any letter submitted for publication. Personal correspondence to the Editor by letter or e-mail must be clearly indicated as "Not for Publication" by the sender. Letters must be signed (although name may be withheld on request) and are subject to editing and abridgment.

New Blood Making Specialty's Future Look Bright

Alexander A. Hannenberg, M.D., Chair
FAER Medical Student Anesthesia Research Fellowship Committee

The Foundation for Anesthesia Education and Research (FAER) launched its Medical Student Anesthesia Research Fellowship (MSARF) in 2005 for the express purpose of making an early impression on medical students about the value and appeal of a research career in anesthesiology. The FAER Board felt that this was an excellent complement to our long history of encouraging and supporting anesthesiology residents, fellows and junior faculty. Our goal is very specific: recruitment not only to the medical specialty of anesthesiology but generating a lifelong commitment to research in our specialty. In the coming years, as our MSARF alumni progress in their careers, we will measure our success. Academic anesthesiology departments and faculty members across the nation have been extraordinarily generous with their interest, financial support and mentoring of the FAER student fellows. More than 30 students were enrolled in the 2007, program with participation in research projects, including basic science, clinical research and health systems analysis. The students come together at the ASA Annual Meeting to present their research projects. One cannot leave this session without a tremendous sense of optimism about the future of research in anesthesiology. The accompanying report by one of our 2005 FAER MSARF participants similarly reflects the value of FAER's investment in our medical students.

Alexander A. Hannenberg, M.D., is Associate Chair, Department of Anesthesiology, Newton Wellesley Hospital, Newton, Massachusetts.

ASA and FAER Opportunities in Academic Anesthesiology: One Medical Student's Experience

Victor G. Moulin, Chair
ASA Medical Student Delegation

Midway through my first year of medical school in San Antonio, Texas, I received an e-mail from David J. Jones, Ph.D., a dean in the school of medicine. As a professor in the Department of Anesthesiology in San Antonio, he had received word of the Medical Student Anesthesia Research Fellowship being offered for the first time by FAER and suggested I apply for the program. I was delighted to learn of the opportunity and anxious about my chances of being accepted. I had no previous fellowship experience or similar awards. I applied.

Correspondence from FAER a few months later advised me that I had matched to Duke University Medical Center, my first choice and the most logical place for my fellowship because I had a year of clinical research there. I benefited from an amazing experience as a FAER MSARF program participant. Eugene W. Moretti, M.D., a professor of anesthesiology and my mentor, tailored my fellowship to broaden my professional horizons. My experience included meetings with the department chair, exposure to basic science labs, clinical shadowing in all of the subspecialties, and attendance at journal clubs, intensive care unit grand rounds and departmental grand rounds. I was introduced to every available opportunity in academic anesthesia with an end result of vigorously reinforcing my wish to travel on the career path toward academic anesthesiology. In addition, I

Victor G. Moulin is a fourth-year medical student at the University of Texas Health Science Center at San Antonio, Texas.

continued my previous work on the research I had done as a clinical trials assistant. I was fortunate to be part of this work, which has since been published.[1]

As a student, I had always been drawn to anesthesiology for its diversity and depth of knowledge. I asked myself, "What could be more attractive than a job in which I can pursue my scientific goals, care for a broad spectrum of patients and be a part of a team of stellar colleagues?" The FAER fellowship provided my foundation as a future anesthesiologist. I gained a new understanding of academic anesthesiology and pursued an independent study of perioperative genomics and its clinical applications. I now know for certain that academic anesthesiology is in my future. I hope to train in critical care medicine, becoming a researcher, a critical care specialist and a versatile operating room anesthesiologist.

Thankfully my professional growth experience did not end after my FAER fellowship summer in North Carolina. The fellowship allowed me to interact with additional mentors and physician scientists and enabled me to connect with ASA. Two opportunities for medical students occurred simultaneously for me: the FAER Medical Student Anesthesia Research Fellowship, inaugurated in 2005, and the ASA Medical Student Delegation, formed in 2003. Armed with my strong interest in anesthesiology and the knowledge gained from my fellowship, I applied for a position in the student delegation. The committee of officers, recognizing that I was a recipient of the FAER fellowship, selected me to lead the student delegation. During the 2005 ASA Annual Meeting in Atlanta, I had the honor of representing FAER and also the Medical Student Delegation leadership. What has happened since then can be seen on the delegation's Web page www.ASAhq.org/msd and in the minutes of various student meetings.

I have been extremely fortunate that these academic and organizational opportunities existed during medical school. I cannot thank ASA and FAER enough for creating and supporting these extracurricular activities for medical students interested in academic anesthesiology. I believe that these medical student opportunities are invaluable and essential.

As a grateful student, I would like to thank the FAER Board, Eugene W. Moretti, M.D., Debra A. Schwinn, M.D., Kathryn P. King, M.D., Tong J. Gan, M.D., and Mark F. Newman, M.D., and all of the other professors who supported my fellowship activities by granting me their time and tireless efforts. In addition I would like to thank the department of anesthesiology at my medical school (University of Texas Health Science Center at San Antonio) and professors Christopher A. Bracken, M.D., Ph.D., Mary A. Gurkowski, M.D., and J. Jeffrey Andrews, M.D., who continue to support my attendance at ASA meetings and my career in academic anesthesiology.

References:

1. Moretti EW, Morris RW, Podgoreanu M, et al. APOE polymorphism is associated with risk of severe sepsis in surgical patients. *Crit Care Med.* 2005; 33(11):2521-2526. Cited in PubMed; PMID:16276176.

Arthur S. Keats. M.D. — 1923-2007

Continued from page 32

he received the ASA's Distinguished Service Award while he was still in his prime. He continued to write independently and profoundly about anesthesia risk and mortality and was the first chair of the Scientific Evaluation Committee of the Anesthesia Patient Safety Foundation. Over his career, he delivered 12 eponymous lectures and participated in national meetings of multiple groups outside of anesthesiology.

Arthur Keats was a loving and beloved husband to Marilyn and father to his four children; he was a doting grandfather. He did not suffer fools or phonies, but if he was your friend, it was forever. For those who knew him casually or by reputation, his wit and intellect were often intimidating; for those who knew him well, he was the classic loveable curmudgeon. As was typical for many others, in the 34 years of our relationship, he went from my employer to mentor and harshest critic, to colleague and then best friend. His life was full, his friends and family will miss him, and our specialty and medicine have been enriched by his time with us. For those who would like to know him better, I strongly recommend his autobiographical essay "Between the Lines" in *Careers in Anesthesiology, Autobiographical Memoirs,* volume II, 1998, pages 34-59. He was truly "A Man for All Seasons." I'm only sorry he isn't here to proofread this commemoration of his life. As always, he would have made it better.