The burgeoning specialty of pain medicine is in need of physicians who will help to define and develop it. As the leaders in pain medicine, anesthesiologists are poised to spearhead collaborative efforts and address issues in this crucial medical specialty.

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SUBSTANCE ABUSE HOTLINE:
Contact the ASA Executive Office at (847) 825-5586 to obtain the addresses and telephone numbers for state medical society programs and services that assist impaired physicians.
Each year the holiday season just doesn’t seem complete unless I have read Charles Dickens’ *A Christmas Carol* and watched the Peanuts special *A Charlie Brown Christmas*. The first tradition began in medical school — exams were over, and while waiting for the inevitably delayed flight back to Buffalo from LaGuardia, it seemed a perfect time to read. The words of Dickens are special and conjure an image that only Patrick Stewart has come close to conveying on either the big or little screen.

*A Charlie Brown Christmas* is a personal tradition that dates back to my early childhood. I have watched the show for almost the entire 40 years it has aired, and I was even given the VHS tape a number of years ago as a present. Yet both Dickens’ classic tale and Charles Schultz’s animated special have lessons to teach us.

Scrooge, a mean spirited man, is the central character in Dickens’ work. His transformation from miser to philanthropist covers the entire novel. In the course of events, Scrooge is shown how his love of money has denied him many of the joys in life, including a caring wife and family. His poor assistant, Bob Cratchit, lives in misery, with a small son who is handicapped. It is Tiny Tim who tugs at the readers’, and ultimately Scrooge’s, heartstrings. The fear Scrooge feels at seeing his future, unmourned, unloved and unknown, is the final blow that changes him. The world around him changes as well, and I’ve often wished I could be present to see the look on Mrs. Cratchit’s face when the turkey is delivered to her door!

There are those in anesthesiology who resemble Scrooge. Three years ago at the Annual Meeting, a special reference committee was convened to hear testimony about a possible change in reimbursement methodologies. The committee met all afternoon until everyone who wanted to have a say was allowed to speak his or her piece. The conclusion was that anesthesiology should not change its cost computation methodology, although the use of time in our equation has caused much concern with the Centers for Medicare & Medicaid Services (CMS) and other private health insurers. The idea of eliminating time remains one of the most cherished beliefs in the anesthesiology community. Yet is it a chain that weighs us down, like the chains Scrooge was forming as his former partner Jacob Marley showed him?

What if we eliminated anesthesia time? Would we no longer be the nail that sticks out, needing to be hammered down by CMS? Would we not fit better into the house of medicine, like the renewed Scrooge fits into Victorian England? Are we so wedded to that which we have done that change is impossible? While this issue is not on the forefront of any political agenda at the moment, it shall return. How we as a specialty address this issue will have a lasting impact not only on our economic viability but on the survivability of our unique practice in the future.

The ASA Political Action Committee (ASAPAC) could benefit from a reformed, or Christmas morning, Scrooge. Alabama once again won the race for greatest support of the PAC (see page 18). Hard work by individuals in Alabama, educating their members to the issues and the need for the specialty to address those issues at all levels of government, opened purse strings and helped ASAPAC to grow. In this season, even though our current election cycle is complete, there remains a great need for our ASA members to contribute again. We need to rebuild our PAC coffers and be prepared to face the multitude of challenges the coming year will bring. Yet without a renewed spirit of generosity, like Scrooge on Christmas morning, we will not have the resources to fight as effectively as possible.

So how does *A Charlie Brown Christmas* fit into all of this?

One of the recurrent themes of the television special centers around a Christmas tree. Charlie Brown and Linus Van Pelt leave the other children at the schoolhouse and go to find a tree. Contrary to the opinions of his peers, Charlie Brown picks out a small, scraggly little pine tree. When he brings it back to the school house, he faces the derisive laughter of his contemporaries. Taking the tree home, he attempts to trim it with one of the ornaments from Snoopy’s award-winning, gaudy doghouse decor-a
The tree bends over, and Charlie Brown believes he has killed it and walks away. The children who made such fun of him at school come, and with Linus’ “a little love,” they transform the “dead” wood into a beautiful Christmas tree.

If for a moment we can liken anesthesiology to Charlie Brown’s tree, some interesting introspection occurs. What is essential to the specialty? What are the limbs of our “tree”? Are we bending with the weight of the changes imposed upon us, or are we breaking? Can we transform ourselves into a beautiful symbol for the house of medicine? What is the “love” that is needed to make anesthesiology all that it can be?

At the moment, anesthesiology is under siege from a number of sources looking to strip the needles from the tree. As John P. Abenstein, M.D., points out in his “Administrative Update” on page 3, sedation practice is slowly eroding away some of our traditional practice. CMS continues to apply the teaching rule, which unfairly penalizes academic departments so critical to the next generation of anesthesiologists and the future of the specialty. Our relationship with organized nurse anesthesia remains one of caution and concern. Our part of the National Institutes of Health research dollars is less than our proportion of practicing physicians. Research holds the key to the next generation of innovations in the practice of the specialty.

Yet, like the tree in A Charlie Brown Christmas, there is “a little love” and many helping hands to create a beautiful Christmas tree. We have four large beautiful ornaments, our foundations. The support for their endeavors has never been stronger — if the recent 100th anniversary Gala is any indication. The house of medicine has tried to imitate our innovation, the Anesthesia Patient Safety Foundation. We have many bright lights on the tree. Our journal Anesthesiology remains the premier journal of the specialty. We are active in providing critical care and pain medicine to patients everywhere. Indeed what other medical specialty is dedicated to the relief of pain and consequently suffering in the operating room, pain clinic and intensive care unit? We have much to be proud of in our daily practice.

As this holiday season is celebrated, and as we approach the new year, it is a time to reflect upon where we as a specialty have gone and where we should be traveling. Our leadership is strong, not only within the ASA officer corps and the ASA staff, but among the rank-and-file anesthesiologists of the Society. Rejoice in the triumphs of the year, however small, and look toward next year with renewed hope. It is all of us working together, like the chorus at the end of the Peanuts special, that will make the transformation complete. Anesthesiology, often thought of as the scrawny tree within the house of medicine, has become the beautiful Christmas tree. Let us dedicate ourselves to continuing this tradition each and every day in the coming year — just as Scrooge promises to keep Christmas in his heart each and every day.

— D.R.B.
Will Anesthesiology Enter the Industrial Age?

John P. Abenstein, M.S.E.E., M.D.
Vice-Speaker of the House of Delegates

Prognostications can be difficult – particularly if they are about the future.

— Author unknown

One of the most hotly debated issues at this year’s ASA Annual Meeting was how the Society should address deep sedation conducted by nonanesthesiologists. Most anesthesiologists believe this practice is unacceptable. In spite of concerns voiced by anesthesiologists, however, more and more procedures are being conducted under sedation (i.e., a level of sedation that renders a patient essentially insensible to pain) administered by physicians and nurses who lack training in anesthesia. A simple Medline search of the keywords “deep sedation complications” reveals many papers advocating that deep sedation performed by nonanesthesiologists (usually emergency medicine and gastroenterology physicians) is safe. How could the American medical system reach this point where anesthetics (once thought to be too dangerous for anyone to administer other than those with extensive training and experience) are being administered by physicians and nurses with little or no training in anesthesia?

Most likely the reasons for this broad and disturbing change in practice are multifactorial. Most important is the fact that anesthesia, and by extension I.V. sedation, is now presumed to be very safe. No matter how one defines anesthesia-related mortality, it is now remarkably lower than it was 50 years ago. This improvement in outcome means that many physicians have never seen an anesthesia-related death. Unfortunately this fact leads to the conclusion that the anesthetic agents that anesthesiologists are trained to use are easy to administer and safe to use by anyone with prescriptive authority.

Another issue, however, comes into play and is eloquently summarized in a recent editorial in the American Journal of Gastroenterology:

“The provision of sedation for procedures and tests is labor intensive and, for the foreseeable future, requires human resources far and above those which can be met by individuals whose primary training was in anesthesia care.”

Clearly part of the problem is that demand for anesthesia services is greater than what can be delivered by anesthesiologists. Patients increasingly expect deep sedation or anesthesia for uncomfortable procedures. Since patients require medical care whether we are available or not, their physicians will find other ways to relieve pain during procedures. The absence of anesthesiologist in these circumstances (due to excess demand or, more cynically, economic motivation) places the proceduralist in the role of performing the procedure as well as directing the anesthesia/sedation.

This situation will only get worse because of the confluence of four demographic trends. First, the baby boom generation will begin to enter the Medicare system in just four short years and will be making increasing demands for medical care. Second, the American population as a whole is rapidly expanding, due mostly to immigration. Third, the output of our medical schools is, at best, flat, and there is little interest in significantly expanding the number and/or size of our medical schools. Finally, medical care is changing, and therapeutic interventions are no longer concentrated in the operating suite but are spreading throughout our facilities. These trends are occurring simultaneously and will lead to a discontinuity in the American medical system broadly and will have particularly significant consequences to anesthesiology specifically. One of the consequences of these changes is that demands for anesthesia services will rise substantially while the number of available clinicians will remain flat.

The medical specialty of anesthesiology can respond to this in a number of ways. We could continue to practice as...
we have in the past. We would accept the fact that those patients for whom we are able to care will receive the benefit of physician anesthesia. Patients receiving anesthesia or I.V. sedation from nonanesthesiologists is an unfortunate state of affairs, but there is little we can do about it other than encourage our medical colleagues to improve their practice standards. Our practice “sphere of influence” may shrink as a consequence, but we would continue to deliver high-quality medical care to those lucky enough to receive it. Another potential avenue would be to significantly expand the use of physician extenders (e.g., anesthesiologist assistants, nurses, respiratory therapists, etc.), increase the number of concurrent anesthetics we cover and, in effect, decrease our involvement on a per-patient basis. This option would allow us to maintain or even increase our share of the anesthesia/sedation market but at the cost of diluting the contribution of anesthesiologists to the care of individual patients. I think it is fair to say that many anesthesiologists may not be happy with some of the challenges associated with the utilization of physician extenders. These are just two examples of many possible responses to the increasing imbalance of supply and demand for anesthesia and sedation services.

When one thinks about how we have delivered anesthesia care over the last century, it begins to resemble how craftsmen operated prior to the industrial revolution. We deliver care one patient at a time, customize the anesthetic on a per-patient basis and then assign at least one clinician to each patient. In spite of advances in medical knowledge, pharmacology and technology, our delivery model has remained essentially the same for many decades. Is it possible, with a change in practice model, to increase the involvement of anesthesiologists while decreasing the labor intensity of anesthesia care?

A future model for anesthesia care potentially could make use of information technology, including robotics, architectural redesign of procedural suites and allied health professionals to allow anesthesiologists to care for more patients, achieve better outcomes and decrease costs. Already today, critical care physicians are using the real-time output of physiologic monitors and mechanical ventilators that are processed by a computer which identifies early sepsis and adult respiratory distress syndrome, allowing for much earlier interventions. Could similar developments provide electronically presented information (in contrast to date) to anesthesiologists so they can safely monitor and intervene on four, six or more patients simultaneously? Is it possible to develop medical robotics that can deliver different I.V. fluids (e.g., crystalloids, colloids, blood products) and medications without a human spiking a bag or pushing a syringe? How about systems that could raise or lower the depth of anesthesia or degree of muscle relaxation via closed loop control? It may even be possible that systems could be developed, possibly with the use of ultrasound guidance, to automatically cannulate arteries, veins or even the airway. Can our specialty move from one clinician per patient to a practice that has anesthesiologists in a control cockpit directing other anesthesiologists to patient bedside for necessary direct interventions and supported by still other anesthesiologists in preoperative and postoperative areas? Can we, via the use of appropriate technology, lower costs by decreasing the number of clinicians required to deliver anesthesia services, offering lower fees with improved quality of care?

This vision of the future obviously requires the development of new technology that must be designed and validated prior to clinical use. A future model for anesthesia care potentially could make use of information technology, including robotics, architectural redesign of procedural suites and allied health professionals to allow anesthesiologists to care for more patients, achieve better outcomes and decrease costs. Already today, critical care physicians are using the real-time output of physiologic monitors and mechanical ventilators that are processed by a computer which identifies early sepsis and adult respiratory distress syndrome, allowing for much earlier interventions. Could similar developments provide electronically presented information (in contrast to date) to anesthesiologists so they can safely monitor and intervene on four, six or more patients simultaneously? Is it possible to develop medical robotics that can deliver different I.V. fluids (e.g., crystalloids, colloids, blood products) and medications without a human spiking a bag or pushing a syringe? How about systems that could raise or lower the depth of anesthesia or degree of muscle relaxation via closed loop control? It may even be possible that systems could be developed, possibly with the use of ultrasound guidance, to automatically cannulate arteries, veins or even the airway. Can our specialty move from one clinician per patient to a practice that has anesthesiologists in a control cockpit directing other anesthesiologists to patient bedside for necessary direct interventions and supported by still other anesthesiologists in preoperative and postoperative areas? Can we, via the use of appropriate technology, lower costs by decreasing the number of clinicians required to deliver anesthesia services, offering lower fees with improved quality of care?

This vision of the future obviously requires the development of new technology that must be designed and validated prior to clinical use. More importantly it would require that our specialty radically change its approach to patient care. While I am not advocating for this specific, technology-based approach, I do believe that the impending demographically driven discontinuity in medicine demands that anesthesiologists proactively formulate solutions. Our medical facilities, colleagues and, most importantly, our patients will decide which solution(s) are best, but it is clear that the status quo will not hold. The future is upon us, and we will either embrace these changes or be swept aside by them.

Reference:
Based on the momentum and rebuilding of recent years, ASA is working hard to ensure that our members have a “seat at the table” on a wide range of advocacy and practice management issues. With bold physician leadership and ever-increasing grassroots involvement, your ASA Washington Office staff presents the following information as an update and scorecard of our recent accomplishments and continuing future challenges.

ASA continues working to boost payments for anesthesia services under Medicare. In 2003, ASA secured a 2.1-percent work value boost to the anesthesia conversion factor. Seeking additional increases, in 2004, ASA secured congressional support for a government-endorsed study of low payments for anesthesia services under Medicare to substantiate well-known problems experienced by practicing anesthesiologists. The two-year study, currently under way at the Government Accountability Office (GAO), is expected to be released in the near future. It is believed that it will show that the Medicare anesthesia conversion factor is grossly below the level needed to reflect patient and practice costs.

ASA is aggressively fighting Medicare Sustainable Growth Rate (SGR) payment reductions. Throughout 2006, ASA has worked again in coalition with the American Medical Association (AMA) and other physician groups to avert proposed reductions in Medicare payments for anaesthesiology services. Overall, Medicare SGR cuts were averted in 2003, 2004, 2005 and 2006. These efforts have saved anesthesiologists multiple millions of dollars and will continue unabated until the SGR is eliminated as unworkable and unfair, especially to anesthesiology.

ASA is working to expand anesthesia research opportunities through NIH. In the FY 2006 appropriations bill providing funding for the National Institutes of Health (NIH), ASA convinced key lawmakers to support and include the first-ever provisions directing NIH to enhance research in the areas of anesthesia and pain medicine.

ASA is helping to maintain patient access to important pain-related controlled substances. In response to strong ASA and AMA lobbying, the Drug Enforcement Administration (DEA) published a rule in the September 6, 2006, Federal Register that would allow physicians to issue multiple “dated” prescriptions so that patients undergoing long-term pain management can receive, over time, up to a 90-day supply of their Schedule II medications. DEA had previously sought to restrict the practice. ASA’s educational efforts with DEA will continue building on this renewed basis of understanding.

ASA is advancing efforts to expand rural access to the services of anesthesiologists. In ground-breaking work with Representatives Todd Akin (R-MO) and Henry Cuellar (D-TX), ASA successfully saw legislation
introduced to expand generous Part A hospital rural pass-through payments (currently only available for nonphysician anesthesia providers) to anesthesiologists. H.R. 5955, the “Medicare Access to Rural Anesthesiology Act of 2006,” is currently pending before Congress.

ASA is pushing for accurate health care information for patients to protect them against nonphysician providers who advance misinformation. ASA and other physician groups worked with Representative John Sullivan (R-OK) in the crafting of H.R. 5688, the “Health Care Truth and Transparency Act of 2006.” This legislation would strengthen Federal Trade Commission enforcement against limited-licensed health care providers such as nurse anesthetists who engage in deceptive misrepresentations as to their education, skills and training. The legislation also would keep nonphysicians from holding themselves out as medical doctors (M.D.), doctors of osteopathic medicine (D.O.), doctors of dental surgery (D.D.S.) or doctors of dental medicine (D.M.D.). This bill is currently pending before Congress.

On the state level, ASA is working at the request of its component society members on an array of legislative and regulatory matters.

ASA provides financial assistance to state component societies for legislative/regulatory initiatives and to assist component societies involved in litigation on such matters as office-based surgery, pain medicine and scope-of-practice issues. ASA’s involvement in the Colorado Society of Anesthesiologists’ lawsuit, for example, prevented the governor from opting out of the Medicare supervision requirements. In the past, ASA successfully defended office-based legal challenges in New York, New Jersey and North Carolina, and this year won a similar victory in Illinois.

ASA actively opposes opt-outs of Medicare’s physician supervision requirement in order to ensure greater patient safety. There have been no state opt-outs in 2006 from Medicare’s physician supervision requirements. As part of its educational and lobbying efforts, ASA provides talking points to our members and state component and medical societies to educate them on this issue.

ASA represents its members before the National Conference of State Legislatures (NCSL). NCSL is a bipartisan organization that serves the legislators and staffs of the nation’s 50 states, its commonwealths and territories. ASA’s attendance at its annual meeting increases the visibility of anesthesiologists and educates state legislators about the differences between anesthesiologists and non-physician anesthesia providers, while highlighting accomplishments by anesthesiologists to improve patient safety. ASA is one of 11 physician groups that exhibit together each year.

On the practice management front, ASA remains a leader in assisting its members across a range of important activities. Illustrative of these member benefits are activities in the following areas.

ASA is becoming a force on CPT and RUC issues. ASA is a recognized leader in the Current Procedural Terminology™ (CPT) process. For the last few years, virtually all new codes proposed by ASA have been approved by the CPT Editorial Panel. While challenges remain with the Relative Value Update Committee (RUC) as far as valuing anesthesia work in comparison to other medical services and surgical procedures, ASA has successfully convinced the RUC to accept our recommended base unit values for our new and revised codes. ASA also convinced the RUC to include the value of pre-service practice expense resources to each and every anesthesia code.

ASA is positioning the specialty for success under pay-for-performance programs. ASA has demanded and obtained a front-row seat in negotiating with Medicare and payers on performance measures. As part of this process, ASA has developed five initial quality “incentives” for anesthesiologists and is shepherding them through the external approval process, while discussing future implementation of such incentives with payers.
This past year, I have found myself overwhelmed with challenges, including recertifying in pain boards, Accreditation Council for Graduate Medical Education fellowship program re-accreditation review (not only for certification but to increase fellowship size) and, questionably the most time-intensive, enrolling as a fellow in the Executive Leadership in Academic Medicine, or ELAM, program. This core program of the Institute for Women’s Health and Leadership at Drexel University College of Medicine is in its 13th year and is dedicated to training women in academic medicine to become leaders and agents of change in the clinical, educational, research and community academic medical center arenas. The entire year-long program supports women and minority leadership, involves completing individual and group projects and inducts women into an international network cheering women on in their professional lives.

Part 1: Becoming a Dixie Chick

By nomination of my dean, I found myself in a group of eight very motivated, highly articulate and intelligent women with whom I have the opportunity to retreat, reflect and learn many leadership tools in organizational dynamics, boundaryless structure, conflict management, and building bridges and teams. Extensive personality testing and 360-degree evaluations revealed many personal weaknesses, but my one identifiable strength — indeed, a record high score I was told never achieved by any other participant in the current or earlier classes — was my “warm personality” and “balance of personal and professional life.”

Right then my other less stellar scores were mitigated in the hope that I might have an achievable goal, i.e., to win the title “Miss Congenitality.” I also discovered that my personality type (NF) was called the “great harmonizer,” so I began getting to know my group members to find how we could possibly have the best time and still accomplish everything on our “to do” lists. Our first task was to settle on a name, and as my style is to always try to exceed expectations, we decided in this high-powered group to go for a name that we could surely exceed, and thus were born the Dixie Chicks. In addition most of us have strong emotional, if not physical, connections to the South, a spirit of fun and adventure; indeed, all that we lacked were matching chicken foot tatoos on our ankles.

Part 2: Discovering My Passion

In the ensuing weeks, isolated in conference centers, every traditional and experimental teaching method was employed on our group of eight and the other five groups to cajole, encourage, inspire and command us to find our passions, become agents of change, and then develop a battle plan to storm our individual academic health centers, a.k.a. “The Action Plan.”

“As I so often repeat our credo to my pain fellows, the first words out of a good physician’s mouth should always be, in every circumstance, ‘How may I help you?’”

Mine, of course, was pain medicine, a rapidly emerging, ever-changing, much-in-demand subspecialty that belongs mostly to anesthesiology, as did critical care and resuscitation in the very early years. But also like these disciplines, it has wide, overlapping areas with other specialties. Much like early anesthesiology at the beginning of the last century, newly evolving specialties are open to innovations and creative thinking. Early anesthesiologists experimented with rectal ether for thyroidectomy, sequestration anesthesia employing rubber tire tubing exsanguinations and electric...
shock anesthesia. So in the pain world, we have the standard nerve blocks with local anesthesia and steroids but also cognitive behavioral therapy, new applications for old drugs, innovative surgical and interventional procedures, and complementary medicine techniques. I have even been called on to talk to the puppets that a patient brought in, each one symbolizing a different doctor with whom she wanted me to discuss her pain. Mine was called “Dr. Cope-Well,” Magic Healer of Pain disguised as a golden unicorn. So the unicorn and the black cat (“Dr. Gato” for Dr. Katz, who spoke in a strange accent) discussed the patient’s arm pain. And who knows? She stated that she felt much benefit and has not returned. Maybe there is a study in there somewhere.

Anyway, I have long felt that the burgeoning subspecialty of pain medicine is just now defining itself and is often misunderstood by the world in general and by many operating room anesthesiologists in particular. Many think we are indeed magical and can cure many psychic troubles, including addiction, a history of childhood abuse, anxiety disorders and general sadness, with the application of an epidural needle. Others think our primary function is to dole out mind-altering euphorics with the chief benefit being to clear out their waiting rooms.

So my dilemma was clear: How can we as a division define ourselves and expand our clinical reach and influence to help patients, teach our fellows and residents, participate in collaborative research and, most importantly, let our colleagues know what we can and cannot do to help them practice better medicine by good pain control?

As I so often repeat our credo to my pain fellows, the first words out of a good physician’s mouth should always be, in every circumstance, “How may I help you?”

Part 3: The Evolution of an Idea

So what was I learning in hour after hour (one day lasting 17 hours!) that I could apply? First of all, and these lessons are highly personal and do not reflect on the comprehensiveness or expertise of the program but rather my selective retention:

Lesson 1: As eloquently described by Tom Gilmore, always work toward partnership. When things don’t go your way, one has the choice to “make up a story” with yourself in the center as victim, hero, innocent bystander or whatever and “they” doing or not doing something to hurt you or to get in your way. This sort of myth-making destroys any chance for partnership.1

Lesson 2: We don’t have to live in silos. The best work is done through collaboration rather than competition (back to Lesson 1). Certainly with pain medicine, which I envision as a hub in the wheel of health care, most of the medical disciplines intersect and are all important for clinical care, teaching and research.

Lesson 3: Whenever at all possible, “push things down.”

I have been extremely blessed with a loyal and talented crew of pain physicians, many of whom I have “trained as pups.” It’s a delight to see them solve problems, grow academically and far surpass what I can envision or do alone.

Lesson 4: Explained by Jim Collins in his “Good to Great” studies of the best companies is the intersection of three circles as the best place to devote your efforts and find success. These three components are: 1) what you are deeply passionate about, 2) what you can be best in the world at and 3) what drives your economic engine.2,3,4

In the pain medicine division, we are passionate about achieving the best pain care education and research, we are the pain “experts” at our institution, and we are driven by our reputation, which is defined in our credo, “How may we help you?”

Part 4: The Action Project: The Envoy Principle

When one wants to establish a diplomatic relationship with a foreign country, one sends an envoy, usually bearing gifts, to understand the culture, promote peace and explore opportunity for exchange of goods and services between countries. Pain, to many, is a new subspecialty and a foreign culture. So while I was planning a great campaign, as often occurs, serendipity trumped strategic planning. My epiphany dawned on the afternoon of my third son’s commencement from the University of Pittsburgh. As one of only three medical school faculty members processing with the other faculty in full regalia (necessary to secure a seat in the front section and simultaneously embarrass my son), I encountered the chief of GI medicine, David C. Whitcomb, M.D., Ph.D., who had a daughter graduating and was dressed equally ostentatiously for the very same reasons.

Pain, being my passion, was discussed, and we realized the commonality of our goals while waiting through the interminable processions and name readings. The Digestive Disorder Center, treating thousands of patients suffering from chronic pain, could use our expertise, and we could benefit from participation in their visceral pain research initiatives and understanding their world view. The first envoy posted, ZongFu Chen, M.D., will spend Wednesday afternoons not only adding new treatment options but learning the GI medicine culture and attending their didactic and research conferences with a pain fellow in tow. Already he is hard at work writing book chapters in an invited collaboration with this highly productive group.

Once the first envoy was identified and posted, the possibilities for cultural exploration out of our “Pain Silo” appeared everywhere.

Cheryl D. Bernstein, M.D., a neurologist and another of
ASA works with many other groups to address a variety of issues related to improving health care in the United States. In keeping with that goal, ASA has chosen to participate in the Pain Care Coalition to improve access to care for those suffering from pain and to advance research into an improved understanding of pain and its treatments.

The Pain Care Coalition was originally formed in 2000 by the American Academy of Pain Medicine, the American Pain Society and the American Headache Society. ASA began informal collaborations with the Pain Care Coalition in 2003 and formally joined in 2004. This Coalition works to provide a unified voice regarding pain medicine causes in the legislative process. While the Coalition is the primary voice in Washington for the three founding societies, for ASA it is simply one facet of the substantial and always evolving government affairs program that the Society has operated through its Washington Office for several decades.

The Coalition is managed by a steering committee of eight individuals with two members appointed to represent each of the four societies. The authors of this article currently serve in that capacity for ASA. The steering committee, under the leadership of a rotating chair, currently Joel R. Saper, M.D., of the American Headache Society, develops policy for the Coalition and meets in Washington at least annually for that purpose. Day-to-day representation of the Coalition at the national level is provided by a Washington law and public affairs firm under contract to the Coalition. That firm works under the general direction of the steering committee and works closely with ASA’s Washington Office on matters of particular interest to ASA and the Committee on Pain Medicine.

The stated mission of the Pain Care Coalition is: “To develop, monitor and advocate for responsible Federal Healthcare Policy on behalf of persons with pain by addressing quality of care and access to care issues through legislative, regulatory, and policy research mechanisms.”

Under that broad framework, the Coalition has worked actively to initiate policy change at the federal level and to react to legislative and regulatory developments on the Hill and in the Executive Branch agencies that impact pain physicians and their patients. In its relatively short life, the Pain Care Coalition has monitored or intervened on a wide range of issues affecting different aspects of pain care practice, education and research.

The Coalition’s work led to the drafting and eventual introduction of the first comprehensive pain care bill at the national level. First reintroduced as H.R. 1863 in the 108th Congress and subsequently reintroduced as H.R. 1020 in the 109th, the “Pain Care Policy Act” is an ambitious agenda for 1) increasing resources and infrastructure for pain and palliative care research at the National Institutes of Health (NIH), 2) establishing professional and patient education and training programs through the Department of Health and Human Services and 3) ensuring access by patients to diagnosis and treatment for pain in federally supported health care programs, including those of the Department of Defense and the Veterans Administration.

H.R. 1020, championed by Congressman Michael J. Rogers (R-MI), has been an important legislative effort for several reasons. It has attracted support on a bipartisan basis...
in the House, it has become a focal point for other patient and professional organizations in the pain field, and it has generally increased awareness of pain as a public health problem among legislators and their staff.

There is still a great deal of work that remains to be completed if this bill is to become a serious legislative vehicle in the next Congress. This will likely entail modifications to the bill, particularly as it pertains to NIH, to enhance its prospects for movement in the House and for bringing it to the Senate for consideration.

While H.R. 1020 has been the hallmark activity for the Coalition in recent years, several other initiatives are ongoing, including the following:

1. We have worked with the House Commerce Committee to get some recognition for pain in its efforts to move an NIH re-authorization bill. An NIH bill did, in fact, clear the House in late September, and pain is included as an area for heightened NIH reporting and congressional oversight.

2. We have begun an informal dialogue with the Drug Enforcement Administration (DEA) that shows early signs of promise. A September 6 proposed rule from DEA resolves, in a reasonable and balanced way, previous uncertainty about a physician’s ability to write multiple “do not fill until” prescriptions for Schedule II drugs. The rule would permit that practice for supplies not exceeding 90 days in total.

3. We continue to monitor Medicare payment changes — physician fee schedule, inpatient diagnosis-related group (DRG) rule, outpatient DRG rule, ambulatory surgical center reform and other issues — that impact pain practices, and we will use the resources of the Coalition to support items of interest to ASA as appropriate.

With the congressional elections now behind us, the Pain Care Coalition will be looking for new opportunities to advance its issues with a dramatically changed House and Senate. As ASA’s representatives to the Pain Care Coalition, we look forward to putting anesthesiology’s issues and expertise “front and center” in the pain care debates ahead.

ASA will continue to partner with the Pain Care Coalition as long as the mission and goals remain consistent with the interests of our membership and patients. The long-term goal of this endeavor remains the advancement of appropriate care and improved access to treatment for those in pain, appropriate reimbursement and support for those in practice, and continuing dialogue to enhance pain medicine.

Dr. Deer and Dr. Rosenquist welcome any advice or feedback from the ASA membership on these important issues and the Coalition’s activities.

How May We Help You? From Dixie Chicks to a New Pain Paradigm

Continued from page 8

our pain fellowship graduates, is now infiltrating the Lupus Center one day every other week. Dean Mariano, D.O., and A.J. Carvelli, M.D., again former fellows, are forging links with the neurosurgeons and metastasizing to the spine center.

Other diplomatic missions that we are contemplating include forging links with oncology practices, family practice preceptorships and physical medicine training programs.

The Envoy Principle is my action project to break out of our pain silo and collaborate without boundaries between our program and the rest of the world. The goal is nothing short of excellence in patient care and the educational and research richness that cooperative learning and commonality of purpose can provide. My hope is that in providing physical proximity and face-to-face contact with a new set of physician colleagues and pain patients, we will gain the empathy and understanding to answer our own pain medicine division’s credo: “How may we help you?”

References:
Liability in Pain Medicine

May L. Chin, M.D.
Committee on Pain Medicine

Anesthesiologists have long been at the forefront of the practice of pain medicine, particularly in the application of technical procedures in the management of acute, chronic and cancer pain. Although there are recognized limitations in the analysis, the ASA Closed Claims Project database provides valuable information on the adverse outcomes in chronic pain management from 1970 through December 2000.1

Chronic pain management claims increased from 2 percent in the 1970s to 10 percent in the 1990s. Out of a total of 284 chronic pain management claims, 276 (96 percent) were related to invasive procedures. These procedures included nerve blocks (using local anesthetic as the primary agent), injections (epidural steroids, trigger points, botulinum toxin, tendon or joint injections), ablative procedures, implantation or removal of devices, and maintenance of devices. Of these procedures, blocks and injections comprised 78 percent of the claims. The most common complications involved nerve injury and pneumothorax [Figure 1]. Death or brain injury was less frequent and was related to epidural steroid injections and device maintenance.

Half of the 63 nerve injury claims involved spinal cord injury, including 14 epidural steroid injections, six of which resulted in paraplegia and one quadriplegia. Other procedures associated with nerve injury involving the spinal cord included blocks (5), ablative procedures (3), cervical facet (1), implantation or removal of devices (2) and device maintenance (4). There were 18 claims for paraplegia or quadriplegia, and they included epidural abscess (4), chemical injury from injection into the spinal cord (8) and epidural hematoma (4). Other nerve injury claims included the lumbosacral nerve root (21), the sciatic nerve (2) and the brachial plexus (2).

There were 59 claims for pneumothorax, 40 of which were associated with blocks and 18 from injections, predominantly trigger-point injections. More than half (34) of the patients were diagnosed with pneumothorax after they had been discharged, and of these, 15 patients were diagnosed and treated in an emergency room.

Infection accounted for 13 percent of all claims from invasive procedures. Most were associated with epidural steroid injections and some with implantation, removal or maintenance of implanted devices. Meningitis (12) was the most common presentation followed by epidural abscess (7) and osteomyelitis (3). Surgical intervention was required in six of the seven epidural abscesses with one patient sustaining permanent neurological deficits.

Claims for death or brain damage were associated with epidural steroid injections (9) and device maintenance (9). Of the 114 claims related to epidural steroid injections, 61 of the injections used local anesthetics and or opioids. All nine epidural steroid injections resulting in death or brain damage contained local anesthetics with or without opioids [Figure 2]. Events include unintended intrathecal injection (5), allergic reaction (1), cardiovascular collapse and respiratory depression from inadvertent intrathecal injection at the thoracic level (1), and delayed respiratory depression...
from epidural morphine administered with the steroid (3).

Claims for death (4) or brain damage (5) associated with the maintenance of devices included implanted pumps, epidural injections and patient-controlled analgesia. Opioids were prescribed in all nine claims. Nearly all claims involved the administration of the wrong dose of opioid. Other events included pump programming error, drug interactions and intrathecal migration of the epidural catheter.

Epidural steroid injection, commonly performed to treat radicular pain, has been utilized for more than 40 years and is generally perceived to be a safe procedure. In the ASA Closed Claims Project database, however, epidural steroid injections accounted for 40 percent of all chronic pain claims and more than 80 percent of the claims related to injections. The injuries were serious, relating to nerve injury, infection, death or brain damage. In more recent years, catastrophic events related to cervical transforaminal injection of steroids became apparent.4 These events included severe spinal cord infarction with severe neurologic sequelae. Case reports included cortical blindness and neurologic injury3 and brainstem herniation from cerebellar infarct.5 Paralysis from lumbar transforaminal injection also has been reported.6 It is perceived that particulate steroid injected into a radicular artery critical to spinal cord perfusion results in an embolic phenomenon causing spinal cord infarction. Other factors that may have contributed to these devastating events are lack of detection of intra-arterial injection (with or without real-time fluoroscopy), patient sedation and variable anatomy, particularly in the course of the small radicular vessels in relation to the nerve root.

Last fall the Anesthesia Patient Safety Foundation7 reported claims collected by an insurance company that had “noted an alarming incidence of major claims relating to cervical epidural steroid blocks. In fact the number of claims for these blocks consistently exceeds the combined total of claims for steroid blocks performed at all other levels…..” The company collected and reviewed 13 anesthesiology claims over three years. It was not reported whether the interlaminar or transforaminal approach was used. Injuries reported included arachnoiditis, paralysis, anoxic brain damage and death.

Claims related to chronic pain management have increased over the last several decades.8 Recent catastrophic events associated with epidural steroid injections — in particular, cervical transforaminal injections — will likely lead to a further increase in claims in the coming years. As the practice of pain medicine expands and evolves with new drugs, new devices and new techniques, there is a need for greater awareness of potential injuries to patients and the institution of guidelines regarding safe practice.

Within this context, we should continue to address issues that may potentially 1) improve outcomes related to invasive procedures by minimizing risks for death or brain damage, nerve injury, bleeding, infection and pneumothorax, and 2) decrease the occurrence of claims: issues such as the emphasis on a clear discussion of informed consent and indications for the proposed procedure with alternative treatments presented; adequate training of interventionalists; the consideration of the use of nonparticulate steroid and the use of real-time fluoroscopy with digital subtraction to maximize detection of intra-arterial injection in transforaminal injections; patient sedation; patient monitoring; immediate availability of resuscitation equipment; postprocedure instructions; patient communication; and follow-up.

References:


Advances in pain treatment can be broken down into two distinct areas: pharmacological advances and procedural-based innovations. Both areas are critical to improving patient outcomes and quality of life.

I. Advances in Pharmacological Treatment

There are several new advances in the pharmacological treatment of pain that utilize novel delivery mechanisms for pain medications. At the ASA 2006 Annual Meeting in Chicago last October, several new or upcoming additions to our armamentarium were introduced, including:

- An inhaled liposome-encapsulated fentanyl preparation (AeroLEF);
- A new oral transmucosal fentanyl tablet (Fentora);
- A transmucosal patient-activated bolus of fentanyl (E-trans);
- Intranasal morphine (Rylomine); and
- Intranasal ketamine (PMI-150).

AeroLEF is an investigational fentanyl product that is delivered via an inhaled nebulized treatment. It is indicated for moderate to severe pain. The inhaled liposome-encapsulated fentanyl provides rapid analgesia and extended duration of analgesia whereby the lung serves as a reservoir for prolonged effect. Though this drug is in the initial phase of clinical studies in Canada, clinical trials are planned for the United States in the very near future. It affords patients the ability to self-titrate their analgesia. This mode of delivery may be of use in terminally ill patients for whom potent analgesics need to be administered or in patients who cannot use the oral route of administration.

Rylomine is an intranasal delivery system for morphine that is intended to target a niche portion of the opiate market where rapid onset of analgesia is needed without the need for intravenous access. It provides faster onset of action than oral morphine products, and since it bypasses the gastrointestinal (GI) system, it is associated with fewer GI side effects.

The E-trans fentanyl system is an on-demand delivery mechanism that allows patients to deliver fixed bolus doses of fentanyl of 40 micrograms each through the skin. It utilizes a low-intensity direct current to move fentanyl from a hydrogel reservoir into the skin, which has been shown to be as effective as intravenous-PCA morphine. It does not incorporate a continuous infusion.

Intranasal ketamine is an NMDA receptor antagonist indicated for acute moderate to severe pain. The doses required to treat pain are 1/10th to 1/16th of those used for...
general anesthesia. This is currently in clinical development. Off-label use and previous studies have suggested ketamine is an effective analgesic. Its initial market will be breakthrough pain in orthopedic injuries and postoperative pain where immediate-release opioids are desirable.

Fentora is a fentanyl buccal tablet that is partially absorbed through the mouth and partly absorbed through the stomach. It has incremental doses from 100 micrograms to 800 micrograms. It is intended for breakthrough pain in cancer patients similar to fentanyl lozenges (Actiq).

These novel compounds will offer further options in the care of our patients.

II. Procedural-Based Innovations

The use of interventional procedures can be instrumental in improving outcomes for those suffering from chronic pain. In the past few years, pain physicians have been given many new tools to use in the battle against pain. New advances are important, and physicians should be aware of these issues when seeing these patients in their office. Particularly areas of interest include:

- Spinal cord stimulation;
- Intrathecal drug delivery;
- Minimally invasive disc procedures; and
- Laser-guided fluoroscopy.

Spinal cord stimulation received initial Food and Drug Administration (FDA) approval in the late 1960s. For several decades, the devices consisted of simple anode and cathode arrays that delivered energy at a constant voltage with minimal choice in lead array. Over the past two years, innovations have occurred in several areas of computer technology. These advances include new leads that create a multitude of possibilities for stimulating nerves. The most advanced area of programming includes a new tripole system that focuses cathode energy to the center of the spinal cord. Other exciting areas include rechargeable batteries, independent electrode programming and constant current systems.

Intrathecal drug delivery has been used clinically for more than two decades. The advances in recent years have consisted of smaller pumps with equal or larger volumes, improvements in software programming and new research into more durable catheters by several manufacturers. The biggest advance during the last 24 months has been the approval by the FDA of ziconotide for intrathecal use. This drug, which is derived from a snail toxin, works at the calcium channels to improve neuropathic pain. This is the first drug to receive FDA approval for intrathecal use in more than a decade.

Minimally invasive disc procedures have been a focus of extensive research over the past few years. Advances include new heating probes to treat the annulus, new methods of mechanically removing the nucleus and cutting-edge laser-based techniques to treat complex disc, bone and nerve disorders. These advances may lead to a reduction in the need for costly and risky open surgical techniques.

New technology has allowed for the placement of needles and other tools under fluoroscopic imagery guided by lasers. These new fluoroscopic machines allow for a laser to show the angle of the beam both on the skin and on the X-ray. This technology makes procedures much more efficient, allows for immediate angle correction and may improve safety.

New advances in the treatment of pain will continue over the coming years. It is the responsibility of those practicing medicine to stay abreast of these developments by reading peer-reviewed journals, attending continuing medical education-accredited meetings and sharing information with their colleagues. ASA will strive to be a critical part of this advancement and exchange of information.

### Table 1

<table>
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<th>Trade Name</th>
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<td>1 hr.</td>
<td>100-800 mcg</td>
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</table>
“Pay for performance” (P4P) programs propose to link rates of reimbursement to achievement of specific indicators of quality care. This initiative grew out of several Institute of Medicine (IOM) reports and the care improvement paradigms embraced by the Leapfrog Group and others, which proponents believe will improve quality of care. They also hope to save the U.S. health care system money, as P4P should reward efficiency and substitute quality-based payment for volume-driven payment. Private payers have embraced P4P and already divert large amounts of money to quality programs. The Integrated Healthcare Association (IHA) began its P4P program in 2001. Other payers have initiated “pay for participation” programs in which practitioners and facilities can gain reimbursement by simply sharing outcome data rather than by hitting a particular quality “mark.”

The government is set to fully invest in P4P; in 2005, a bill was filed in the U.S. Senate that proposed redirection of 2 percent of all physician payments to a subset of physicians achieving quality reporting targets (S.1392, 109th Congress). The use of performance-incentive dollars by private health plans also are expanding in both magnitude and the range of physician groups targeted. For example a Massachusetts Blue Cross/Blue Shield plan earmarked $33 million in incentive payments in 2004, with about $5 million directed toward specialist physicians. In 2006, those figures had ballooned to almost $190 million total, with $54 million for specialists (Boston Globe, May 10, 2006).

It is clear that physicians must take these efforts seriously and participate in the determination of how such programs will be structured and which metrics are to be used to “measure” the quality and determine payments. The Centers for Medicare & Medicaid Services (CMS) has invited specialty societies to provide recommendations for appropriate measures of quality to be used in the production of P4P programs. The American Medical Association (AMA) has invested more than $5 million on development of 140 measures that are expected to be ready for use by the end of 2006. Measures for P4P can be outcome, process or structural measures.

What Is an Acceptable Metric for a P4P Program?

The types of measures advocated for use in P4P programs should generally meet the following 10 criteria:

1. **High volume** — the diagnoses involved must be relatively common.
2. **Gravity** — the conditions that are to be affected must be significant.
3. **Evidence-based** — 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.
4. **Gap** — there must be evidence that a significant difference exists between the current practice and the best practice.
5. **Probability** — there must be likelihood that the intervention being promulgated will improve the outcomes as desired.
6. **Reliability** — the measure (or “metric”) is consistent when measured by various observers at various points in time and in various settings.

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**Pay for Performance in Pain Medicine**

Alexander A. Hannenberg, M.D.
Vice-President for Professional Affairs

Douglas G. Merrill, M.D.
Committee on Pain Medicine

Douglas G. Merrill, M.D., is Staff Anesthesiologist, Virginia Mason Clinic, Seattle, Washington.

Alexander A. Hannenberg, M.D., is Associate Chair, Department of Anesthesiology, Newton Wellesley Hospital, Newton, Massachusetts.
Pain Medicine and P4P

Pain medicine will be the subject of P4P programs because pain is widespread and costs our society well over $61 billion a year in productivity. Treatment of pain is expensive, reaching more than $1.8 billion for interventional pain in 2001 and greater than $26 billion expended on back pain alone 10 years ago yet satisfaction with the quality of that pain treatment is often poor. In 2005 and 2006, recognizing that no single specialty society speaks for pain, ASA, the American Pain Society, the American Society of Regional Anesthesia and Pain Medicine, the North American Spine Society, the American Academy of Pain Medicine and the International Spine Intervention Society collaborated on a recommendation to CMS for measures to be used for P4P in chronic pain medicine. The societies recommended as a valid measure the consideration of a comprehensive pain treatment plan, including patient- and practitioner-generated goals and therapeutic recommendations, and coordination of the patient’s care with other caregivers.

In those patients at risk to transition from acute to chronic pain, behavioral therapy can cause rapid and significant improvements in function by diminishing fear, anxiety and associated catastrophizing. A multidisciplinary approach to pain therapy that includes behavioral, vocational and economic rehabilitation strategies is the most economic and effective approach to controlling and improving the pain and function of patients with chronic pain. Indeed, detection of certain psychosocial risk factors early in the course of nonspecific low-back pain may identify those patients who are at risk for development of chronic low-back pain. Also, engaging patients in the process of setting their own goals for improvement and making the treatment plan “patient-centric” is an important factor in successful chronic pain care. Finally, communication and coordination with other caregivers is a necessary aspect of appropriate pain care. CMS may make documentation of care coordination a part of most P4P programs because, as the Medicare Payment Advisory Commission, or MedPAC, notes, “Care is inefficient if providers do not coordinate across settings or assist beneficiaries in managing their conditions between visits.”

Six metrics were chosen as appropriate measures congruent with this evidence. The anticipated structure of a P4P program would be of reimbursement predicated upon documentation that the six tenets were considered in the care of each patient. Reimbursement would not be predicated upon the active performance of each item in all patients, as they would not always be applicable in all chronic pain patients. The six metrics chosen were:

1. Patient education about and inclusion in pain management planning when appropriate;
2. A contingency plan for treatment of any future poorly controlled pain;
3. Documentation of any indications for behavioral-cognitive therapy and actions taken, if any, to provide such therapy;
4. Indications and intent regarding consultation of other health care professionals, including physical or occupational therapists;
5. The plans for follow-up assessments and a description of resources available to the patient for obtaining unplanned (emergent/urgent) follow-up care; and
6. Timely reporting of the patient’s condition and the pain management plan to other health professionals attending the patient, to include at minimum the patient’s primary care physician (if available).

Figure 1 shows one possible manner in which a health care form could be amended to allow these six steps to be efficiently documented on every patient. Whether or not these proposed measurements or others will be chosen by either public or private payers is not yet clear.

How Much P for P?

The incentive sizes that have been discussed usually range from 1 percent to 5 percent of a physician’s total revenue. Providing more money has increased quality in specific markets, but P4P is early in its evaluation. One of the lessons learned at IHA is that larger amounts of payment will induce more rapid and widespread compliance with the program objectives, and 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 percent. 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 reimbursement of those who do not meet the P4P targets and those not participating.
Other Quality Incentive Programs

Differential payment is, however, only one of the tools contemplated by purchasers and payers for promoting improved quality. Offering providers designation as “centers of excellence” and accompanying such designation with reduced patient co-pays, for example, are believed to induce quality by providing a competitive advantage over other providers. In the long run, it is fair to assume that any quality data reported to health plans or the government is likely to be distilled into a public report card on the Internet, such as Medicare’s hospitalcompare.gov or California’s Healthcare Quality Report Card <www.opa.ca.gov/report_card>. This approach may indirectly provide financial benefit by driving increased patient volume, but it requires a competitive marketplace to function and consequently will have little impact in underserved localities or scarce services.

Pain medicine physicians will need to stay attentive to both private and public payer announcements regarding incentive and “quality” payment programs. ASA will continue to work closely with the other specialty societies and AMA to try to keep any such programs as grounded in scientific evidence as possible and to make certain that the cost of participation in such programs (clerical and physician time) is as small as possible.

References are available on the ASA Web site at <www.ASAhq.org/Newsletters/2006/12-06/p4p.html>.

Figure 1

One possible manner in which a health care form could be amended to allow efficient documentation on every patient.
The ASA Political Action Committee (ASAPAC) continues to serve as the bipartisan, non-ideological political voice of ASA to advocate political issues on behalf of all anesthesiologists.

Please review the accompanying table on page 19 for state-specific information regarding ASAPAC. 2006 was a year of improvement — we raised $897,877 from 4,001 contributors. This number represents an increase of $68,640 and an increase of 538 members. ASAPAC is currently supported by 11.5 percent of the membership.

The number of local political events attended or hosted by an anesthesiologist presenting a PAC check increased to 111 for the year for a total of more than 200 for the election cycle.

The special distinction winner was Oregon, with a 10-percent increase of donors and an increase of 75 percent for contributions. Other states recognized for outstanding achievement include Alabama, Arizona, Colorado, Delaware, Georgia, Illinois, Iowa, North Carolina and Missouri.

The Alabama State Society of Anesthesiologists continues to set the benchmark nationally. Thank you, Alabama!

The ASAPAC goals for 2007 remain the same: Increase membership participation and dollars raised. We will continue to be fully engaged. Key unresolved issues essential to the future of our specialty include the Medicare anesthesia teaching rule; proposed Medicare cuts for 2007, along with five-year review proposed cuts; Medicare payment equity for anesthesiologists; Medicare sustainable growth rate reform; Medicare rural pass-through; involvement in pay for performance; scope-of-practice issues; and medical liability reform, to name a few.

Finally, the ASAPAC board will be preparing for the 2008 elections. Associate Director of Governmental Affairs and PAC Director Manuel Bonilla will address the November 2006 elections, highlighting the impact, challenges and opportunities for 2007 in the January 2007 NEWSLETTER.

Remember, united we stand, divided we fall.

James L. Becker, M.D., is a partner in Associated Anesthesiologists, PC. He practices at Iowa Methodist Medical Center, Des Moines Orthopedic Surgery Center, Lakeview Surgery Center and Iowa Methodist Day Surgery, Des Moines, Iowa. He is a member of the Committee on Governmental Affairs.
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ASAPAC Giving
FY 2006

ASAPAC Fiscal Year runs from October 1 – September 30. Bold numbers indicate top three totals or percentages.

Members of the 2006 ASAPAC Executive Board

Chair
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Hector Vila, Jr., M.D.
Tampa, Florida
Globally 1.7 billion adults are overweight, and about 300 million are obese. A majority of these people live in this country. Not only do excess pounds burden these patients but they also contribute to hypertension, diabetes, sleep apnea, congestive heart failure, dyslipidemia, osteoarthritis, cholelithiasis and gout. Weight loss decreases the risks associated with these conditions. The medical approach to weight loss involves changes in lifestyle, dietary habits, drugs and, finally, surgery. Medical options for weight loss are limited, at best. Surgery is the definitive treatment for weight loss.

Bariatric surgery, performed more than 10,000 times per month in the United States and increasing in frequency, presents a unique set of intraoperative challenges to the anesthesiologist. Challenges in starting intravenous (I.V.) lines (difficult to visualize or palpate veins), positioning supine (which predisposes to hypoxemia), ventilation by mask (difficult) and using highly lipophilic drugs (prolonged effects) are just some of the issues.

In the management of these patients, preoperative evaluation, other than the routine, should focus on an assessment of cardiopulmonary status and the airway, including systemic and pulmonary hypertension, right and left heart failure, ischemic heart disease and diabetes. Assessing common signs of heart failure — such as raised jugular venous pressure, added heart sounds, pulmonary crackles, hepatomegaly and peripheral edema in the super morbidly obese — is complex. Symptoms of pulmonary hypertension such as exertional dyspnea, fatigue and syncope are similarly difficult to assess in patients who are probably not very active and possibly bed- or wheelchair-bound.

One may suspect tricuspid regurgitation (TR), implying pulmonary hypertension, by an electrocardiogram showing tall R waves, right axis deviation and right ventricular strain. The diagnosis of TR can then be confirmed by echocardiography. Prominent pulmonary artery markings, on chest radiographs, are further evidence of pulmonary disease.

Other things to be considered at the preoperative evaluation should include an assessment of peripheral and central venous access sites as well as potential sites of arterial cannulation. Preoperative arterial blood gases may indicate levels of carbon dioxide and thereby suggest intraoperative and postoperative ventilation.

“A combined approach of care, planned and agreed upon between anesthesiologists and surgeons along with nursing and respiratory care, will usually lead to improved outcomes.”

The problem of obstructive sleep apnea (OSA) is another common comorbid factor in this patient population. Most patients will have been tested preoperatively and should be advised to bring their continuous positive airway pressure (CPAP) mask and/or machine to the hospital for use.

As a general rule, patients should have all current medications preoperatively except oral hypoglycemics and insulin. Since postoperative infections are a relatively common occurrence and a big concern in this population, appropriate selection, timing and dose of antibiotics are important. It also is important to clearly explain nothing-by-mouth guidelines to the patient.

Even a small-gauge I.V. access to get the case started is acceptable. After induction and intubation, vasodilatation from volatile agents help with placement of a second, larger I.V. Titration of benzodiazepines in small doses for analgesia is preferable in these cases. Aspiration prophylaxis is probably best achieved by a pre-induction administration of a 5HT3 antagonist along with a prokinetic agent. Similarly, deep venous thrombosis (DVT) prophylaxis should be addressed preoperatively. At our institution, some patients who have the appropriate history and risk factors receive a prophylactic inferior vena cava filter before surgery. Alternately, SQ doses of 5,000 to 10,000 U of heparin q 8-12 hours are also utilized frequently.

For patients having open gastric bypass, even though technically difficult, a functioning epidural goes a long way in advancing rapid recovery by promoting ambulation, decreasing DVT, decreasing O2 consumption, decreasing left ventricular stroke work and promoting intestinal recovery. We have an approximately 80-percent epidural success rate.
rate in our super-morbidly obese patients. In laparoscopically performed procedures, we prefer control pain by I.V. patient-controlled anesthesia combined with instillation of local anesthetic solutions in the incision.

In the operating room, positioning of the patient on a ramp versus the sniffing position, after placement of standard monitors, allows better conditions for intubation. The patient is positioned such that the external auditory meatus is at about the level as the sternal notch, which is achieved by either commercial sponge devices, a pile of blankets or by tilting the bed.

Prior to induction, preoxygenation is accentuated by pressure support ventilation (PSV). Having an anesthesia machine capable of delivering PSV with 100 percent oxygen facilitates preoxygenation significantly. A few minutes of PSV achieves an improved reserve (PaO₂) and allows a few critical extra moments during apnea before the predictable and rapid desaturation with apnea.

Based on the analysis of the airway classification, the common induction option is rapid sequence with a small dose of an opioid and short-acting drugs (unless contraindicated) such as propofol and succinylcholine. Due to relaxation of oropharyngeal soft tissue after induction, these patients are frequently more difficult to ventilate than to intubate. Placement of a nasal airway (or trumpet) immediately after induction may allow better oxygen delivery if mask ventilation is attempted or needed.

Whether a difficult airway is expected or not prior to induction, a plan for managing a difficult intubation should be in place. Fiberoptic intubation is one such option. Spontaneously breathing the patient down with sevoflurane is another option. It is advisable to have multiple tools for a difficult intubation in place, including different sizes and styles of blades (GlideScope®, Fastrack®, Airtraq®) and other airway devices. The laryngeal mask airway (LMA) is one commonly used, good temporizing measure with which most anesthesia practitioners are familiar. Should direct laryngoscopy fail initially, by placing a functioning LMA, it is relatively easy to exchange the LMA for the endotracheal tube (ETT) via either a Cook Exchange Airway Catheter® or an Aintree®.

Given the nature of surgery and the physiology of the patient, a combination of desflurane in oxygen and air is probably preferable to using nitrous oxide. Superiority of desflurane has been established in the last few years. Some recent data suggest that the difference between desflurane and sevoflurane may not be significant. Moderate positive end-expiratory pressure of 7 cms to 10 cms, tidal volume of 10-12 cc/kg and a respiratory rate of 12-14 per minute are probably appropriate. A recruitment maneuver utilizing 30 cms of water pressure for 30 seconds to deal with desaturation caused by atelectasis at induction, or intraoperatively, is a good first step and will usually result in an immediate improvement of SaO₂.

Once the airway is secured with an inflated ETT, we start another I.V., apply warming devices, place a Foley catheter and position the patient for surgery. The Foley helps in assessing intraoperative hydration, since these patients also are at increased risk of acute tubular necrosis if allowed to run on the dry side. Even in a two- to three-hour case, with minimal blood loss, the morbidly obese patient may need four to five liters of crystalloids.

Intraoperative drug dosing should recognize that the patient’s fat stores will significantly affect metabolism of lipophilic drugs. Lipophilic drugs such as barbiturates and benzodiazepines have an increased volume of distribution; the relevant exceptions to this are remifentanil, digoxin and procainamide. Conversely, lipophobic drugs should be dosed for ideal body weight or lean body mass.

Toward the end of the case, an appropriate amount of I.V. morphine may be administered (0.1 mg/kg, up to 10 mgs). To facilitate analgesia in the absence of respiratory depression, adjunctive nonsteroidal anti-inflammatory drugs should be considered. Extubation after complete reversal of paralysis in the semirecumbent position is ideal. Patients with a history of CPAP usage at home are placed on the CPAP or a bi-level positive airway pressure machine as soon as possible. After meeting all appropriate criteria, these patients should be discharged from the postanesthesia care unit to a monitored bed in the hospital.

The anesthetic challenges of morbid obesity are many, but the corresponding satisfaction achieved after a successful case is large. A combined approach of care, planned and agreed upon between anesthesiologists and surgeons along with nursing and respiratory care, will usually lead to improved outcomes. Much anesthetic research still needs to be done in this field, from modes of optimal preinduction oxygenation to postoperative pain control.

References:

A

SA has committed to a strategic plan of expanding the
types and range of continuing medical education (CME)
courses that it makes available to anesthesiologists. We rec-
ognize that our members have extremely busy practices but
seek quality CME programs that are conveniently available.
Accordingly, we plan to take full advantage of the Internet to
bring high-quality CME to your local office and homes.

Our Annual Meeting is ASA’s premium CME event, and
many anesthesiologists do their very best to attend each
year. Practice demands, however, do not allow most to
attend our Annual Meeting. Because of this, the Committee
on Outreach Education and the Committee on Annual Meet-
ing Oversight have jointly developed an exciting new CME
program titled “Annual Meeting Highlights.”

This Internet-based program should be available to mem-
bers in January 2007 and will include approximately 15
hours of CME credit. The following presentations are
planned:

**The Patient With Sleep Apnea Syndrome for Ambula-
tory Surgery:** Girish P. Joshi, M.D.

**The Epidemic of Metabolic Syndrome and Implica-
tions for Perioperative Medicine and Organ Protection
Strategies:** Robert N. Sladen, M.B. (moderator)

**What Is the Metabolic Syndrome and What Can We Do
About It?:** Judy R. Kersten, M.D.

**Advances in the Management of Perioperative Hyperten-
sion:** Manuel L. Fontes, M.D.

**Renal Insufficiency and Failure-Prevalence, Prevention
and Treatment:** Mark Stafford-Smith, M.D.

**Mechanical Ventilatory Support in 2006: Getting the
Most From the Ventilator:** Michael A. Gropper, M.D.,
Ph.D.

**Perioperative Care of the Patient With Acute CNS
Injury:** Susan Black, M.D. (moderator)

**Brain Trauma:** Audreé A. Bendo, M.D.

**Cervical Spine:** Susan Black, M.D.

**Fluid Management:** Donald S. Prough, M.D.

**Depth of Anesthesia: Clinical Applications, Awareness
and Beyond:** Daniel J. Cole, M.D., and Karen B.
Domino, M.D.

**Current Controversies in Obstetric Anesthesia:**
William R. Camann, M.D.

**Sedation/Analgesia for Diagnostic Procedures in
Children Outside the Operating Room:** Richard F.
Kaplan, M.D.

**Spinal Cord and Peripheral Nerve Stimulation for the
Treatment of Pain:** Allen W. Burton, M.D.

**No Blood, No Pus, No Pain — Avoiding Hemorrhag-
ic, Infectious and Neurologic Complications Associated
With Regional Anesthesia:** James R. Hebl, M.D., (moder-
ator)

**No Pus — Avoiding Infectious Complications:** Dr. Hebl

**No Blood — Avoiding Hemorrhagic Complications:**
Terese T. Horlocker, M.D.

**No Pain — Avoiding Neurologic Complications:** Joseph
M. Neal, M.D.
Clinical Information Resources in the Operating Room: Keith J. Ruskin, M.D.

2006 Emery A. Rovenstine Memorial Lecture: We Are What We Make: Jerry Reves, M.D.

2006 Annual Meeting Plenary Session: Vulnerability of Pulmonary Capillaries in Health and Disease: John West, M.D.

The 2006 Annual Meeting Highlights CME program is an Internet-based production using audio recordings of contributors’ Annual Meeting presentations plus lectures slides. Contributors also will provide follow-up materials for further, optional study. The subscriber will be able to sign up for the entire program or any specific presentation he/she chooses. CME credit may be requested upon completion of a short post-test and course evaluation.

Again, please look for this program to appear in January 2007.

The 2006 Problem-Based Learning Discussion (PBLD) Program consisted of 150 cases that were selected from more than 350 submitted during the open-call process. Each was offered twice during the 2006 Annual Meeting in Chicago, thus allowing attendees more opportunities to be involved in the PBLD program. Attendees responded by filling 96 percent of available seats! The PBLD Committee again wishes to continue the open-call process, which has led to the vibrant nature and ultimate success of the PBLD program.

We are seeking submissions to complete each of the anesthesia tracks that will be offered: ambulatory anesthesia, cardiac anesthesia, critical care medicine, neuroanesthesia, obstetric anesthesia, pain medicine, pediatric anesthesia, regional anesthesia, basic science/clinical anesthesia and professional issues. Cases will be reviewed by several members of the committee for relevance, content, scholarship and conformity to the guidelines that appear on the ASA Web site. All cases must be submitted online in the Annual Meeting section of the ASA Web site <www.ASAhq.org>.

The deadline for submission is February 1.

PBLD 2007 Open Call for Case Submissions

Meg A. Rosenblatt, M.D., Chair
Committee on Problem-Based Learning Discussions

T he 2006 Problem-Based Learning Discussion (PBLD) Program consisted of 150 cases that were selected from more than 350 submitted during the open-call process. Each was offered twice during the 2006 Annual Meeting in Chicago, thus allowing attendees more opportunities to be involved in the PBLD program. Attendees responded by filling 96 percent of available seats! The PBLD Committee again wishes to continue the open-call process, which has led to the vibrant nature and ultimate success of the PBLD program.

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The deadline for submission is February 1.
The ASA 2006 Annual Meeting will go down as one of the most memorable in ASA history. To begin with, 2006 marked the highest attendance ever recorded — 18,497, including 7,805 member physicians, 4,009 exhibitors, 3,003 spouses and 3,680 nonmembers and other related professionals.

2006 also was a milestone transition year as it represented the first time that the meeting’s educational content was implemented entirely in the learning track curriculum. The learning track system (encompassing the areas of pain medicine, cardiac anesthesia, critical care medicine, obstetric anesthesia, pediatric anesthesia, regional anesthesia, ambulatory anesthesia, neuroanesthesia and basic science/clinical anesthesia and professional issues) was designed to streamline attendees’ educational itineraries around his/her own interests, and indications are that it succeeded. Success breeds success, and so expanded learning track content and added subspecialty areas are already in the works for 2007.

The long-anticipated (and long sold-out) Centennial Gala dinner was enormously successful, and it was suggested by many attendees that such a formal event take place every five to 10 years. Originally planned for the 2005 Annual Meeting in New Orleans to coincide with the Society’s 100th anniversary, the Gala was displaced by Hurricane Katrina and postponed until suitable accommodations could be found. It was a long wait, but ultimately well worth it.

One small but gratifying perk of organizing the meeting so close to ASA headquarters was the fact that attendees had the chance visit the world-class Wood Library-Museum of Anesthesiology (WLM) and even get a glimpse of the day-to-day activities at the headquarters building. The popularity of the WLM tours, which were given as part of the Annual Meeting social activities program, exceeded expectations.

Although it won’t be until 2011 that the Annual Meeting comes back to ASA’s “home town,” the 2006 Annual Meeting in Chicago left an indelible imprint on the city and on ASA and set far-reaching precedents for future meetings.

Other highlights of this year’s Annual Meeting appear below.

**Installation of ASA President**

Mark J. Lema, M.D., Ph.D., was installed as ASA President for 2007. Dr. Lema is currently Chair of the Department of Anesthesiology, Pain Medicine and Critical Care at Roswell Park Cancer Institute, Buffalo, New York, and Professor and Chair of Anesthesiology, University at Buffalo, State University of New York School of Medicine and Biomedical Sciences. He has served ASA as President-Elect (2006) and First Vice-President (2005). He was ASA NEWSLETTER Editor from 1997-03.

Dr. Lema has served as Past President (2002), President (2001), President-Elect (2000) and Vice-President (1999) of the New York State Society of Anesthesiologists (NYSSA) and Past President (2005), President (2004), President-Elect (2003) and Vice-President (2002) of the American Society of Regional Anesthesia and Pain Medicine.

He is a graduate of the State University of New York, Downstate Medical Center, Brooklyn, New York, Harvard School of Public Health Program for Chiefs of Clinical Services and Harvard School of Public Health Advanced Program for Chiefs of Clinical Services and received a National Institutes of Health Predoctoral Fellowship and Ph.D. (physiology) at the University at Buffalo, State University of New York.

Dr. Lema and his wife, Suzanne, live in East Amherst, New York.
Other ASA Officers

President-Elect
Jeffrey L. Apfelbaum, M.D.

Immediate Past President
Orin F. Guidry, M.D.

First Vice-President
Roger A. Moore, M.D.

Vice-President for Scientific Affairs
Charles W. Otto, M.D.

Vice-President for Professional Affairs
Alexander A. Hannenberg, M.D.

Secretary
Gregory K. Unruh, M.D.

Treasurer
John M. Zerwas, M.D.

Assistant Secretary
Arthur M. Boudreaux, M.D.

Assistant Treasurer
James D. Grant, M.D.

Speaker, House of Delegates
Candace E. Keller, M.D.

Vice-Speaker, House of Delegates
John P. Abenstein, M.D.

Newly elected Assistant Treasurer James D. Grant, M.D., is a first-time officer.

Dr. Grant is the Vice-Chair of the Department of Anesthesiology, Director of Perioperative Services, Director of Orthopaedic Anesthesiology and attending staff in the William Beaumont Hospital System, Royal Oak, Michigan. He has served ASA as a member of the Board of Directors (2002-06), Alternate Director for Michigan (1999-2002), Secretary of the Midwest Caucus (2002-06), Delegate, House of Delegates (1995-98), Alternate Delegate, House of Delegates (1993-94) and has served on the committees on Communications, Governmental Affairs, Economics, Young Physicians, Membership and Legislative Review, among others. Dr. Grant has served in his home state as Secretary-Treasurer (1996-98), President-Elect (1998-99) and President (1999-2000) of the Michigan Society of Anesthesiologists. He serves as Alternate Delegate from the Michigan State Medical Society to the American Medical Association House of Delegates (2000-present) and sits on the Finance Committee and Board of Directors of the Michigan State Medical Society. He was awarded the Michigan Doctors Political Action Committee Distinguished Service Award in 2006.

Awards and Honors

Jerome H. Modell, M.D., Professor Emeritus of the University of Florida, was the recipient of the 2005 Distinguished Service Award. In addition, Carl C. Hug, Jr., M.D., Ph.D., was selected as the 2006 recipient to be awarded at the 2007 Annual Meeting. The 2006 Award for Excellence in Research was presented to Nicholas P. Franks, Ph.D., Professor of Biophysics and Anaesthetics at Imperial College and Head of Biophysics at Blackett Laboratory, London, England. The Emery A. Ravenstine Memorial Lecture was given by Jerry Reves, M.D., Professor of Anesthesia and Perioperative Medicine, Professor in the Department of Cell and Molecular Pharmacology and Experimental Therapeutics, and Vice-President for Medical Affairs and Dean, College of Medicine of the Medical University of South Carolina in Charleston. Dr. Reves’ talk, “We Are What We Make,” explored the state of academic anesthesiology today and in the future. The Lewis H. Wright Memorial Lecture was given by Alastair A. Spence, C.B.E., M.D., F.R.C.A., Professor Emeritus of University of Edinburgh and Past President (1991-94) of the Royal College of Anaesthetists. Dr. Spence’s talk was titled “The Scottish Enlightenment: A Hotbed of Genius.”

P.D. Allen, M.D., Ph.D., Professor of Anesthesia at Harvard Medical School, gave the 2006 Foundation for Anesthesia Education and Research Honorary Research Lecture, which focused on “Calcium: This Is Everything.”

Media Awards

In honor of the late Philip S. Weintraub, former ASA Public Relations Manager and Director of Communications, the name of the ASA media award was changed this year to the Philip S. Weintraub Media Award. Winners of the 2006 award included Joseph T. Hallinan of the Wall Street Journal and NBC Dateline producers Matthew Fields, Karen McKinley and Maia Samuel. Mr. Hallinan received his award for a June 21, 2005 article “Heal Thyself — Once Seen as Risky, One Group of Doctors Changes Its Ways;” which focused on the successful efforts of anesthesiologists, ASA and the Anesthesia Patient Safety Foundation to increase patient safety and lower liability premiums. The September 25, 2005 Dateline television production “Modern Anesthesia” explored awareness and how ASA and other individuals and organizations are dealing with this rare but troubling event.

Information on Scientific and Educational Exhibit Award winners will appear in the January 2007 NEWSLETTER. A summary of media activity related to the meeting also will appear in January.
The Committee on Rural Access to Anesthesia Care is proud to announce a new ASA scholarship program for medical students studying anesthesiology in rural areas. The ASA House of Delegates approved a pilot program on October 18, 2006, for $10,000 per year for three years. Medical students will be able to apply for scholarships to pay for expenses up to $750 for travel and lodging for a rural clerkship. Details will be provided on the ASA Medical Student Delegation Web page in January 2007. If anyone knows of an organization or foundation that may match the ASA funds for this rural medical education program, please contact me. Thank you to all the many people who have made this opportunity possible for medical students to experience rural anesthesiology.

The Committee on Rural Access to Anesthesia Care presented a panel discussion at the 2006 Annual Meeting in Chicago. John C. Chatelain, M.D., North Dakota, reviewed the basic demographics and definitions of rural America. He reviewed the history and current status of the rural geographic practice cost index (GPCI) on Medicare payments. In 2003, Congress approved a temporary equalization of rural work GPCI to raise Medicare reimbursement in rural areas toward the national average payment. This congressional act for equalization of payments sunsets in December 2006. Without congressional action for an extension, 2007 will return to the deep discounts for Medicare services in rural America.

Dr. Chatelain explained that 25 percent of the U.S. population lives in rural areas, but only 12.5 percent of the surgeons practice in rural areas. Accurate data for the percentage of anesthesiologists practicing in rural areas is not available but is estimated to be less than 5 percent of the total number of practicing anesthesiologists in America. Dr. Chatelain described the challenges and benefits of rural living while providing necessary care to an aging population.

Wallace H. Good, Jr., M.D., Vermont, described a unique program to meet the needs of rural anesthesiologists, hospitals and patients. Dr. Good calls this approach to an anesthesiology practice “spinning.” The need for regular part-time anesthesiology staff in a rural region to cover the operating rooms and nonclinical time for local anesthesiologists is always present. He explained the benefits of spreading the knowledge of “best practices” throughout a region with these webs of anesthesia practice. Dr. Good explained how the issues of availability, scheduling, compensation, insurance, local hospital cultures and different medical staff regulations could be navigated. He outlined the benefits of working in multiple facilities with access to different recreational experiences. He shared stories of the fishing, hiking and skiing available near these facilities.

I described our hospital’s successes with a new process for preoperative workups for patients who may travel more than 500 hundred miles roundtrip for their surgery. Several years ago, the facility experienced a more than 20-percent cancellation or delay rate the day of surgery for the operating room. This was reduced to less than 5 percent. Many patients previously arrived on the day of surgery with little or no preoperative medical evaluation. Now the preoperative process sets a target that all labs, consults, and history and physicals be completed 72 hours prior to surgery. Follow-up with the surgeon’s office by fax is now routine for every patient 24-48 hours prior to surgery to identify those patients with the preoperative process complete and any patient who still has specific data pending. Protocols were

Continued on page 34
The Anesthesia Patient Safety Foundation (APSF) believes that opioid-induced depression of ventilation during patient-controlled analgesia (PCA) and neuraxial analgesia is a preventable cause of morbidity and mortality. A panel of experts discussed this topic, and attendees at the conference contributed their views during the APSF Board of Directors Workshop on October 13, 2006.

The conference attendees and participants agreed that there is a significant and underappreciated risk of injury from PCA and neuraxial opioids administered in the postoperative period. While some patient populations (notably those patients with obstructive sleep apnea) appear to be at higher risk, there is still a low but unpredictable incidence of life-threatening opioid-induced depression of ventilation in young, healthy patients.

Based on the data presented at the October 13, 2006, conference and the comments of the participants, APSF endorses a goal that no patient shall be harmed by opioid-induced ventilatory depression in the postoperative period. To address this goal, APSF urges health care professionals to give consideration to the potential safety value of continuous monitoring of oxygenation (pulse oximetry) and ventilation in patients receiving PCA or neuraxial opioids in the postoperative period. Although pulse oximetry will monitor oxygenation, it is not a sensitive or specific monitor for hypoventilation when supplemental oxygen is being administered. When supplemental oxygen is indicated, monitoring of ventilation may warrant the use of technology designed to detect breathing or estimate arterial carbon dioxide concentrations.

Continuous monitoring is most important for at-risk patients, but depending on clinical judgment, could be applied to other patients. APSF also believes it is critical that any monitoring system be linked to a reliable process to summon a competent health care professional to the patient’s bedside in a timely manner.

APSF recognizes that future developments may improve the ability to utilize continuous monitoring of oxygenation and ventilation in the postoperative period. In this regard, APSF encourages research and education in postoperative monitoring of patients receiving opioids. The status quo while awaiting the perfect monitor(s), however, is not acceptable, and APSF urges consideration of continuous postoperative monitoring of oxygenation and ventilation in appropriate patients without delay.

A complete report of the conference presentations and an expanded description of APSF’s goals and conclusions will be published in a future issue of the APSF Newsletter at <www.apsf.org/resource_center/newsletters.mspx>.

“...continuous postoperative monitoring of oxygenation and ventilation in appropriate patients without delay.”

Robert K. Stoelting, M.D., President
Anesthesia Patient Safety Foundation

Robert K. Stoelting, M.D., Indianapolis, Indiana, is President of the Anesthesia Patient Safety Foundation.
Two years ago, this “Practice Management” column introduced pay-for-performance (P4P) as “The Hot Health Policy Topic of 2005.” P4P has become even hotter; at a late October meeting in Washington, a speaker described some of the participants as “having their hair on fire.”

The temperature is considerably higher in the policy-making, employer- and payer-driven arena than it is in the anesthesiology department. Debates and discussions at the ASA 2006 Annual Meeting in Chicago — and within subspecialty societies — nevertheless suggest that a progress report could be useful to all of our members.

**Performance Measures for Anesthesiologists**

The basic units of P4P programs are, of course, the measures themselves. ASA has produced five “quality incentives” or P4P measures to date:

1. Timely administration of antibiotic prophylaxis;
2. Maintenance of normothermia;
3. Comprehensive planning for chronic pain management;
4. Prevention of ventilator-associated pneumonia; and
5. Prevention of catheter-related bloodstream infections.

All but the chronic pain measure are adaptations of institutional quality measures developed by nationally recognized groups, including the Surgical Care Improvement Project (SCIP, a national partnership of public and private organizations, including ASA, formed in 2003 with the goal of improving the quality of surgery by reducing the incidence of postoperative complications), the Centers for Disease Control and Prevention, the Joint Commission on Accreditation of Healthcare Organizations and the Institute for Healthcare Improvement. Three members of ASA’s Committee on Performance and Outcomes Measurement (CPOM) represent the specialty within SCIP. The chronic pain measure was drafted by ASA’s Committee on Pain Medicine and subsequently endorsed by five additional specialty organizations representing pain physicians.

CPOM presented a P4P panel at the Annual Meeting in which Committee Chair Robert S. Lagasse, M.D., proposed additional interventions that could be the basis for potential measures:

1. Choice of perioperative antibiotics;
2. Maintenance of perioperative serum glucose at or below 200 mg/dl during cardiac surgery;
4. Perioperative prophylaxis for venous thromboembolism;
5. Elevation of the head of bed in patients mechanically ventilated postoperatively; and
6. Application of weaning protocols for patients mechanically ventilated in the postoperative period.

As much examination and refinement as these measures have received and will continue to receive within our Society as well as within the pain medicine and critical care subspecialty societies, the external standardization and vetting process required by most payers is still in its early stages. Only the antibiotic prophylaxis measure has been approved for use by the Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA) Physician Consortium on Performance Improvement (the Consortium or PCPI) and the Surgical and Ambulatory Quality Alliances (SQA, AQA). At press time, the normothermia and the critical care measures are under consideration at AMA. The roles of the numerous organizations involved in this process have changed since their names were placed before *NEWSLETTER* readers in 2005. Indeed some of today’s major players in Table 1 on page 29 did not exist two years ago.

**Vetting Organizations: The 2006 Scorecard**

First of all, why are we seeking external validation of any sort? ASA has a long and respected history of publish-
ing evidence-based practice parameters without consulting third-party “stakeholders.” Practice guidelines do not translate automatically into performance incentives, however. The payers in particular contemplate using bonus payments and/or withholds in order to affect the practice patterns of physicians in multiple specialties at the same time. Accordingly they want a thorough and uniform validation system that will shield them from multiple versions of a given performance measure as well as from individuals’ or interest groups’ pressures or subsequent challenges, as they see it. That uniform validation process is still taking shape.

Table 1: ASA Representation to the Key Measure Development and Endorsement Organizations

<table>
<thead>
<tr>
<th>Organization</th>
<th>Workgroup</th>
<th>Primary ASA Representative</th>
<th>Other Active ASA Participants *</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS</td>
<td>PVRP</td>
<td>Alexander A. Hannenberg, M.D.</td>
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<tr>
<td></td>
<td>Physician Voluntary Reporting Program</td>
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<tr>
<td>AMA</td>
<td>PCPI</td>
<td>Ronald A. Gabel, M.D.</td>
<td>Alexander A. Hannenberg, M.D.</td>
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<tr>
<td></td>
<td>Physician Consortium for Performance Improvement</td>
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<tr>
<td>AQA (Ambulatory Quality Alliance)</td>
<td>Various</td>
<td>Alexander A. Hannenberg, M.D.</td>
<td>Gerald A. Maccioli, M.D. Frank Rosinia, M.D.</td>
</tr>
<tr>
<td>SQA (Surgical Quality Alliance)</td>
<td></td>
<td>Alexander A. Hannenberg, M.D.</td>
<td>Frank Rosinia, M.D. Gerald A. Maccioli, M.D.</td>
</tr>
<tr>
<td>SCIP (Surgical Care Improvement Project)</td>
<td></td>
<td>Ronald A. Gabel, M.D.**</td>
<td>Robert S. Lagasse, M.D.** Lee A. Fleisher, M.D.**</td>
</tr>
<tr>
<td>NQF (National Quality Forum)</td>
<td>HP3 (Health Professional, Provider and Health Plan Council)</td>
<td>Alexander A. Hannenberg, M.D.</td>
<td>Gerald A. Maccioli, M.D. Frank Rosinia, M.D.</td>
</tr>
<tr>
<td></td>
<td>Anesthesiology and Surgery Advisory Panel</td>
<td>Gene N. Peterson, M.D.</td>
<td>Alexander A. Hannenberg, M.D.</td>
</tr>
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<td></td>
<td>Ambulatory</td>
<td>TBA</td>
<td></td>
</tr>
</tbody>
</table>

* ASA’s Executive Officers and senior staff are also “active participants”
** All three are “primary” representatives

The CMS Physician Voluntary Reporting Program (PVRP)

The definitive role of CMS in accepting measures for use in the PVRP is clear. The PVRP will be very important if
final Medicare physician payment legislation bases any part of the fee schedule payments on reporting measures approved by the government. (This possibility has been described in several legislative alerts on the ASA Web site.) Adoption of PVRP measures in the private sector, on the other hand, is an open question.

PVRP measures may come from and through various sources. Last year CMS decided not to include any of the three measures that ASA placed before it. In mid-October, CMS published a white paper with a list of 86 potential quality measures for 2007. Among these is a single anesthesiology measure denominated “prophylactic antibiotic timing,” which does not provide a clue as to whether the measure will be structured in such a way as to be usable by our members. If it is the same measure approved by the Consortium, it will be one that anesthesiologists can report.

The Consortium: ASA has participated in the multispecialty Consortium led by AMA for more than a decade, together with more than 100 national and state medical societies, CMS and the federal Agency for Healthcare Research and Quality (AHRQ), and experts in methodology. The Consortium has developed numerous measures relating to chronic diseases and preventive screening. The pace accelerated considerably throughout 2006 with the launch of perioperative (co-chaired by Ronald A. Gabel, M.D., who has represented ASA for more than a decade) and anesthesiology (co-chaired by Alexander A. Hannenberg, M.D.) workgroups. The result, as noted above, was adoption of a measure for the timely administration of antibiotic prophylaxis and the initiation of work on our normothermia and critical care measures.

Most specialty societies, including ASA, believe that the Consortium is the right entity to develop evidence-based clinical performance measures. CMS, however, gives equal consideration to the National Committee for Quality Assurance (NCQA, which accredits health plans) to certain specialty societies and to one disease-specific organization. Most recently CMS has awarded a contract to the Medicare Quality Improvement Organization (QIO) for Pennsylvania to create measures for specialties that have no current PVRP measures. Those of us participating in the Consortium will be interested in the extent to which the QIO seeks physician involvement.

When the Consortium adopts and publishes a performance measure, CMS and most private payers “give preference to” measures sent on to the National Quality Forum (NQF) and to the AQA for endorsement and decisions on implementation.

The NQF: This large organization, of which ASA is a dues-paying member, manages an evaluation and consensus process by which its own staff, all interested members and the public endorse performance measures on the basis of

Register Now for the Annual ASA Conference on Practice Management

Anesthesiologists interested in:
• The business side of working in ambulatory surgical centers;
• Exclusive contracts;
• Health information technology and anesthesiology;
• Working part time;
• Future trends in the economics and politics of anesthesiology practice and other topics;


their “validity, usability and importance as measures of healthcare quality.” To some extent, it is being challenged in this role by AQA.”

The AQA: “Ambulatory” in “AQA” has meant “primary care” since the organization was launched in 2005. The initial concept of the AQA was to promote uniformity in the implementation of physician performance measures. Its membership therefore encompassed, from the outset, CMS, AHRQ, America’s Health Insurance Plans (AHIP) and a considerable number of individual health plans and large employers that contract with the health plans as well as the primary care and some specialty care physician organizations.

It quickly began to appear that the AQA intended to choose for itself which physician performance measures would be adopted by the private payers responding to pressures from the employers to launch P4P programs. The American College of Surgeons and ASA saw an urgent need for a perioperative analogue that would either stand alone or that would turn the AQA into a receptive partner, and thus was born the Surgical Quality Alliance (SQA).

The SQA: At the October meeting of the AQA, both an initial set of perioperative measures — including three distinct measures for selecting, ordering and administering prophylactic antibiotics — and a set of ophthalmologic measures were unanimously adopted. Thus the SQA has accomplished its mission and set the stage for further success as the unified voice of surgery and anesthesiology. Frank G. Opelka, M.D., F.A.C.S., is to be congratulated on his appointment to the AQA Steering Committee and on his brilliant leadership of a group with many interests and agendas. His presentation at the 2007 ASA Conference on Practice Management will be inspirational. The contributions of ASA SQA representatives Dr. Hannenberg, Gerald A. Maccioli, M.D., and Frank A. Rosinia, M.D., have made a real difference for ASA and our surgical colleagues.

2007 and Beyond
Anesthesiology is entering the new year with two major P4P assets: a starter set of performance measures that are gaining acceptance in the payer organizations and an even stronger reputation as a leader in improving the safety and quality of patient care. As stated by Dr. Hannenberg, “Quality improvement is part of anesthesiology’s culture.

We can do well with a new generation of quality initiatives launched with our commitment to constant refinement.”

This does not obscure the fact that most anesthesiologists have yet to enjoy the “pay” component of P4P. As an organization, we are fully engaged in the arenas where the methodologies for paying for excellence or improvement in clinical performance are developing. Individual anesthesiologists and their practices also must watch for opportunities to report and to be recognized for their performance. Such opportunities are likely to appear first in the context of hospital contracts and physician-hospital organizations. (The medical director of one such organization called the Washington Office several days ago to determine the status of the quality indicators on the ASA Web site. His organization is planning to distribute annual performance rewards of up to $5,000 starting in 2008, assuming that anesthesiology benchmarks have been established and surpassed.)

Maintaining a focus on future measures also is a responsibility of ASA leadership, of the P4P team, of interested committees and of our members in their own practices. Some of the potential subjects for P4P incentives that are now commanding payer attention are participation in data reporting programs such as registries, where we have experience dating back to the launch of the Closed Claims Project, and (more alarming) “value,” or the cost-efficiency of care. Sharing our information and strategies has never been more important.

Source Materials:


NCSL’s Annual Meeting provides ASA with an opportunity to increase the visibility of anesthesiologists and to educate state legislators about their achievements in patient safety as well as other issues facing physicians. Participating on behalf of the Tennessee Society of Anesthesiologists (TSA) were Steven R. Dickerson, M.D., Julie K. Hudson, M.D., Ph.D., Monica M. Jones, M.D., Bradley E. Smith, M.D., Christopher E. Young, M.D., and TSA Executive Director Bill Bond.

Thank you to everyone who volunteered their time. ASA has already begun planning for NCSL’s 2007 Annual Meeting, which will be held in Boston, Massachusetts, on August 5-9, 2007.
The population is rapidly aging, and the oldest (>85 years) in our society represent the most rapidly growing section of the U.S. population. As this group of individuals continues to expand, we as anesthesiologists will need to understand the consequences of aging to provide the type of care patients expect from our profession.

Dedicated to Improved Care

The Society for the Advancement of Geriatric Anesthesia (SAGA) <www.sagahq.org> is dedicated to promoting improved care of the elderly patient through research, education, and clinical expertise. This Society continues to grow and thrive in our aging world, and its seventh Annual Meeting was held in Chicago on Sunday, October 15, 2006. The meeting featured a special presentation and discussion with Arnold J. Berry, M.D., Chair of the Foundation for Anesthesia Education and Research (FAER) Geriatrics Research Council, on the topic of “The Geriatric Anesthesiology Fellowship — Coming of Age?”

The FAER council is formulating a proposal, cosponsored with SAGA and the ASA Committee on Geriatric Anesthesia, to facilitate the development of geriatric anesthesiology fellowships at institutions that have the faculty and resources to prepare anesthesiologists committed to pursuing careers as practitioners, teachers, and researchers in the field of geriatric anesthesiology. The plan is to train anesthesiologists during a postresidency fellowship, and FAER will be seeking to partner with outside foundations to fund these fellowships. It is envisioned that the fellowship awards would provide salary and research support for one to two years for the recipient to pursue research in an area related to aging and anesthesia. In addition to research and clinical geriatric anesthesia experience, the fellow would be expected to spend time with his/her institution’s geriatric medicine department and thus truly develop expertise in the management of the elderly surgical patient.

Following the fellowship, these individuals would be qualified to be competitive for further research funding opportunities in geriatric anesthesiology. The ultimate goal of this unique fellowship is to develop future leaders in geriatric anesthesiology who will have both clinical and research expertise in the perioperative care of the elderly patient. Stay posted on this one!

Teaching the Young to Care for the Old

Education of our younger anesthesiologists and trainees in geriatrics also is critical if we are to successfully take care of the explosion of elderly patients we are facing, and the ASA Committee on Geriatric Anesthesia has been instrumental in promoting geriatric education in anesthesiology. Working together with SAGA and the American Geriatrics Society, the committee is currently putting together a new Geriatric Anesthesia Curriculum. The goal of this curriculum is to provide a comprehensive list of topics for the consultant in geriatric anesthesiology. Each section will contain one or more broad goals accompanied by corresponding objectives. A select bibliography will be included, with a brief statement of relevance for each article. It is understood that the depth of knowledge and expertise will vary depending on the interest and practice of the practitioner. The curriculum will ultimately be posted on both the ASA and SAGA Web sites.

Geriatric Issues at ASA Annual Meeting

Although the aging of our society may not be news to anyone, there was plenty of news about the elderly at the ASA 2006 Annual Meeting in Chicago. It was evident that aging issues in anesthesiology are gaining recognition, especially

Sheila R. Barnett, M.D., is Assistant Professor of Anesthesiology, Harvard Medical School and Beth Israel Deaconess Medical Center, Boston, Massachusetts.
around postoperative cognitive disorders. The geriatric influence was present throughout the meeting in panels, Problem-Based Learning Discussions, Refresher Course Lectures, clinical forums and scientific presentations. Several SAGA officers presented and spoke on panels, including Deborah J. Culley, M.D., the newly elected SAGA treasurer; Jeffrey H. Silverstein, M.D., former president and board member; Terri G. Monk, M.D., immediate past president; Christopher J. Jankowski, M.D., president-elect; Frederick E. Sieber, M.D., our newly elected secretary; and Leanne Groban, M.D., a new board of directors member. Many others also contributed to the meeting and to SAGA.

For those interested in geriatric anesthesiology, please visit the SAGA Web site at <www.sagahq.org> for information about the Society. There also are unique funding opportunities through the American Geriatrics Society. The Dennis W. Jahnigen Career Development Scholars Award is a two-year grant given to subspecialty faculty pursuing research in age-related issues. This grant provides an excellent opportunity for young faculty interested in pursuing careers in aging, and more information can be found at <www.healthinaging.org/hartford/>.

Although our Society is young, we have tremendous opportunities to address head-on the challenges facing our profession in the coming years. Stay tuned!

Committee on Rural Access to Anesthesia Care

Continued from page 26

described to gather this information from sometimes distant facilities and physicians by fax, e-mail and telephone calls.

A unique electronic educational resource called OR PEER was demonstrated. This simple software system can be used to develop education tools for new staff. OR PEER is a quick resource review that illustrates with photos and text the tasks that may be infrequently performed to increase confidence and job satisfaction for intermediate employees (only on the job for one to three years). These intermediate employees are critical to retain on your staff because they help to preserve knowledge for your institution’s future and the future of perioperative nursing. OR PEER also can quickly demonstrate to travelers how procedures are done in your local institution.

The goal is for rural facilities with limited staff to improve patient safety in the operating room or even other areas of the facility. The updated version of OR PEER <www.orpeer.com> has the ability to test for competency and track the results for nurse continuing education unit credits or physician continuing medical education hours. This quick and easy electronic educational resource can speed your staff’s learning curve and enhance your organization’s experience curve.

Rural physicians recognize that without academic training programs, we will have no anesthesiologists to recruit to rural America. The Committee on Rural Access to Anesthesia Care supports fair and equal payments for services provided by physicians in anesthesia training programs. The Resident Component House of Delegates has passed a recommendation to study the feasibility of anesthesia residency rotations in rural areas.

Nationally, family practice programs have led the way in rural training, and general surgery has developed residency training for rural practices. If Medicare reimbursement for medical care to academic programs improves, anesthesiologists can follow this pathway to rural America.

Reference:

As I waited in line for breakfast on the final day of this year’s ASA Annual Meeting, the comparison of the bounty before me and the numerous opportunities available at the meeting was simple but profound. I observed different anesthesiologists (identifiable by their flamboyant colored badges) choosing the delectable items according to their palates’ preferences that morning. Herbivores, carnivores and, of course, the moderate omnivores (like myself) had it their way. The wonderful breakfast buffet at this year’s meeting had something for everyone. Whether you were a politician, a researcher or a social butterfly, Chicago had it all.

Day 1

Like the way many people start a buffet, we started the resident activities with “the meat” or politics of our specialty. Thus the first resident function of the conference was the Grassroots Advocacy/Leadership Training Workshop. The panel included ASA Resident Component officers and ASA Director of Governmental Affairs and General Counsel Ronald Szabat, J.D. They reported that a fix for the Centers for Medicare & Medicaid Services (CMS) teaching rule and the current flawed sustainable growth rate (SGR) formula was in reach but required the full support of the ASA membership through ASA Political Action Committee (ASAPAC) contributions, e-mails, letters and telephone calls to Congress. It was reiterated that the CMS teaching rule has drained and continues to drain our teaching programs by approximately $400,000 per program per year. Most Medicare reimbursement policy private payers have decided to follow suit and pay with the same method. The SGR formula for Medicare reimbursement compounds the issue with a planned 5.1-percent reduction in payment to anesthesiologists beginning January 1, 2007. More cuts are anticipated in the future based on the current formula.

The panel also emphasized that we must be active during this crucial time and that a tangible expression of our commitment to our specialty was to pay our ASAPAC and state PAC dues. Currently ASAPAC dues for residents are a mere $20 dollars per year. Resident PAC participation is approximately 9 percent, a remarkably low percentage considering what we stand to lose or gain. The resident delegation from Alabama must be recognized for 100-percent resident PAC participation. For further information on ASAPAC, visit <www2.ASAhq.org/pac/web/> or follow the links through the “Members Only” section of the ASA Web site <www.ASAhq.org>.

Day 2

Day two of the conference started with the ASA Resident Component (ASARC) House of Delegates, which gave residents the opportunity to present and debate resolutions. Resolutions that passed the House of Delegates and that will be forwarded to the ASA House include Resolution 6, encouraging ASA to ensure that resident insurance policies cover rehabilitative services for substance addiction. As a body, we also passed Resolution 8, asking that the ASA House create an independent medical student component. Similarly the House passed ASARC Resolution 9, calling for ASA to study the feasibility of a rural anesthesiology elective for interested CA-3 residents.

The Resident Component officers each reported on the year’s accomplishments, which represented an unprecedented amount of activity. We are extremely appreciative of the establishment of the five $1,000 grants for ASA resident delegates to host regional meetings and the major modifications to the ASARC Web site, which has improved our communications tremendously.

Finally, the ASARC elected its officers. Congratulations to the new ASA Resident Component Officers: Secretary Melissa Matte, M.D.; American Medical Association (AMA) Alternate Delegate Joseph A. Walker III, M.D.; and “Residents’ Review” Co-Editor Anagh A. Vora, M.D. And I would like to thank you for selecting me as President-Elect. We look forward to supporting our officers who are continuing in their terms: President Paloma Toledo; M.D.; AMA Delegate Jesse M. Ehrenfeld, M.D.; Residency Review Committee for Anesthesiology Representative Maggie A. Jeffries, M.D.; and “Residents’ Review” Co-Editor Michael.

Christopher R. Cook, D.O., is a CA-2 resident at Baylor College of Medicine, Houston, Texas.
S. Axley, M.D.  A huge round of applause to the outgoing officers for the lasting contribution to our Society: Immediate Past President Benjamin D. Unger, M.D.; AMA Delegate Jerome Adams, M.D.; Secretary Joshua H. Atkins, M.D.; and “Residents’ Review” Co-Editor Warren K. Eng, M.D.  We are indebted for their service both at this year’s meeting and for their terms of service to the ASARC.

Days 3, 4 and 5
Many participants took advantage of the resident-specific seminars and workshops. The Resident Practice Management Seminar was an invaluable experience allowing residents to compare both academic and private practice career paths and to better decipher the intricacies of contract negotiation. In addition we learned about anesthesia-related compliance issues with regard to Medicare. The Resident Research Forum gave our up-and-coming physician scientists a forum in which to present their studies and to compete for Foundation for Anesthesia Education and Research scholarships.

The Regional Anesthesia Workshop presented a hands-on format to learn ultrasound-guided and neurostimulator techniques for peripheral nerve blocks with the experts in this subspecialty. One of my personal favorite activities was the Resident Communication Seminar — a fantastic setting to witness and practice interviews, public speaking and non-verbal communication skills.

We completed the tour of the ASA buffet, but no banquet would be complete without dessert. By far, the desserts of the meeting were the resident social functions. After the conference days ended, the real opportunity arose to experience the Chicago nightlife, to network and to build lifetime contacts with residents from other cities.

Call for Residents to Serve on ASA Committees:
Each year ASA invites residents to serve as adjunct members on several of its committees. This is a great opportunity for a resident to learn more about how ASA operates, and it also benefits the committee by bringing a resident perspective to discussions. For a full list of committees available and more information on the committee appointment process, please visit the ASA Web site at <www.ASAhq.org/aboutASA/asaCommitteeListing.htm>.

Residents who would like to be nominated to serve on a committee should submit a curriculum vitae and letter specifying why they are interested in a specific committee to Paloma Toledo, M.D., at <paloma@alumni.duke.edu>. Deadline for submission is December 22, 2006.

As president-elect of the ASA Resident Component, I encourage you to not only come and enjoy the buffet at the ASA Annual Meeting but also to partake from the cornucopia of leadership, scholarship and service opportunities ASA has to offer.

I would like to call all future leaders of anesthesiology to check the ASARC Web site <www.ASAhq.org/asarc/index.html> for the latest calendar of events in the coming year. Be sure to view the monthly NEWSLETTER and sign up for the listserv and podcasts to receive updates on ASARC activity. Please contact me at <cc145239@bcm.tmc.edu> if I may be of service or if you have any questions.
ABA Announces ...

ABA Subspecialty Certification Examinations 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 15, 2007. 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 an Accreditation Council for Graduate Medical Education-accredited pain medicine program by August 31, 2007. They also must be certified in anesthesiology by ABA or scheduled for ABA oral examination in 2007. After January 15, 2007, applicants may use the ABA Web site <www.theABA.org> to submit their applications for a subspecialty certification examination electronically.

The standard application deadline is March 15, 2007. ABA will consider late applications received by March 31, 2007. Applications received after the late deadline will not be considered. The deadline by which diplomates must qualify to take the examination is May 15, 2007.

ABA Subspecialty Recertification Examinations 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 22 to October 6, 2007, 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 the ABA may apply to recertify in the subspecialty. After January 15, 2007, applicants may use the ABA website <www.theABA.org> to submit their application for a subspecialty recertification examination electronically.

The standard application deadline is March 15, 2007. ABA will consider late applications received by March 31, 2007. Applications received after the late deadline will not be considered. The deadline by which diplomates must qualify to take the examination is May 15, 2007.

In Memoriam

Notice has been received of the deaths of the following ASA members.

Marc Balin, M.D.
Timberlake, Ohio
October 17, 2006

Byron J. Casey, Jr., M.D.
New Orleans, Louisiana
September 25, 2006

Robert S. Turner, M.D.
Frederick, Maryland
October 3, 2006

Joan M. Baumgartner, M.D.
Seattle, Washington
October 18, 2006

Jon A. Faeth, M.D.
Bettendorf, Iowa
August 28, 2006

Vernon E. Wallace, M.D.
West Palm Beach, Florida
May 12, 2006

Roy E. Boggs, M.D.
Indianapolis, Indiana
August 26, 2006

Edward E. Lowe, M.D.
Cincinnati, Ohio
September 15, 2006

Robert F. Waldvogel, M.D.
Decatur, Illinois
September 17, 2006

C.P. Boylan, M.D.
Richmond, Virginia
May 6, 2006

Richard A. Rink, M.D.
Peoria, Arizona
July 14, 2006
Information for Authors

Preparation

Manuscripts must be submitted electronically to <communications@ASAhq.org>. The NEWSLETTER editor should be copied on the transmitting e-mail at <bacon.douglas@mayo.edu>. Brief, concise articles are preferred. Feature articles should be between 1,000 and 1,500 words; “Administrative Update,” “Subspecialty News,” “What’s New In …” and “Committee News” articles should be no more than 750 to 1,000 words.

Each author will be asked to submit a recent photograph. Clear color photographs are required. Photos should depict a head-and-shoulders portrait of the subject with sufficient uncluttered background around the head; passport photos and photos downloaded from Web sites are unacceptable.

We can accept a digital photo scan, providing the resolution is a minimum of 300 dpi. The preferred formats are: TIF or EPS. Size should be approx. 5” x 7” but no smaller than 3” x 3”. Do not crop the photo; please leave sufficient background image.

In addition, the author(s) will be asked for a brief biographical author profile, including current position/title, hospital/institution affiliation, current ASA involvements (committee memberships, committee chairs), and city and state of practice or residence. A curriculum vitae may be submitted if available.

Manuscripts

Deadline. The deadline for articles is the first of the month prior to the month of publication; e.g., the deadline for the March issue is February 1, for the April issue is March 1, etc.

Title Page. Authors may suggest a title for their articles. Titles should be brief. Include a title page with all authors’ names and their highest academic ranks and affiliation. Restrict authorship to direct participants. Also include the corresponding author’s name, address, telephone number, fax number and e-mail address (if available).

Submission Format. An electronic file of the manuscript should be provided on computer disk or by e-mail to <communications@ASAhq.org> when possible. ASA has both PC-compatible and Macintosh-compatible capabilities for most word processing programs.

Editorial Policies

Editorial Review. All articles, whether solicited or unsolicited, are subject to editorial review. All material will be reviewed by the editor, the editorial staff and/or the editorial board as needed. Articles will be edited to ensure clarity, good grammar and appropriate language, and to conform to ASA NEWSLETTER style, format and space restrictions.

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ASA procedure for reprint requests is to review all written requests based on individual merit of each request and proposed use(s) of the material. If the reprint request is deemed valid, ASA may authorize the reprint request contingent on the requester’s agreement to contact the original author(s) of the material.

ASA does not publish anonymous, nonattributable, previously published or commercially produced articles. With few exceptions, the articles contributed to the NEWSLETTER are researched and prepared by physician members or staff of the Society. Prior approval must be obtained from the Editor for nonmember-authored articles. An article submitted by an individual will carry the byline of that individual. An article prepared, reviewed and submitted by a con-

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mittee will carry the byline of the chair of that committee. A committee chair may submit an article that is not necessarily based on committee review or consensus; in that instance, the author’s designation as chair of that committee may not be included in the byline.

The views expressed in the NEWSLETTER are those of the authors and do not necessarily represent or reflect the views, policies or actions of the American Society of Anesthesiologists.

Disclosure. The NEWSLETTER expects authors to disclose voluntarily any institutional or commercial affiliations or associations that might pose a conflict of interest in connection with the submitted material. All funding sources supporting the work should be acknowledged in a footnote. Institutional or corporate affiliations of the authors that might constitute a conflict of interest should be brought to the attention of the editor.

Graphics. The NEWSLETTER requests advance notification if the submission will include graphics (e.g., tables, illustrations, photographs, charts, graphs). Do not embed graphics in the electronic manuscript; please submit as separate files or scans.

Illustrative material must be identified by its reference number in the text and must be accompanied by a short caption, legend or summary statement. Tables should be self-explanatory and should supplement, not duplicate, the text. Photographs should be color glossy prints, if possible, and should also include a suitable caption. The size of most graphics can be reduced or enlarged during production.

Abbreviations. Define all abbreviations and acronyms except those that have been approved by the International System of Units for length, mass, time, electric current, temperature, luminous intensity and amount of substance. Do not create new abbreviations for drugs, procedures or substrates.

Drug Names and Endorsements. Use generic names for all drugs, products and commercial services whenever possible. If any product or brand name(s) must be included for accuracy or clarity, notify the editor or editorial staff.

References. The ASA NEWSLETTER will print a maximum of 10 references. If more than 10 sources are cited or if space in a particular issue is limited, readers will be referred to the author for the complete list of references and references will be available on the ASA Web site. Bibliographies will be published if relevant to the article and if limited to no more than 10 citations, as space permits.

References should be numbered in the order cited in the text; reference numbers in the text should be typed as superscripts. Bibliographical entries should be listed in alphabetical order by last name of the lead author. Authors are responsible for the accuracy and completeness of all references. Authors should follow guidelines as outlined in the AMA Manual of Style (Lippincott Williams & Wilkins). Abbreviations of journal names must follow those in Index Medicus.

Example References:

**JOURNAL**
1. Author IN, Author IN. Title title title title. *J Title*. year; volume:page-page.

**JOURNAL WITH SUPPLEMENT**
1. Author IN, Author IN. Title title title title. *J Title*. year; volume (Suppl #):page-page.

**BOOK**
1. Author IN, Author IN. Editor IN, ed. *Title Title Title: Title Title Title Title*. Xth ed. Place: Publisher; year:page-page.

**BOOK CHAPTER**
**Back Pain Takes a Front Seat**

Maunak V. Rana, M.D., was quoted in a June 25 Chicago Tribune article that focused on achieving good posture and eliminating back pain.

**Restricting Participation in Execution Procedures**

2006 ASA President Orin F. Guidry, M.D., was quoted in an August 28 American Medical News article that focused on steps by the North Carolina Medical Board to restrict physician active participation in execution procedures.

**Cool Kids Have Less Postop Pain**

A September 5, 2006 Orlando Sentinel article reported on study results that children who were anxious before surgery suffered more pain after the operations. ASA member Zeev N. Kain, M.D., is quoted, noting that the results indicate that decreasing children’s anxiety before surgery will result in improved recovery and reduced pain.

**Finding Sleep Apnea Before Surgery**

Kevin J. Finkel, M.D., and Robert A. Caplan, M.D., were quoted in a September 8 Associated Press article that focused on the initiative of screening for obstructive sleep apnea prior to surgery at Barnes-Jewish Hospital in St. Louis.

**“20/20” Piece on Separation Surgery**

William B. McIlvaine, M.D., was interviewed and appeared in a September 8, “20/20” segment on the separation of conjoined twins Regina and Renata Fierros. Dr. McIlvaine was the anesthesiologist during the July separation surgery.

**Anesthesiologist’s Invention Gets Kudos**

A September 9 Bradenton Herald article focused on Leonides Y. Teves, M.D., for the invention Ned’s Expandable Trocar (NET), a surgical tool intended to create safer, simplified laparoscopic procedures. The NET is not yet in clinical trials. Dr. Teves received an honorable mention for the invention in a recent Modern Marvels Invent Now Challenge sponsored by The History Channel.

**Getting to the Bottom of Anesthetic Action**

Emery N. Brown, M.D., Ph.D., was featured in The Boston Globe on September 11 in an article about his research on how anesthesia works and its effects on the brain. Dr. Brown hopes to pinpoint the parts of the brain that need to be affected to eliminate the feeling of pain, allowing for the design of more effective anesthetic drugs.

**Taking ‘Notes’ in the O.R.**

Andrew G. Roth, M.D., and Zeev N. Kain, M.D., were quoted in September 17 Chicago Tribune articles on the positive effects and choices of music in the operating room.

**NPR Segment on Lethal Injection in CA**

Southern California National Public Radio affiliate KPCC featured an interview with Mark A. Singleton, M.D., on a September 28 “Air Talk” segment focusing on lethal injection in California.

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.
Fight Crime With Those PDRs!

Wondering what to do with that old Physicians’ Desk Reference when the new one arrives? Drop it off at your local law enforcement agency. A favorite trick of people who possess illegal drugs is to put them in a prescription bottle and claim that they are legitimate medications. The section in the front of the PDR can be used by police and other law enforcement personnel to quickly determine whether the pills in the bottle match those in the PDR.

Susan Dorsch, M.D.
Orange Park, Florida

Medicare’s Anesthesia Underpayments – It Is Time to Act

In response to Karen Bierstein’s article “Medicare Proposes More Cuts in Payments to Specialists” in the September 2006 ASA NEWSLETTER, I am saddened to hear nothing new from ASA about this very serious problem.

Medicare Payment Advisory Commission data demonstrates that the problem is now 14 years old.

I personally believe that we created the problem in 1991 by requesting the retention of actual time. By not becoming a part of the fee schedule like all other physicians, we not only immediately accepted a 29-percent reduction in the anesthesia conversion factor, but now we cannot effectively compare anesthesia work intensity to other physician services. Future revisions to the Resource-Based Relative Value Scale (RBRVS) will only make the problem much worse.

While I agree that the flawed sustainable growth rate (SGR) is a compounding issue, it should not be the advocacy priority of ASA. The American Medical Association will deal with the SGR problem because it affects all physicians.

Only ASA can fix the anesthesiology work relative value problem. It is our fight alone. Now is the time to act.

I believe that in order to develop an effective strategy, we must accept the following two facts. First, the current structure of the Relative Value Update Committee and the statutory limitation of RBRVS fiscal impacts create a zero-sum environment that will always preclude parity for anesthesia services. We have tried this approach for a decade now, and it has not worked. Second, and more importantly, ASA seems unwilling or unable to develop an effective advocacy strategy to fix this problem. This is a political problem that needs a political solution.

We can win this fight. Many, if not most, state societies have been very successful in lobbying for parity in their Medicaid programs. ASA can do the same.

We can begin by making this the ASA’s number-one advocacy issue. I believe most ASA members would agree.

Rodney L. Trytko, M.D., M.B.A.
Spokane, Washington

Private Practitioners Can Help Academic Departments

I read with interest and concern Dr. Bacon’s editorial regarding the financial plight of academic departments resulting from Medicare’s refusal to compensate faculty for supervision of more than one anesthetic procedure (October 2006).

I concur that this is a threat to all anesthesiologists, academic and private practice, and to the future of the specialty. I agree that we should contact our elected representatives to inform them of our concerns.

I would add another perspective by which private practice anesthesiologists can, in a very concrete and financial manner, assist our academic colleagues and their essential training programs.

After I retired, Ronald D. Miller, M.D., chairman of the UCSF Department of Anesthesia, was gracious enough to appoint me to his volunteer clinical teaching staff. For the
next seven years, I had one of the most exciting professional experiences of my career. Depending upon my schedule and the staffing needs of the UCSF anesthesia department, I would supervise residents four to six times per month in the O.R. setting. The department billed for and collected anesthesia fees for my services, covered all malpractice insurance and provided parking privileges.

The department paid a stipend to some other nonacademic clinical staff, so I also received a stipend. I donated my stipend back to the department chairman's discretionary fund. During those seven years, approximately $200,000 of my stipend went into that fund. The stipend was not large, certainly less than the billings for my services and hopefully also less than the actual collections for my services. The department should have netted significantly more than my stipend.

Although my contribution over those years was but a small fraction of the budget for a large department, I felt that it must have helped. If five to 10 other individuals did likewise, a greater contribution would result. I cannot but wonder what might happen if academic anesthesiology departments nationwide were to develop a program by which their ex-residents and other anesthesiologists in practice proximal to the department were able to donate professional services one or two days a month. If they did, that would significantly help these financially strapped departments.

For certain, some efforts must be made by the academic departments.

Facilitation of the credentialling of these volunteer faculty, provision for parking and, if residing a considerable distance from the department, lodging and such would need to be arranged. I think that there is a reservoir of good will that could benefit many academic departments. It remains largely untapped. The creative and problem-solving intellects of academic departments ought to be able to resolve the obstacles to establishing such a program and meet the needs of ex-residents and practitioners in their areas who are willing to participate in a volunteer teaching program.

Obviously this is not a solution preferable to the Medicare program changing its payment policy. It could be a mutually beneficial program to the academic programs and the nonacademic participants that will intellectually and professionally benefit from their close association with faculty and residents.

One need not be retired to participate in such a program. If retired, yes, volunteer more than one to two days a month, but if in practice, try to find one to two days per month to give back to those programs that gave us so much and launched our professional careers.

Clair S. Weenig, M.D.
Walnut Creek, California

Academia Starving

Thank you, Dr. Bacon, for the update and comments in your October ASA NEWSLETTER about the ongoing perils facing academic anesthesiology. Even as an anesthesiologist who does not practice in a setting with an anesthesiology teaching program, it is evident that the well-being of our specialty is dependent on the continuing vitality of our academic programs. Without ongoing, dynamic, top-flight programs and faculty providing the training for high-quality physicians, the gains in patient safety we have ushered in will, in the end, be only a distant memory of better days.

Our nation’s leaders, and, yes, the American Association of Nurse Anesthetists itself, must understand the crucial importance of strong academic anesthesiology programs. Robust academic anesthesiology programs and research benefit our patients and all of us administering anesthesia — physician anesthesiologists and nurse anesthetists alike. I am reminded of the conclusion of a chapter describing the demise of the Norse peoples in Greenland in a compelling book, Collapse, by UCLA professor Jared Diamond. Dr. Diamond observes: “The last right they obtained for themselves was the privilege of being the last to starve.”

Thanks for the opportunity to comment.

Steven R. Young, M.D.
Indianapolis, Indiana
FAER Board of Directors Holds Elections

During the 2006 ASA Annual Meeting, several changes were made to the Foundation for Anesthesia Education and Research (FAER) Board of Directors. D. David Glass, M.D., was elected chair and succeeds Joanne M. Conroy, M.D.; Denham S. Ward, M.D., Ph.D., was elected vice-chair; Ronald G. Pearl, M.D., Ph.D., was re-elected secretary; and Ms. Suzanne Anderson continues as treasurer. Board members reappointed for another term are James F. Arens, M.D., Simon Gelman, M.D., Ph.D., Glenn W. Johnson and Myer H. Rosenthal, M.D. New members appointed to the board are David L. Brown, M.D., James C. Eisenach, M.D., Jeffrey R. Kirsch, M.D., Armin Schubert, M.D., and Jeanine P. Wiener-Kronish, M.D. Charles W. Otto, M.D., ASA Vice-President for Scientific Affairs, will continue as an ex-officio member.


Recognition for FAER Board Service

FAER wishes to express its sincere appreciation to departing board members Alex S. Evers, M.D. (1997-2006); Alan W. Grogono, M.D. (1997-2006); Joanne Jene, M.D. (2000-2006); Monte Lichtiger, M.D. (2002-2006); and Ronald D. Miller, M.D. (1997-2006). Their contributions individually and collectively have been invaluable in enabling FAER to advance and achieve our mission. In their years of service, both the grant funding and FAER endowment doubled, and new programs in mentoring and medical school research fellowships were started.

August 2006 FAER Grants: Award Recipients

FAER is pleased to announce the recipients of the August 2006 research grant award cycle whose research projects will begin on January 1, 2007. The projects funded included grants that are in close alignment with the request for proposals issued by FAER research councils. The FAER Board of Directors expresses appreciation for the time and effort that the applicants, the ASA Committee on Research and the FAER Education Committee committed to this important process.

MRTG - Mentored Research Training Grant ($75,000 year one; $100,000 year two; Mentor Stipend $40,000/year)

Ian R. Carroll, M.D., Stanford University, Stanford, California: Mechanisms of Analgesic Response During I.V. Lidocaine Infusions in Neuropathic Pain Patients. Mentor: Sean Mackey, M.D., Ph.D.

R. Blaine Easley, M.D., Johns Hopkins University, Baltimore, Maryland: Molecular Mechanisms of Regional Lung Dysfunction in Ventilator-Associated Lung Injury. Mentor: Brett A. Simon, M.D., Ph.D.

Markus G. Klass, M.D., Ph.D., Emory University, Atlanta, Georgia: Stem Cells for the Treatment of Neuropathic Pain. Mentor: Marie E. Csete, M.D., Ph.D.

Jeffrey W. Sall, M.D., Ph.D., University of California, San Francisco: Volatile Anesthetic Toxicity in Hippocampal-Derived Progenitor Cells. Mentor: Philip E. Bickler, M.D., Ph.D.

James H. Williams, M.D., Ph.D., Massachusetts General Hospital, Boston, Massachusetts: Cortical-Hippocampal Interactions During Propofol Administration. Mentors: Emery N. Brown, M.D., Ph.D., and Matthew A. Wilson, Ph.D.

REG - Research in Education Grant ($50,000 year one; $50,000 year two)

Geoffrey K. Lighthall, M.D., Ph.D., Stanford University, Stanford, California: Evaluating the Impact of Educational Programs on the Management of Septic Shock Using Human Patient Simulation. Mentor: David M. Gaba, M.D.
FAER Research Councils Seek Research-Funding for Applications

The FAER Research Councils are seeking applications in several areas of board-identified interest. Applications will be reviewed and evaluated competitively with other FAER grant applications. Information regarding FAER grants and application deadlines is available at <faer.org/grants.php>.

FAER Critical Care Research Council
Through its Critical Care Research Council, FAER is seeking applications for research funding for basic, translational, patient-oriented and population-based investigations relevant to all aspects of critical care medicine. Applications in any of the FAER grant categories will be considered.

FAER Geriatrics Research Council
The FAER Geriatrics Research Council is seeking applications for research funding for studies that will identify factors that are associated with or predictive of perioperative complications in geriatric patients. Applications in any of the FAER grant categories will be considered.

FAER Pain Research Council
The FAER Pain Research Council is encouraging research funding applications in the following area(s). Applications in any of the FAER grant categories will be considered.

“Frameworks to evaluate safety, efficacy, competency and outcomes in patient populations with pain from preclinical to clinical settings.”

“Studies in the area of physician education in pain medicine.”

FAER Pediatrics Research Council
The FAER Pediatrics Research Council is seeking research funding applications to promote and encourage research in pediatric anesthesia through basic, translational, patient-oriented and population-based investigations. Studies in the biology of anesthesia in the developing organism and studies on the plasticity and programming associated with anesthesia experienced during development are especially encouraged. Applications in any of the FAER grant categories will be considered.