The PAC provides a legal channel for political contribution of ASA members to collectively support election campaigns. The committee is registered with the Federal Election Commission (FEC) and is held to the standards of the 1975 Federal Election Campaign Act. All campaign contributions are openly monitored and follow the FEC guide for corporations and labor organizations. The ASAPAC is a Separate Segregate Fund PAC, as opposed to a non-connected PAC, which enables the PAC to solicit contributions only from individual dues paying members within the ASA.

The ASAPAC provides political support for ASA’s advocacy efforts related to anesthesiology-related regulations and legislation, e.g., legislation which influences Centers for Medicare & Medicaid (CMS) reimbursement, patient safety, medical liability reform, physician supervision and pain management. In 2008, the ASAPAC was instrumental in helping House Resolution 6331 not only pass in Congress, but also override President Bush’s veto of the bill. This bill helped reverse previous legislation that had singled out anesthesia teaching programs for unfair reimbursement practices (a.k.a. “The Teaching Rule”) and blocked cuts in Medicare payments to physicians.

Since 1991, the ASAPAC has directly supported political candidates and ASAPAC members have participated in fundraising for countless political campaigns.

The political activities of ASAPAC allow anesthesiologists to participate directly and tangibly in the political process. With ASA membership support, the ASAPAC has the ability to positively influence the future of anesthesiology practice.

CHAPTER 26
The Key to Your Future: The ASA and the AMA

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This chapter outlines the overriding importance of organized medicine, such as the American Society of Anesthesiologists (ASA) and the American Medical Association (AMA), to your future.

Let’s begin at what turned out to be my earliest statement about organized medicine: “I have no interest in medical politics. I simply want to be a good doctor.” These words were in response to a question posed by my soon-to-be wife in 1974, and I sincerely meant every word.

I believe today’s students would champion a similar idealistic view such as that from Benjamin D. Unger, M.D., 2006 President of the ASA Resident Council Governing Council, “I like to consider myself of the generation of doctors whose practice is evidence-based and data driven.” His views are similar to mine but couched in the language of today’s medicine.

I soon learned, however, as you will, that being a good physician is necessary but not sufficient to fulfill our duty to protect and improve the health of our patients and to advance medical knowledge.
1. The United States spends more than any other nation on health care, some $6,300 per person annually or 15 percent of the Gross Domestic Product.2

2. Forty-five million Americans are uninsured.

3. Some sources rank the United States 37th in the world in terms of value received for money spent on health care.1

4. Voters consistently rank “affordability of health care” second only to the economy as a major concern.4

5. Levels of reimbursement are not controlled by physicians but are dominated by the federal government through the Medicare program, which determines both the manner and amount of reimbursement for physician services.

6. In the private sector, the consolidation of health plans into a few dominant payers, who frequently reimburse a percentage of Medicare’s payments for similar services (sometimes less than 100 percent), has severely limited the ability of physicians and physician groups to negotiate for non-government controlled payments.

7. The hugely flawed sustainable growth rate (SGR) formula for determining physician reimbursement under Medicare has resulted in reimbursements falling behind the government’s own estimates of the growth in practice costs by 12 percent over the last 4 years with further reductions projected to be 37 percent by 2015, a period during which practice costs are projected to rise by 22 percent. Clearly we cannot sustain these reductions.

8. The Affordable Health Care Act and its impact on patients, doctors, different health care providers and the health care industry in general.

Consider the following:

Excerpts from the CPR’s Joint Statement include the following:

1. “It is inappropriate for physician organizations to advise consumers, legislators, regulators, policy makers or payors regarding the scope of practice of licensed healthcare professionals whose practice is authorized in statutes other than medical practice acts. The erroneous assumption that physician organizations should determine what is best for other licensed healthcare professions is an outdated line of thinking that does not serve today’s patients.” (Emphasis added)
2. “With America’s population aging, we are the answer to the challenge of keeping pace with the demand for quality health care services.”

3. “Our members are not physician adjuncts, and are independently responsible for their actions, regardless of whether physicians are involved.”

You have probably heard little, perhaps nothing, in your medical school education about the issues I have briefly addressed, yet these are major, “real world” issues that ASA and AMA are attempting to address on behalf of every physician in the nation. The outcome of these issues will affect the way you practice medicine for the rest of your career.

Staying on the sidelines, “above the fray,” with others fighting the battle for you is not an honorable or acceptable option. The minimal acceptable level of participation is membership in the organizations of medicine (your local and state medical associations, the AMA, your local and state anesthesia societies and the ASA) and at least the minimum contributions to all of these organizations’ PACs (political action committees).

Let me close with the wise words of the 2006 president of the ASA, Dr. Orin F. Guidry: “We must be politically active and politically astute in medical politics as well as in governmental politics. AMA is important (really important!).”

References:
1. Unger BD. Killing two birds with one stone: ASA offers $1,000 grants for resident leadership and education. ASA Newsletter. 2006;70(1):31-32.
3. Ibid

CHAPTER 27
Pediatric Anesthesiology and The Society for Pediatric Anesthesia
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Pediatric Anesthesiology
The practice of pediatric anesthesiology is an exciting and challenging subspecialty of anesthesiology practice. Working with children requires a broad understanding of the fundamental anatomical, physiologic and pharmacologic differences between the pediatric and adult populations. The unique mix of developmental age, temperament, parental relationships, health, illness and surgical needs ensure that the practice of pediatric anesthesiology is consistently engaging.

It is not uncommon when having a routine procedure, such as tonsillectomy, that the parent is most concerned about the anesthetic. The art of pediatric anesthesiology entails the ability to communicate effectively with children and parents, and engender their trust in a limited period of time.

Since the inception of anesthesiology practice in the 1840s, anesthetic techniques have evolved and are increasingly tailored to the unique needs of children. The ability to perform increasingly complex surgical procedures is a direct result of the increased safety of pediatric anesthesiology perioperative care. Pediatric anesthesiology practice has progressed from the ability to provide three to four minutes of unconsciousness after inhaling from an ether-soaked rag to the ability to safely anesthetize a 600 gram, 24-week premature infant for a tracheoesophageal fistula repair.

Anesthesiology residency training can include exposure to general pediatrics during the intern year and pediatric anesthesiology rotations during the CA-2 and CA-3 years (though some programs offer rotations during the CA-1 year). The goal is for the resident to manage the perioperative care for children with diverse age ranges, variations on the health-illness continuum, and who require a variety of surgical procedures. The management of pediatric acute, chronic and perioperative pain is also an important aspect of pediatric anesthesia practice.

Additional training through a one-year fellowship in pediatric anesthesia is available. Pediatric fellowship presents the opportunity to develop the clinical judgement and skills to provide perioperative care for complex patients such as neonates, children with craniofacial and metabolic syndromes, and children with congenital cardiac defects. The fellowship also includes experience in the management of critically ill children in the pediatric intensive care unit, management of chronic pain, and performance of regional techniques such as peripheral nerve blocks and epidurals under general anesthesia.