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Many critical care anesthesiology teams function as a consulting service. They directly participate and coordinate patient care as part of a multidisciplinary team approach. Like other intensivists, they take a multidisciplinary approach to the individual patient and direct his or her care with the participation of the primary admitting service (surgeon). Other essential team members include respiratory therapists (RRTs), registered dietician, pharmacists Ph.D. (Pharm.D.), occupational and physical therapists, social worker, chaplain, and of course the critical care nursing staff. In academic practices, the critical care team includes a variety of residents (surgery and/or anesthesiology) as well as medical students. As a team, they manage the care of the individual patient and coordinate the surgical intensive care unit operation from infection control, quality control and improvement practices through the collection of data. This information is used to provide excellent health care as well as the conservation of limited and expensive resources. Collection and analysis of data become a vital role for the intensivist in order to improve quality of care, patient outcome and risk assessment, as well as cost reduction strategies. Further information on the field of critical care anesthesiology can be found at the Society of Critical Care Anesthesiologists (SOCCA) formerly ASCCA website (www.soccca.org).

For more information on the field of critical care medicine, please see the Society of Critical Care Medicine website (www.sccm.org).

Role of the Critical Care Anesthesiologist – Investigator

Standardized practice in the ICU setting has resulted in a marked reduction in the morbidity and mortality of critically ill patients. Initiation of conservative ventilation practices, conservative blood transfusion, and aggressive glycemic control are a few strategies that have recently demonstrated improved outcome. The intensivist frequently has the opportunity to enroll patients in clinical research trials in an effort to improve

patient outcome. Some clinicians dedicate a large amount of their time conducting clinical and/or basic science research. This practice is not specific to critical care anesthesiologists, but mentioned for those interested in becoming a clinician-investigator.

Conclusion

The field of anesthesiology is one that provides the opportunity to participate in the care of essentially all patient populations. The anesthesiologist intensivist has the opportunity to implement many of the techniques unique to anesthesiology training in order to provide exceptional care of critically ill surgical patients. Such techniques vary as follows: one patient may require transesophageal echocardiography for evaluation of hemodynamic instability while another may require regional anesthesia to alleviate pain or improve vascular compromise by creating a selective sympathectomy.

Critical care anesthesiologists can tailor their practice from critical care medicine to a combination of both critical care and anesthesiology. Medical students with an interest and aptitude for the surgical specialties, a lifelong love of learning and “cutting edge” medicine should strongly consider a career in anesthesiology as well as subspecialty training in critical care medicine.

CHAPTER 25

Political Activism and The American Society of Anesthesiologists Political Action Committee

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The American Society of Anesthesiologists Political Action Committee (ASAPAC) was formed in October 1991 by a vote of the American Society of Anesthesiologists (ASA) House of Delegates. The goal of the ASAPAC is to allow ASA membership to participate fully in the United States political process. The ASAPAC’s mission statement is: “To advance the goals of the medical specialty of anesthesiology through the bipartisan support of candidates who demonstrate commitment to patient safety and quality of care.”

Since its inception, ASAPAC has provided a unified and empowered voice to ASA and its individual members. ASA is the largest physician PAC and consistently in the top 50 of the over 3,000 association and corporate PACs. ASAPAC consistently raises over \$3 million in an election cycle.

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.



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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."¹ 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.