FSA Today

Serving 1,938 Anesthesiologists

An Official Publication of the Florida Society of Anesthesiologists Vol. 48 No. 4 Fall 2005

Presidential Pennings

Dale E. Wickstrom, D.O.

"As we enter into 2006, the FSA is 1,938 members strong, the largest number on record."

Membership Has Its Privileges

We have just concluded the annual FMA meeting at the Boca Raton Resort and Club. Seven delegates from the FSA attended. This number is based on the number of anesthesiologists who are FMA members. In addition to our delegates, many more anesthesiologists represented their county societies, which is very important because "politics is local." At the county level we have a great opportunity to inform our colleagues of the issues that are important to anesthesiologists and how certain issues can impact their specialties. Dr. Dennis Agliano transferred the gavel to Troy Tippett, M.D., who is a neurosurgeon from Pensacola. Yank Coble, M.D., president of the World Medical Association, was also in attendance. The invited guest speaker at the Good Government Luncheon was Congressman E. Clay Shaw, who has always been a valuable supporter of physicians.

The focus of this year's FMA legislative agenda will be to address the lack of regulation

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Joint Boards Address Drug Abuse

The Joint Boards Pain Management Committee met in Tallahassee on September 19 to address prescription drug abuse. Dr. Rafael Miguel attended and presented on behalf of the FSA. After some chilling presentations ("6 patients die daily [in Florida] with lethal amounts of prescription narcotic drugs in their system," J. McDonough; "10.5% of high school seniors have taken hydrocodone over 5 times for non-medical reasons in the past year," R. Pomm) and discussion, the committee approved a joint statement. The committee is recommending a call for action, including the establishment of an electronic monitoring system for prescription of controlled substances (Schedule II-IV). Bills addressing this need (SB 176 and SB 178) have already been filed for the 2006 Legislative Session. The text of these bills may be viewed at *www.flsenate.gov*. The joint boards plan to send a letter to the governor, which will be signed off by all the interested medical societies (FMA, FOMA, FSA, FAPM, etc.), requesting his support for the aforementioned bills. Due to

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of expert witnesses. This will include the development of ethical guidelines and professional responsibilities for physicians serving as expert witnesses. The FMA will also vigorously oppose legislation that expands scope of practice for non-physicians or removes a physician's right to self insure. The FMA will seek legislation to increase physician reimbursement in areas of managed care, Medicaid, Worker's Compensation and PIP. Other issues include physician supervision of nurses, hospital issues to include ability to seek injunction relief and empowerment of medical staffs, doctor of nursing degree, foreign physician licensing, patient safety and pay for performance issues, just to mention a few. As you can see, the FMA has a full plate, and we must support these efforts with our membership in order for us all to benefit.

The FMA installation ceremony, left to right: Dr. Brian Jurbala, orthopedic surgeon; Dr. Jennifer Nixon, OB/GYN; Dr. Troy Tippett, neurosurgeon and FMA president; Dr. Dennis Agliano, ENT surgeon and FMA immediate past president; Dr. Ralph Nobo, OB/GYN and past president of the Polk County Medical Association; and Dr. Dale Wickstrom, anesthesiologist, FSA president and past president of the Polk County Medical Association.

Most specialists are members of their specialty society, but we must all be members of our parent organizations, the FMA and the AMA. We depend on our specialty societies for information and support related to our specialty, but sometimes we need the support of our parent organizations to help us with issues such as scope of practice. On the surface it may seem unnecessary to be a member of the FMA and the AMA, but when we go to legislators for support on an issue, their first question is usually, "What is the FMA's or the AMA's position on this?" Therefore, it is important for all specialists to maintain membership in the FMA/AMA. For more information, go to their websites: *www.fmaonline.org* and *www.ama-assn.org*.

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FSA Membership

Anesthesiologists have always understood the importance of power in numbers. As we enter into 2006, the FSA is 1,938 members strong, the largest number on record. The majority of members fall between 35 and 54 years of age. Congratulations to you, the members of the FSA, who have made us one of the most powerful lobbying bodies in Florida and within the ASA. As our organization matures, we are learning how to use the potential influence we have within our state and the ASA.

Patient Safety

As we prepare for our busy winter season, let us be reminded that our primary goal is patient safety. We have made great strides for our patients in the area of patient safety, primarily due to vigilant monitoring. In October 2004 our ASA House of Delegates added CO2 monitoring as an option for regional and MAC cases. Use this as an opportunity to acquire more monitors in areas such as MRI, endoscopy and cath lab to improve patient safety in those areas. In Florida last year there were two deaths in MRI suites under sedation, and 38 deaths in endoscopy suites in ASCs over the past four years. Let's make a difference!

FSA President Dale Wickstrom, D.O., visits with FSA Past President Larry Gorfine, M.D., at the FMA meeting in Boca Raton.

Joint Boards Address Drug Abuse, continued from page 1

its enormous impact on public safety, the FSA will follow the progress of this issue closely and will be actively involved in law and rule development.

Dr. James Andriole, chairman of the Board of Osteopathic Medicine, served as committee chair for the September 19 meeting. The boards represented were the Boards of Medicine, Nursing, Osteopathic Medicine and Pharmacy. Each respective board chair was present (except Medicine, which was ably represented by Dr. Nabil El-Sanadi, vice-chair, BOM), and key board members and executive directors from the respective boards also attended. Also in attendance were Mr. Jim McDonough, director of the Council on Drug Policy (i.e., the "drug czar"); Dr. Ray Pomm, PRN director; Ms. Francie Plendl, chief counsel for the FMA; representatives from the Florida Osteopathic Medical Association; representatives from the Florida Association Nurse Anesthetists; representatives from law enforcement; and assistants from the state House of Representatives.

Tallahassee Report

Jon Johnson, FSA Legislative Consultant

" … the rumored special session that would focus on the legislative approval and implementation of the governor's Medicaid reform initiative may be delayed …"

Work Continues on Medicaid Reform

Efforts May Be Delayed by Hurricane Recovery

The Florida Medicaid waiver submitted by the Agency for Health Care Administration (AHCA) is in the hands of the federal government. The state of Florida has been involved with heavy discussions and negotiations with the governmental agencies in Washington, D.C., and is continuing communication to resolve one final issue, the upper payment limit for hospitals.

AHCA Secretary Alan Levine continues to stand by his commitment to maintain this mechanism to provide payment to hospitals for uncompensated care.

He also has stated that if the parties are unable to come to an agreement, then Medicaid reform will not be possible.

Due to the devastating nature of Hurricane Katrina that passed through the Gulf Coast areas of Alabama, Mississippi and Louisiana on August 29, 2005, the rumored special session that would focus on the legislative approval and implementation of the governor's Medicaid reform initiative may be delayed, since much of the government's time and resources have been diverted to the recovery efforts related to this storm.

FSA Goes to Tallahassee To Discuss Patient Safety

Rafael Miguel, M.D., FSA president-elect; Dale Wickstrom, D.O., FSA president; Governor Jeb Bush; and Kurt Markgraf, M.D., FSA 2nd vice-president, in the governor's office

Pay-4-Performance: An Update

by David G. Whalley, M.B., Ch.B.
Chief of Anesthesia, Cleveland Clinic Florida Naples

P4P: What Is It?

Pay-4-Performance is an umbrella term that describes programs initiated by a number of organizations that seek to improve healthcare by encouraging the reporting of performance data and, crucially, linking the outcome of those data to healthcare dollars. The primary player at this stage is the Centers for Medicare and Medicaid Services (CMS), which is promoting the public reporting of performance data, thus in the first instance demonstrating comparative hospital data. Hospital Compare[1] is the result of a partnership between the CMS and the Hospital Quality Alliance, which itself is an association of healthcare organizations such as the American Hospital Association, Association of American Medical Colleges and the Joint Commission on Accreditation of Healthcare Organizations.

Hospital Compare provides for the public a mechanism whereby there is overt public disclosure of compliance with "performance measures," with the ultimate goal of improving the quality of care provided by the nation's hospitals. These measures are evidence-based therapies or practices that are to be applied to just three common clinical conditions: acute myocardial infarction, heart failure and pneumonia. For example, the performance measures for AMI include aspirin and beta-blocker on arrival and discharge, ACE inhibitor for left ventricular systolic dysfunction, thrombolytic agent and PTCA within 30 minutes and 90 minutes of hospital arrival respectively, and counseling on cessation of smoking. Some of the measures are common to each of the three clinical conditions, but, importantly, the measures are "voluntarily" reported. Data are analyzed and reported on the Hospital Compare website, where hospitals are compared geographically against other hospitals in the region as well as to state and national averages.[2] Patients have access to this web-based information and are encouraged to discuss the results with their physicians in order to make informed decisions on how to get the best hospital care.

The assumption is that this public demonstration of performance will challenge hospitals to examine their practices, not only for the three clinical conditions but also for other DRGs, and that there will be some financial incentive for doing so. It is our observation that the "pay" portion of P4P has yet to materialize in any substantial way, but it is true that those hospitals not reporting will see a 0.4-percent reduction in their Medicare update for 2005 through 2007, as stipulated in the Medicare Modernization Act of 2003. Small wonder then that compliance is at the 99th percentile!

Perhaps something more financially substantial will come from the Premier Hospital Quality Incentive Demonstration. The stated aim of this initiative, which is the product of a partnership between CMS and Premier Inc. not-for-profit hospitals, is to provide financial rewards to hospitals that demonstrate high-quality performance in a number of areas of acute care. These areas include the three clinical conditions described in Hospital Compare but in addition include coronary artery bypass grafting and hip and knee replacements. Hospitals are to be scored and ranked by decile on quality measures related to each of the five conditions, such as surgical antibiotic prophylaxis, postoperative physiologic and metabolic derangement, readmission and mortality. Those in the top decile will be awarded a 2-percent bonus of their Medicare payments for the measured condition, while those in the second decile will receive a 1-percent bonus. According to the CMS, the cost of the bonuses will be about $7 million a year and will supposedly come from 1-percent and 2-percent downward adjustments of Medicare payments to hospitals scoring below the 9th and 10th decile baseline level.

What's This Got To Do With Me?

There is little immediate impact at this time from the programs just described since the clinical conditions and quality measures are not a direct function of involvement of anesthesia practice and personnel. It would, however, be shortsighted of us to write this off as being none of our concern and to leave the issue to hospitals and other specialties. Medicare reimbursement is continuously being reduced, and if the CMS wishes to link quality healthcare with payment, then it behooves us

to be proactive in bringing to its attention our own excellent safety record and those elements of our practice that are known to improve outcomes. ASA leadership and the committees on Performance and Outcomes Measurement, Economics and Practice Parameters are beginning to identify measures that are relevant to anesthesiology and pain medicine, which can be used to take advantage of payer incentives while at the same time promote the continued high quality and safety of our specialty. For those of you able to attend the annual meeting this year, much of the latest on P4P will be discussed at a panel presentation entitled "Pay for Performance or 'P4P' – Pathway 2 Quality," moderated by the Committee on Quality Management and Departmental Administration.

It is important to understand that P4P is not just the concern of the CMS; commercial payers are beginning to get in on the act. Launched in 2000, the Leapfrog Group[3] is a growing consortium of Fortune 500 companies and other large private and public healthcare purchasers that provide health benefits to more than 36 million Americans—employees, families and retirees—in all 50 states. The group's initial focus arose out of the 1999 Institute of Medicine's (IOM) report that there are more deaths in hospitals each year from preventable medical mistakes than there are from vehicle accidents, breast cancer and AIDS. The IOM's report, incidentally, gave our specialty a public relations shot in the arm by publicizing our successful efforts in addressing safety in anesthesia practice, but it also recommended that large employers provide more market reinforcement for the quality and safety of healthcare. The mission of Leapfrog is to trigger "leaps forward" in the safety, quality and affordability of healthcare by supporting informed healthcare decisions by those who use and pay for healthcare and by promoting high-value healthcare *through incentives and rewards* (emphasis added).

Leapfrog initially came up with three quality and safety practices that it considers to have the potential to save over 65,000 lives, prevent up to 900,000 medication errors and save up to $41.5 billion annually. The three practices are

1. **Computer Physician Order Entry** — use of prescribing error prevention software during computer entry of medication prescriptions;
2. **Evidence-based Hospital Referral** — referring patients to hospitals that have a good track record for a particular procedure; and
3. **ICU Physician Staffing** — staffing ICUs with board-certified intensivists.

A fourth quality and safety practice has recently been added, termed the **Leapfrog Safe Practices Score**. Leapfrog adopted the National Quality Forum's 27 Safe Practices, covering a range of practices that, if implemented, would reduce the risk of harm in certain processes, systems or environments of care.

It is in this area that we can make a substantial contribution at the local level. Many hospitals have signed on to Leapfrog—at last count there were 1,664 urban, suburban and rural hospitals across the country submitting data to the group. Leapfrog is a major player: The group firmly believes it has taken the moral high ground to reduce preventable medical mistakes and that its four quality and safety practices are endorsed by strong scientific evidence. Furthermore, the group has every intention of using its purchasing power to select those healthcare providers that conform to its definition of safe practice, which it believes will consequently improve hospital safety and quality.

Clearly the impetus for compliance with the Leapfrog initiative is commercial, but insomuch as the financial welfare of the hospitals in which we practice is our concern, our participation in the implementation and monitoring of the identified safe practices is something that is well within our capabilities and areas of expertise. For example, Safe Practice #15 deals with the prophylactic treatment with beta-blockers of elective surgical patients at high-risk for an acute ischemic cardiac event. It would be very easy and politically astute for anesthesia personnel to take the leadership in developing this practice guideline and to monitor its compliance.

Conclusion

Pay-for-Performance is very much a part of the current healthcare landscape. Both the CMS and commercial payers through their purchasers are seeking to link quality of healthcare with reimbursement. As yet the specialty of anesthesia has not been challenged by this concept, but now is the time for us to be proactive and describe measures that can define those elements of our practice that will demonstrably improve the healthcare we deliver to our patients. The secondary outcome of this initiative is the financial benefit that will accrue to the specialty.

References and Source Material

1. *www.cms.hhs.gov/quality/hospital*

2. *www.hospitalcompare.hhs.gov*

3. *www.leapfroggroup.org*

Minutes of the Meeting

Florida Society of Anesthesiologists

Board of Directors Meeting
September 3, 2005
The Boca Raton Resort & Club

Directors Present:

Thomas Andrews, M.D.
Charles J. Chase, M.D.
Jay H. Epstein, M.D.
Eugene Fu, M.D.
Fred A. Furgang, M.D.
Richard L. Henry, M.D.
James J. Jacque, M.D.
A. Joseph Layon, M.D.
Michael C. Lewis, M.D.
David C. Mackey, M.D.
Kurt W. Markgraf, M.D.
Rafael V. Miguel, M.D.
Gary M. Richman, M.D.
Don E. Sokolik, M.D.
David Varlotta, M.D.
Hector Vila, Jr., M.D.
Rebecca H. Welch, M.D.
David Whalley, M.D.
Dale E. Wickstrom, D.O.

Guests Present:

Leif Dahleen, M.D., University of Florida Resident Representative

Ramiro Gumcio, M.D., University of Miami Resident Representative

Rep. Ed Homan, M.D., Florida House of Representatives

Staff Present:

Susan Cabrera, Executive Director

Kari Glisson, Deputy Executive Director

Jerome Hoffman, Legal Counsel

Al Rothstein, Media Relations Consultant

I. Call to Order

President Dale Wickstrom determined a quorum was present and called the meeting to order at 1:12 p.m.

II. Introduction of Guests

Rep. Ed Homan, M.D., an orthopedic surgeon from Tampa and a representative of the Florida House of Representatives, introduced himself and explained that he was present to encourage the FSA board of directors to continue to be active in the political activities and campaigns in the state of Florida. A brief question and answer session ensued.

III. Call for Additional Agenda Items/Approval of Agenda

It was noted that the location of the 2008 FSA annual meeting would need to be discussed and the issue was added to the action agenda. The annual Florida reception at the ASA annual meeting was also added to the action agenda. The action agenda was subsequently approved.

IV. Consent Agenda

A motion was made to accept the minutes of the June 26, 2005, board of directors meeting. The motion was **seconded and approved**. A motion was made to accept the remaining consent agenda items. The motion was **seconded and approved**.

V. Action Agenda

The agenda items were addressed out of the original order in the interest of time and organization.

A. Critical Care Committee Report: Dr. Layon requested that the board allow him to present the Critical Care committee report and presentation. Dr. Layon discussed the committee's work on continuing education sessions and FSA speakers at other association meetings, e.g., FLASPAN. Discussion ensued. Dr. Layon asked the board members if they would prefer the presentation(s) to be reviewed during the meeting or to have the presentation(s) posted to the FSA website for the board's review as desired. It was determined that the board would like the presentation(s) posted to the website under the password protected section for review. Mr. Rothstein spoke on the development of the presentations. There are three-to-four presentations in development, and each are approximately 15-to-30 minutes in length. The presentation can be edited and customized for a speaker's audience. More discussion ensued.

B. Acceptance of August 2005 Financial Reports: Dr. Sokolik, secretary/treasurer, reported that the FSA is running under budget and

Applicants Approved

ACTIVE

Adriana L. Anderson, M.D.
Tampa

Lloy E. Anderson, M.D.
Ft. Lauderdale

Aharon Avramovich, M.D.
Miami

Richard E. Berlin, M.D.
Sunrise

Georges Desjardins, M.D.
Boca Raton

Jeffrey Alan Kidd, M.D.
Oviedo

Ahmad H. Lateef, M.B., B.S.
Hernando

Amir Littman, M.D.
Coral Springs

Michelle D. MacBeth, M.D.
St. Augustine

Marisol Perales, M.D.
Weston

Sarah Hallman Phelps, M.D.
Bradenton

William D. Sefton, M.D.
Maitland

Jonathan H. Slonin, M.D.
Sunrise

Matthew S. Stevenson, M.D.
Jacksonville

Antal Takacs, M.D.
Jacksonville

Guy E Tanner, M.D.
Crystal River

James Thoene, M.D.
Ft. Myers

Birgit Vogl, M.D.
Miami

Adam Wendling, M.D.
Gainesville

AFFILIATE

Otto R. Albuschat, M.D.
Gainesville

RESIDENT

Daylie Diaz, M.D.
Tampa

Jonathan D. Dreier, M.D.
Tampa

Gary O. Gomez, M.D.
Tampa

Yeneisy Gonzalez, M.D.
Tampa

is financially healthy. Dr. Lewis reported that there was a profit of approximately $15,000 from the 2005 annual meeting, and there were no complaints received on the new guest fees for family members at the meeting. A motion was made to accept the financial reports. The motion was **seconded and approved.**

C. **ASA Nomenclature Resolution:** Dr. Mackey reported on the resolution. The resolution verbiage must be ready when it goes before the ASA Reference Committee in October.

D. **FAER Donation:** The amount of the requested increase was reviewed ($5.00 per active FSA member). A motion was made to accept the increase. The motion was **seconded and approved.**

E. **Committee Reports Requiring Board Action**

1. **Electronic Media Committee**: Dr. Epstein addressed the board on the current status of the redesign of the FSA website (*www.fsahq.org*). Dr. Epstein has asked for input and material from the board and will be asking the same of the FSA membership. The website structure is up, and the report in the agenda packet outlines the site map. Certain areas will be password protected for members only and board members only. He will address an email account via the website for each member, and the website will have increasing levels of security. There will be a "Links" section or a page with links to allied societies. There has been a good start on content (bylaws, minutes, etc.).

F. **2008 Annual Meeting Location** (added late to

See Minutes, page 11

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agenda): The choices presented for the site of the 2008 annual meeting are The Breakers or the Boca Raton Resort & Club. Ms. Cabrera discussed the Boca Raton proposal and her opinion of the property. Discussion ensued on the various pros and cons of each location. A motion was made to continue the annual meeting at The Breakers for 2008. The motion was **seconded and approved.**

G. **Discussion of Propofol Administration by Non-anesthesiologists**: Dr. Miguel, president-elect, presented to the board a recommendation of the Executive Committee. The Executive Committee recommended that the FSA submit a letter to the ASA stating that the FSA opposes re-labeling of the propofol package insert and that FSA believes propofol is a general anesthetic and can never be administered safely by someone not trained in airway management. It was suggested by the board that the letter to the ASA be signed by the FSA president. It was also determined that the letter should include the declaratory statement by the Florida Board of Nursing that states RNs cannot administer propofol, and the FSA should send a copy of the letter to the Food & Drug Administration. A motion was made to accept the Executive Committee's recommendation along with the above stated additions. The motion was **seconded and approved.**

H. **Florida Reception at the 2005 ASA Annual Meeting:** It was reiterated that the ASA 2005 annual meeting has been moved from New Orleans to Atlanta during the same dates in October. Some events and activities have been rescheduled, and others have been cancelled. The Executive Committee recommended to the board that in light of the recent catastrophe caused by Hurricane Katrina in New Orleans, and the cancellation of all ASA social activities, that the FSA and co-sponsors (UF, UM and USF) make a donation of $10,000, equally divided among the four co-sponsoring organizations, to assist in the recovery efforts for Hurricane Katrina to a charity to be determined pending further research. A motion was made to accept the Executive Committee's recommendation. The motion was **seconded and approved.**

VI. Deliberation

A. **ASA Contested Elections:** The candidates for the positions of ASA assistant secretary and ASA 1st vice president were discussed. The board voiced the concern for more organization and unity in the Florida Delegation to the ASA. Discussion ensued.

B. **Critical Care Committee Report**: Moved to action agenda; already discussed.

The meeting was adjourned at 2:57 p.m.
Respectfully submitted,
Kari Glisson
Deputy Executive Director

Education Committee Report

At the 2005 FSA annual meeting in Palm Beach, there was a total of 116 full registration attendees and 54 sponsors/exhibitors. The total income was $115,938. Total expenses were $99,018.74, resulting in a net profit of $16,919.26. Special thanks go to Susan Cabrera, Kari Glisson and Dr. Mike Lewis for their efforts in making the meeting a success. We are scheduled to continue having the annual meeting at The Breakers through 2007. For the upcoming 2006 meeting, we will continue with the format of having concurrent sessions on Saturday morning. The three forums include the OR Forum, Critical Care Forum and Pain/Regional Anesthesia Forum. For the residents, we will continue to have the Resident Jeopardy contest, and plans are underway to have a board prep review session. In the meantime, the Education Committee is seeking help from board and society members to thank past vendors for their support and to solicit more vendors to provide sponsorship for the 2006 meeting.

Society News

Florida ASA Director's Report

by David C. Mackey, M.D.

The ASA continues to be confronted with a number of issues that threaten our ability to deliver the level of care our patients deserve and that promise to impact the future vitality of our specialty. Here are several I believe deserve the continuous attention of every anesthesiologist:

CMS Reimbursement for Anesthesia Services

As practicing anesthesiologists know all too well, the implementation of the Medicare fee schedule in 1992 instantly sliced Medicare/Medicaid reimbursement for anesthesia services by 50 percent. Suddenly anesthesiologists were being reimbursed by Medicare at a rate of approximately 37 percent of that of commercial payers, while other specialties were (and continue to be) reimbursed at an average rate of approximately80 percent of that of commercial payers. Naturally, this has had a devastating effect upon anesthesia practices in states such as Florida that have large Medicare and Medicaid populations. At this time, over 60 percent of Florida hospitals are subsidizing their anesthesia groups to ensure their survival, a state of affairs that does not bode well for us. The ASA has repeatedly approached the American Medical Association's Resource Utilization Committee (RUC) with thorough studies documenting the need to increase the CMS anesthesia work value, but it has met with zero success, principally because Medicare Part B reimbursement is a zero-sum game: Any increase paid by the CMS for anesthesia services has to come out of the pockets of the other specialties. Naturally, our colleagues in other specialties have little enthusiasm for this.

The most fascinating aspect of the CMS anesthesia services reimbursement issue is that no one in the ASA, either physician or staff, can tell us precisely how the CMS arrived at such a grossly inappropriate value for anesthesia services when it published the Medicare fee schedule in 1992. For such a devastating event, this amazes me! What was the CMS (HCFA in those days) thinking? And, more importantly, what were *we* thinking? Why didn't we mount a more forceful response at that time? Moreover, since we have not succeeded in fixing this critical problem through the normal pathway, i.e., appealing the grossly undervalued anesthesia work value to the AMA RUC, why don't we take a more aggressive approach? Are legal remedies available? Should all anesthesiologists opt out of Medicare—a payment system with more and more strings attached, legal landmines and promises to pay less and less?

Pay for Performance (P4P)

This program from the CMS has the goal of increasing the quality of medical care by rewarding physicians with above-average outcomes, while penalizing those whose results fall below the norm. If you believe that is what is going to happen, I have some prime Key Biscayne waterfront property to sell you. No one can argue it isn't a laudable goal, but as with all ambitious projects of this nature, the devil is in the details. Note that it will require accurate data gathering and accurate assessments as to clinical practice efficiency and quality—tasks the feds are not exactly known to excel in. And please note that there is no increase in the pot of money involved here. Those physicians who can somehow "prove" that their outcomes are better may receive higher Medicare reimbursement, but those who cannot will receive less. And it is likely this arrangement will encourage physicians to fight among themselves over exactly who will get how much. Arguably, P4P will in reality be just another step in the continuum of progressively lower Medicare reimbursement with even more bureaucratic requirements.

Propofol Redux

As you know, the Food and Drug Administration currently requires propofol labels to state

that this medication should be "administered only by persons trained in the administration of general anesthesia and not involved in the conduct of the surgical/diagnostic procedure." On June 28 of this year the American College of Gastroenterology (ACG) filed a petition with the FDA to broaden the restrictions on who is allowed to administer propofol. This proposed label change would allow gastroenterologists and other non-anesthesiologist physicians, or nurses under their supervision, to administer this anesthetic drug themselves. A good summary of the issue, along with a hotlink allowing you to provide your comments on this issue to Congress, can be found on the website of the organization Anesthesiologists for the Safe Administration of Propofol (ASAP): *http://safepropofol.org/*.

Both the ASA and the FSA are actively opposing this ill-advised initiative by the ACG. As an anesthesiologist with patient safety in mind, please visit the ASAP website and provide your expert comments on the proposed propofol label change at your earliest convenience.

The ThoughtBridge Project

For nearly 18 months now the ASA leadership has been meeting regularly with the leadership of the American Association of Nurse Anesthetists (AANA) in an attempt to resolve many of the contentious issues separating these two organizations, with the ThoughtBridge organization serving as moderator. Not surprisingly, at least to me, not a single critical issue of conflict between these two organizations has found resolution through this process. By the end of this year the ASA will have spent over $200,000, plus countless hours of our leadership's time. What will we have of value to show for this expenditure of scarce resources?

CMS Anesthesiology Teaching Rule

In 1996 HCFA (now CMS) changed remuneration for anesthesia services involving anesthesiology residents, essentially cutting reimbursement in such cases by a full 50%—and this is in addition to the above-noted 50% decrease our entire specialty suffered in 1992. As one would readily surmise, this has had a devastating effect upon the financial well-being of anesthesiology teaching programs, a situation worsened by the fact that these programs were already typically saddled with very low-reimbursement payer mixes. Obviously, the health of anesthesiology residency programs is essential for the long-term viability of our specialty, and accordingly the ASA has been vigorously pursuing a remedy with the CMS concerning this issue. The AANA must also have grasped the long-term implications of this CMS teaching rule reimbursement cut, since the AANA PAC is now encouraging anesthesia nurses to contact the CMS *in opposition* to a fix of this problem. This action by the AANA PAC has provoked a sharp, and most appropriate, written rebuke by the ASA leadership to the AANA leadership. More and more anesthesiologists are asking if it is in our best interest to persist with the anesthesia nursing extender model, whose lobby seemingly never fails to seize the opportunity to oppose the interests of our specialty.

The Future of Anesthesiology

The ASA has established a Task Force on New Anesthesia Practice Paradigms, chaired by Ron Miller,

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The Information You Need

FSA

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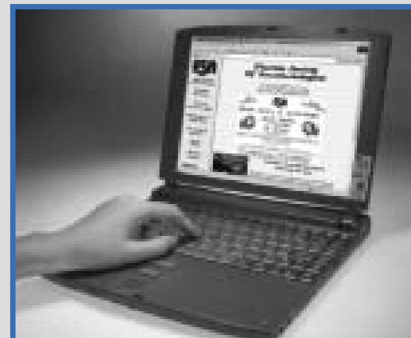

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and at the August ASA board of directors meeting Dr. Miller presented the task force's initial observations and conclusions concerning what the next decade will likely hold for us. The overall prediction is that hospitals will continue the current trend of becoming primarily operating rooms and intensive care units, with post-anesthesia care units expanding their function as "mini-ICUs." Most inpatients will be procedural patients, but with higher acuity. Reimbursement for traditional operating room anesthesia will continue to decline, and OR practice will become a small niche in the overall picture with much lower levels of compensation. Overseas outsourcing of surgical procedures may become common. (Kaiser Permanente is investigating the possibility of sending its CABG patients to India for their operations, where the cost is $12,000 per patient as compared to $60,000 per patient in California, with outcomes reportedly similar.) The greatest opportunity for our specialty's growth will come from participation in organizational systems and outcomes—i.e., clinical pathways and best practices—in integrated healthcare delivery systems.

With the above transformation of the hospital as we currently know it, what type of physician will staff the ICU and PACU, perform preoperative evaluations and deliver postoperative care? The consensus is that anesthesiologists are currently the best-prepared to function in these capacities, but that our specialty probably will not step up to the plate and deliver. But if we don't evolve to a practice primarily outside of the operating room, who will take over these areas of practice? Enter the hospitalists. This new specialty already proclaims that its members are the best-equipped physicians to provide preoperative and postoperative care. Ten years ago there were almost no hospitalists. Now there are 10,000 of these physicians, with this total predicted to rise to 30,000 by 2010. If anesthesiology intends to remain a principal specialty in the United States, it needs to begin expanding its emphasis outside of the operating room. The future of operating room anesthesia, as painted by Dr. Miller's task force, is grim indeed, with reimbursement for OR anesthesia portrayed as a bubble that will certainly burst. All of us need to pay attention to the final report of the ASA Task Force on New Anesthesia Practice Paradigms when it is released later this year.

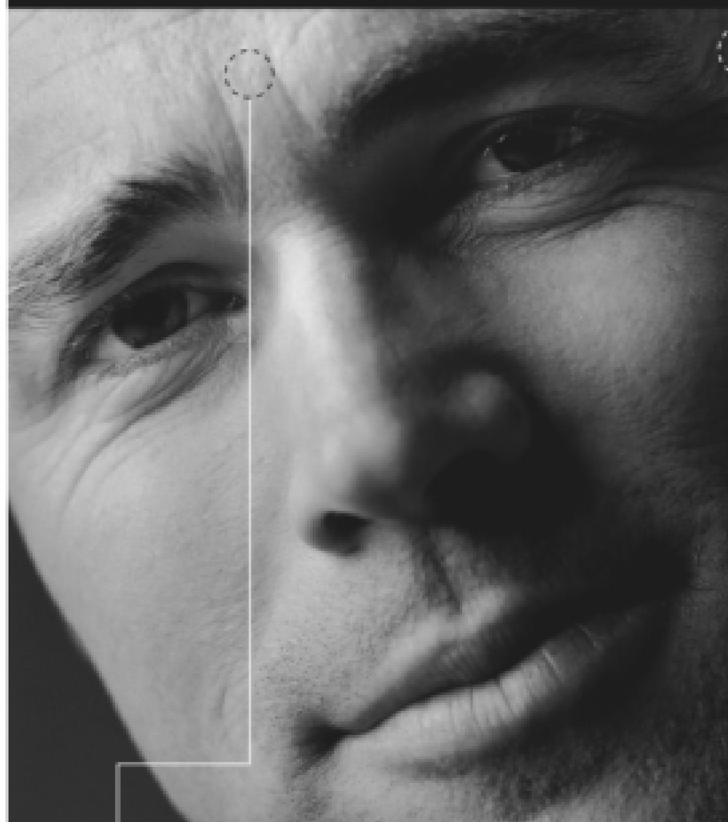
Support Anesthesiologist Assistants!

As I have stated many times, I am very supportive of the anesthesia care team and of anesthesia nurses. I have always practiced in the anesthesia care team mode and expect to always do so in the future. However, the anesthesia nurse lobby is another issue altogether. With its consistent interference in physician affairs—extender scope of practice, AA licensure and the Medicare anesthesiology teaching rule, for example—our specialty really has no larger thorn in its side. With this issue in the forefront, I am astonished to hear that several large anesthesiology practices in Florida have reportedly bowed to ultimatums from their anesthesia nurses and decided as a policy to not hire AAs. If this is true, it is a shortsighted decision contrary to the best interests of our specialty.

The Big Picture

I can think of no specialty I would rather practice than anesthesiology, and I regard tomorrow as an opportunity, not a threat. All of us should realize that to a great extent our future will be determined by the level of political involvement of practicing anesthesiologists. And the longer you have until retirement, the more seriously you must take this challenge. Investigate ways in which your group can expand its services beyond the operating room. Make sure your colleagues all belong to the FSA and the ASA and that everyone gives to the FSA and the ASA PACs. Support the AA movement by hiring AAs and pushing for more AA school startups. Be willing to make phone calls and send letters and emails to politicians and governmental officials in support of your specialty's interests. There is little doubt that the future of our specialty is vulnerable, but we can end up stronger than ever if we all work together. Keep issues such as those I have outlined above in mind, develop a strategic vision for anesthesiology, and engage!

PEACE OF MIND FOR A COUPLE PIECES OF YOUR MIND.



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2005 Calendar of Events

October 21-26, 2005
ASA Annual Meeting
Atlanta, GA

December 10, 2005
FSA Board of Directors Meeting
(10 a.m. - 2 p.m.)
Hyatt Orlando Airport
Orlando

(**Please note:** The October 23, 2005, FSA Reception in New Orleans was cancelled due to the effects of Hurricane Katrina. The ASA annual meeting has moved to Atlanta, Ga., but the dates have not changed.)

Florida CME Events
The American Society of Anesthesiologists sponsors CME courses throughout Florida. For a complete listing of ASA educational opportunities, visit *http://events.asahq.org*.