AUA
Association of University Anesthesiologists
Update
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# Anesthesiologist Assistants *in the* United States

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To help address workforce needs, as well as address the increasingly complex and technologic practice of anesthesia, the health professions specialty *anesthesiologist assistant* (AA) was created in 1969. Education of AAs was initiated at two medical schools, Emory University in Atlanta, Georgia, and Case Western Reserve University in Cleveland, Ohio. The original programs and all new programs are accredited by the Commission on Accreditation of Allied Health Education Programs.

Didactic coverage in the educational programs includes both basic science courses and applied anesthesiology courses. For example, at Emory, students take 165 hours of anatomy, physiology and pharmacology taught by basic science faculty in the school of medicine. Anesthesiology courses (495 hours) include airways, medical physics, anesthesia systems, monitoring and instrumentation, applied pharmacology, clinical methods and anesthesiology practice, a systems-based course covering pathophysiology, and principles of anesthetic management.

Clinical training is a critical part of AA education. At Emory, students begin clinical rotations in their second week of the program, spending half days at affiliated clinical sites throughout Atlanta. In the second (senior) year, students rotate in one-month blocks at affiliated clinical sites throughout the United States. For every student, senior clinical rotations include cardiac, obstetrics and pediatrics. The senior clinical rotations are not only educational for the students but also offer clinical departments the opportunity to learn about AA practice and to interact with students who may be looking for employment opportunities. Clinical time for Emory students totals approximately 2,500 hours, which is similar to other AA educational programs.

Graduates of AA educational programs are awarded master's degrees and are eligible to take the Certifying Examination for Anesthesiologist Assistants, which

*Continued on page 3*

> ***"The AA model, which has proven extraordinarily successful during the past 30 years, offers a unique means to create mid-level practitioners that work with anesthesiologists in the anesthesia care team mode and do so without depleting the ranks of nursing, which also is suffering a severe national shortage."***

# Update on the Teaching Rule

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With the 2006 congressional session rapidly drawing to a close, the involvement of every academic anesthesiologist is more urgently needed than ever to help save anesthesiology teaching programs. The American Society of Anesthesiologists (ASA) is waging an aggressive grassroots campaign to seek more supporters for H.R. 5246, H.R. 5348 and S. 2990, legislation that would restore full funding to our programs.

As academic anesthesiologists know all too well, since 1994 the Centers for Medicare & Medicaid Services (CMS) has halved payments to programs when attendings work with residents on overlapping cases. H.R. 5246, H.R. 5348 and S. 2990 would require CMS to pay 100 percent for each case — as it did prior to 1994 and as it currently does for all other teaching physicians.

Unless Congress fixes this payment problem, anesthesiology teaching programs will continue to lose vital funding. These dollars could be well-spent on innovative research initiatives and top-notch faculty. Ultimately the funding would sustain the overall viability of academic programs and ensure opportunities for young physicians to pursue the medical specialty of anesthesiology.

Every academic anesthesiologist is strongly encouraged to contact the Representative and Senators who represent their program if they are not already a supporter of H.R. 5246, H.R. 5348 or S. 2990. They should also get in touch with members from their state who serve on the House committees on Energy and Commerce and Ways and Means, and the Senate Finance Committee, which have jurisdiction over the legislation.

During the August congressional recess, most members of Congress will spend a considerable amount of time in their home district or state. This break provides a prime opportunity for academic anesthesiologists to arrange valuable face-to-face meetings with their legislators. The Capitol Switchboard at (202) 225-3121 can be used to connect with legislative staff and to schedule meetings.

After contacting legislators or scheduling meetings in local congressional offices, it is crucial to share any information with ASA Washington Office staff by e-mailing <mail@asawash.org>. This feedback will be used in follow-up meetings on the Hill as well as strategic communication with key legislators and aides.

Over the last six months, ASA members, staff and officers have engaged congressional leaders and CMS personnel on new approaches to fix the 50-percent payment penalty for teaching anesthesiologists. To continue furthering these efforts, every academic anesthesiologist must take action.

To date, these efforts have met success. Because of the diligent efforts of anesthesiologists throughout the country, more than 100 members of Congress have cosponsored the Teaching Rule legislation. This is a noteworthy accomplishment, and physicians are to be commended for their involvement in this endeavor.

A victory for anesthesiology is within reach if the academic community unites in the final stretch of our effort. It is vital to secure more cosponsors and advance the legislation before Congress adjourns this year.

Questions can be addressed to <mail@asawash.org> or call (202) 289-2222.

**What YOU Can Do to Save Anesthesiology Teaching Programs:**

- ✓ **Call your Representative and Senators to ask them to cosponsor H.R. 5246, H.R. 5348 or S. 2990. Use the Capitol Switchboard, (202) 225-3121.**
- ✓ **Schedule a meeting with your Representative or Senator in his or her local office.**
- ✓ **Provide ASA with any feedback you receive from conversations or meetings with staff or legislators.**

# Anesthesiologist Assistants in the United States

*Continued from page 1*

is offered annually by the National Commission for Certification of Anesthesiologist Assistants and the National Board of Medical Examiners. Upon successful completion of the certifying examination, the "AA-C" is eligible to file for a Centers for Medicare & Medicaid Services billing number and to obtain credentialing by state medical boards, hospitals and practice groups.

Today, AAs are participating in the anesthesia care team mode of practice in 27 states and Washington, D.C., either under regulations established by medical boards or under delegatory authority. The preferred mode of practice is licensure through regulations, which currently exists in Alabama, Florida, Georgia, Kentucky, Missouri, New Mexico, Ohio, South Carolina, Texas, Vermont and Washington, D.C.

*…[A]nesthesiologists and organizations within the specialty should utilize available resources to start new AA educational programs in as many states as possible …*

With the startup of two new AA educational programs (Nova Southeastern University, Fort Lauderdale, Florida, and South University, Savannah, Georgia), more than 100 AAs should be entering practice each year as of 2008. This is, however, only a fraction of the number needed to address the current severe shortage of mid-level anesthesia providers in the United States. Our specialty is at a critical point in developing methods to deliver anesthesia care. The AA model, which has proven extraordinarily successful during the past 30 years, offers a unique means to create mid-level practitioners who work with anesthesiologists in the anesthesia care team mode and do so without depleting the ranks of nursing, which also is suffering a severe national shortage (see box at right).

To this end, anesthesiologists and organizations within the specialty should utilize available resources to start new AA educational programs in as many states as possible and to help develop appropriate regulations for AA licensure in those states that do not have them. The American Society of Anesthesiologists Committee on Anesthesiologist Assistant Education and Practice is one such resource. Another is Emory's anesthesiology program, which not only has provided assistance to groups in the United States but also has helped the National Health Service of Great Britain and the Royal College of Anaesthetists as they developed their mid-level anesthesia practitioner. Emory will begin offering a formal course on educational program development for anesthesiologists, AAs and administrators beginning in early 2007.

# 'U.S. Plan to Lure Nurses May Hurt Poor Nations'

**From the May 24, 2006 *New York Times***

Some excerpts:

- "As the United States runs short of nurses, senators are looking abroad. A little-noticed provision in their immigration bill would throw open the gate to nurses and, some fear, drain them from the world's developing countries."

- "The exodus of nurses from poor to rich countries has strained health systems in the developing world, which are already facing severe shortages of their own."

- "The nurse proposal has strong backing from the American Hospital Association, which reported in April that American hospitals had 118,000 vacancies for registered nurses."

- "The American Nurses Association, a professional trade association that represents 155,000 registered nurses, opposes the measure."

See full text at:

**<www.nytimes.com/2006/05/24/world/americas/24nurses.html>**

# EAB Report: Other Issues of Education

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All 8,000 training programs in the United States are undergoing numerous transformations. The Accreditation Council for Graduate Medical Education is asking us to develop core competencies, improve resident performance assessments, pay attention to duty hours and work environment, and annually update goals and objectives. Programs in anesthesiology are not exempt from these important changes. In addition the Residency Review Committee for Anesthesiology is asking us to review rotations in order to better prepare our residents for the future marketplace and interact at a higher level with physicians in other specialties. There is much work ahead of us in these areas.

As we attempt to adapt to these changes, we also should consider and prepare for other equally important issues that will require management decisions. One of these issues concerns admission criteria for our residency programs. The second issue involves downward pressures on the financial support for graduate medical education (GME).

## Aggressive Marketing Needed

We are currently receiving applications from outstanding medical students and equally superb non-Match applicants who have changed their minds about their original specialty. As we ride this crest, we should decide how our programs would respond if the academic standing of our applicants lessened, if the number of applications decreased or if both situations simultaneously occurred, as they did in the 1990s. We would do ourselves a favor by finding and aggressively marketing this specialty to the top 20 percent of medical students in each of our schools and attracting them to our specialty. We should establish admission criteria that allow only the best candidates to enter anesthesiology. If we notice that the number of outstanding applicants is decreasing, let us challenge ourselves not to lower admission criteria.

## Paying for Training Costs

Another issue looming over our programs is our threatened ability to pay the costs of training residents. GME costs related to resident stipends and benefits are funded courtesy of Medicare, and revenue streams to hospitals are based on direct and indirect payments. Hospitals receive the sum of the direct and indirect payments. Direct GME payments link to the percentage of Medicare beds per hospital multiplied by a base amount. If the percentage of Medicare beds is very low, as it is in some of our city and county hospitals, then the amount of the direct payment is correspondingly very low, and the hospital cannot fully fund our residents. Recognizing that costs of running teaching hospitals are higher than costs for nonteaching hospitals, Medicare additionally pays indirect expenses to teaching hospitals. Indirect payments are influenced by the intern-resident-to-bed ratio. It is actually the indirect amount that provides many hospitals with a positive revenue stream that pays for our residents. Medicare constantly attempts to reduce the indirect amount, leaving some hospitals with a deficit that they must reconcile with funds from operating revenues. Inner-city hospitals therefore tend to pay residents on dollar calculations rather than full-time equivalent calculations. How long can these hospitals continue to support resident stipends?

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Consider departmental costs. Recruiting, direct payments for visiting professors, local educational workshops and other special events held for resident education, travel expenses and educational allowances comprise a portion of direct costs to the department. Factor in indirect costs as well. Indirect faculty costs are determined by performing a time study that allocates faculty time spent in GME endeavors. Multiply this allocated percentage by faculty salaries and benefits to determine faculty costs. Administrative costs are an important part of indirect total costs and include an allocation for the chair and members of the chair's office. The difficult part of using activity-based costing is determining how much university overhead should be applied to residency education. A potential driver is the same percentage of faculty time used to determine faculty indirect costs. Add all these numbers, and you will be astounded at the total costs.

## Prepare for 'Plan B'

In this day of budget neutrality at the Centers for Medicare & Medicaid Services, higher numbers of Medicaid and self-pay patients, constant Medicaid adjustments, thin hospital margins and reduced indirect medical education payments, we can count neither on federal sources nor on the hospitals to totally fund GME in the future. Training programs are already negotiating with hospitals to support faculty salaries and other costs, placing additional pressures on academic hospitals. Our professional practices cannot carry the load. Schools of medicine philosophically support GME, but if other sources of funding are not available, they could not provide funding above current levels.

There is no clear answer to the potential for dwindling GME funding. The management decision is to find sources to fund as much departmental cost as possible. What is your "plan B" should hospitals not be able to continue their current levels of funding?

# ASCCA: A Crucial Subspecialty at a Critical Time

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The American Society of Critical Care Anesthesiologists (ASCCA) was founded in 1986 and is a subspecialty organization of the American Society of Anesthesiologists (ASA). ASCCA is the only professional organization devoted exclusively to critical care medicine as practiced by anesthesiologists. The organization is dedicated to the education of all anesthesiologists in the care of the critically ill patient. Although most ASCCA members are practicing intensivists, the practice of many anesthesiologists incorporates many aspects of critical care. ASCCA welcomes the membership of these individuals as well.

The major educational forum of ASCCA is its Annual Meeting, which is held on the Friday before the ASA Annual Meeting. The meeting has changed in several respects this year. For the first time, we have an educational panel sponsored jointly by ASCCA and the Society of Cardiovascular Anesthesiologists (SCA). Second, with the exception of the Young Investigator Award, there will be no oral abstract presentations. All abstracts will be presented in a facilitated poster session in the body of the meeting (rather than at the end of the meeting) to promote exchanges among the audience and poster presenters. Third, we have more lectures that are of shorter duration and more focused than in the past. Finally, in an attempt to promote critical care to anesthesiology residents, Michael F. O'Connor, M.D., of the University of Chicago, and I have written every anesthesiology chair and program director in the country to encourage the sponsorship of one CA-2 resident to attend the meeting. We have had a gratifying response to our requests. Indeed some programs are sending more than one resident.

More than a decade ago, the Society published the "Resident's Guide to the Intensive Care Unit." The guide has been very popular among anesthesiology residents and has gone through several revisions. Editor Daniel S. Talmor, M.D., Beth Israel Deaconess Medical Center, Associate Editor Larry J. Caruso, M.D., University of Florida, and Associate Editor Steven J. Hata, M.D., University of Iowa, are in the process of revising the guide and hope to have it available by the end of this calendar year.

*Stephen O. Heard, M.D.*

In the past decade, results of clinical research have revolutionized many aspects of the practice of critical care medicine. Many ASCCA members were involved in these clinical trials. ASCCA is committed to supporting critical care research by anesthesiologists. In the past, we have partnered with the Foundation for Anesthesia Education and Research and Abbott Laboratories to provide a yearly grant to support young anesthesiologists in the research of issues of importance to the care of critically ill patients. Pratik Pandharipande, M.D., Vanderbilt University School of Medicine, is the current recipient of this research award. His grant is titled "A randomized, double blind trial in ventilated ICU patients comparing treatment with an a2 agonist versus a gamma aminobutyric acid (GABA)-agonist to determine delirium rates, efficacy of sedation and analgesia and clinical outcomes including duration of mechanical ventilation and 3-month cognitive status." Delirium is a common problem of patients in the intensive care unit (ICU), and it has been recently shown to be an independent risk factor for death in the ICU. Dr. Pandharipande's research protocol is particularly timely. Abbott Laboratories is continuing its commitment to anesthesia critical care research with its support of these grants via Hospira (the global hospital products business of Abbott Laboratories).

In conjunction with the ASA Committee on Critical Medicine and its chair, Gerald A. Maccioli, M.D., ASCCA has helped to develop several proposals regarding pay for performance, which was initiated by the Centers for Medicare & Medicaid Services. At least two of these proposals ("Prevention of Ventilator-Associated Pneumonia" and "Prevention of Catheter-Related Bloodstream Infections") are under consideration by other specialty societies.

Formal training in adult cardiothoracic anesthesiology fellowship through programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) is now a reality. An important component of this training is at least a month spent in an ICU managing adult cardiothoracic patients. ASCCA and SCA are building a collaborative arrangement whereby education of its members and fellows in training in areas of mutual interest can be enhanced.

*Continued on page 8*

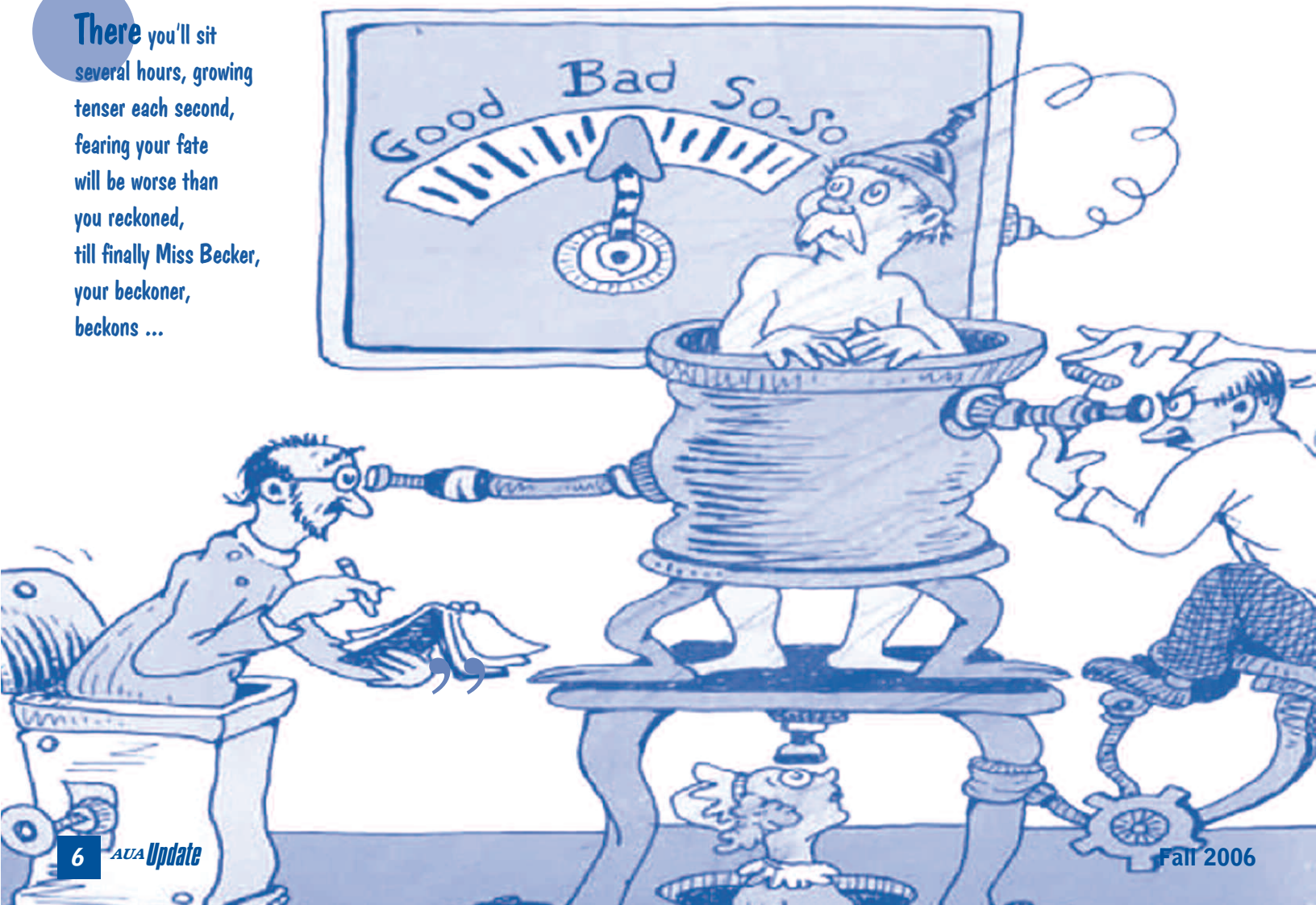
# You're Only Old Once!

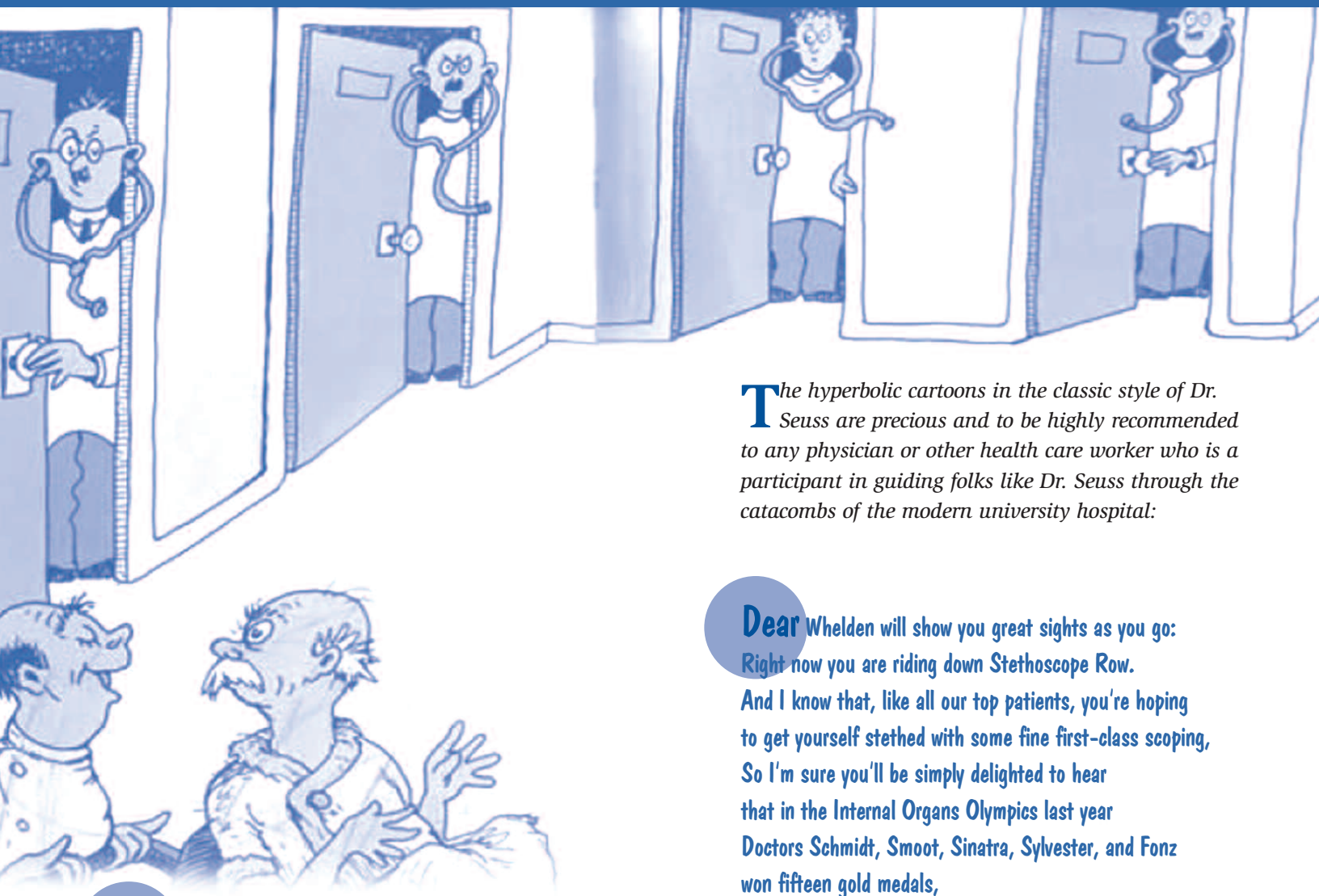
## By Dr. Seuss

IN those green-pastured mountains of Fotta-fa-Zee
everybody feels fine at a hundred and three
'cause the air that they breathe is potassium-free
and because they chew nuts from the Tutt-a-Tutt Tree.
This gives strength to their teeth, it gives length to their hair,
and they live without doctors, with nary a care.
And you'll find yourself wishing that you were out there in Fotta-fa-Zee
and not here in this chair in the Golden Years Clinic on Century Square
for Spleen Readjustment and Muffler Repair.

*And so this delightful book goes. Apparently Mr. Geisel, a.k.a. Dr. Seuss, had his singular experience with being old and got back! As a parody on the health care system from the perspective of a confused oldster trying to wend his way through the health care system dealing with costs, multiple specialists, uncomfortable and intrusive tests, obscure signs and directions, and long wait times:*

There you'll sit
several hours, growing
tenser each second,
fearing your fate
will be worse than
you reckoned,
till finally Miss Becker,
your beckoner,
beckons ...





*The hyperbolic cartoons in the classic style of Dr. Seuss are precious and to be highly recommended to any physician or other health care worker who is a participant in guiding folks like Dr. Seuss through the catacombs of the modern university hospital:*

**Dear** Whelden will show you great sights as you go:
Right now you are riding down Stethoscope Row.
And I know that, like all our top patients, you're hoping
to get yourself stethed with some fine first-class scoping,
So I'm sure you'll be simply delighted to hear
that in the Internal Organs Olympics last year
Doctors Schmidt, Smoot, Sinatra, Sylvester, and Fonz
won fifteen gold medals,
nine silver,
six bronze!
For the moment, however, we'll by-pass this bunch.
There is plenty of time to see *them* after lunch.

**For** your pill drill you'll go to Room Six Sixty-three,
Where a voice will instruct you,
repeat after me...
When at last we are sure you've been properly pilled,
Then a few paper forms must be properly filled
so that you and your heirs
may be properly billed.


*Until finally the book ends with a happy ending (it is a children's book, after all). I heartily recommend this book for those who are not yet old to get a teasing yet eye-opening view of the bureaucratic perils faced by our aging patients.*

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## ASCCA: A Crucial Subspecialty at a Critical Time

*Continued from page 5*

Finally, in the June issue of *Critical Care Medicine*, Mitchell P. Fink, M.D., and Peter M. Suter, M.D., published an article titled "The Future of Our Specialty: Critical Care Medicine a Decade From Now." This article is a synopsis of a consensus of a Round Table Conference of intensivists from diverse backgrounds. One of the interesting proposals cited in the paper is the establishment of a primary specialty in critical care medicine, such as exists in Japan and Spain, for instance. As proposed by the authors, the development and implementation of this pathway would be carried out in parallel with the training pathways that already exist within other specialties (e.g., anesthesiology, surgery and internal medicine). The Society of Critical Care Medicine (SCCM) recently conducted a survey of its members regarding the future of critical care medicine. The primary focus was on the methodology by which future intensivists should be trained and certified. An individual specialty in critical care medicine was listed as one of the options in addition to several others. Taking into account the proposal by Drs. Fink and Suter, it is interesting that the majority of the SCCM membership does not favor a separate critical care medicine specialty.