

# Arizona Society of Anesthesiologists

October 2008 Vol 2

## Newsletter



### So What “Blood Thinner” Are You On? Update on Anticoagulant Drugs

In recent years a number of new drugs have been developed to prevent thrombotic events through more selective mechanisms than heparin and warfarin in order to decrease unwanted side-effects and make dosing easier. In order to better understand how these drugs work a brief review of the coagulation cascade will be helpful. The intrinsic path is activated when the coagulation contact phase molecules (prekallikrein, kininogen, factor XI and factor XII) come in contact with negatively charged surfaces such as bacteria or lipoproteins such as chylomicrons and VLDLs (1). This pathway involves activation of factors VIII, IX, X, XI, and XII. This pathway, however, is not the major path for homeostasis, and as such patients with deficiencies in prekallikrein, kininogen, factor XI or factor XII (the contact phase molecules) do not have major clotting problems (1). The extrinsic pathway is initiated when Tissue Factor III (TF), which is usually outside the bloodstream, enters the blood at the site of a vascular injury and binds to factor VII which is then cleaved by proteases to VIIa (1). Tissue Factor and factor VIIa then go on to activate X to Xa which results in the activation of the rest of the extrinsic cascade with the conversion of prothrombin (factor II) to thrombin (factor IIa). (1, 2) Thrombin is then important in the conversion of fibrinogen to fibrin as well as activating an intracellular signaling system via G-protein-coupled receptors called protease activated receptors (PARS). These intracellular signals increase platelet activation and leukocyte adhesion. (1) Fibrinogen also activates platelets by interaction with GPIIb/GPIIIa receptor complexes on the surface of the platelets which is involved in platelet adhesion and aggregation (3). The coagulation cascade is terminated by the bonding of antithrombin III (AT), a normally circulating protein produced by the liver, to the activated proteases thrombin, factors IXa, Xa, XIa, and XIIa, kallikrein and plasmin. (2) Formed clots are removed after tissue repair has occurred by the conversion of plasminogen to plasmin by tissue plasminogen activator (tPA) (1).

Heparin and Warfarin (Coumadin, Jantoven, Marevan, Waran) are the most commonly known anticoagulants. Heparin works as an anticoagulant by binding to antithrombin III (AT) and increasing its ability to bind and inactivate thrombin IIa and factor Xa which are needed for

clot formation. (1, 2). Native heparin must be given as a continuous drip for efficient anticoagulation and can have a very unpredictable response which requires adjustment of the dose using serial evaluations of APTT. Should heparin overdoses occur they can be reversed with the administration of protamine sulfate (2, 4). Heparin is most common derived from mucosal tissues of pig (porcine) intestine or cow (bovine) lung. Like insulin, the body of some individuals will form antibodies to the heparin and result in heparin-induced thrombocytopenia (2). This situation is usually reversed upon discontinuation of the drug, and synthetic heparins can be safely used in these individuals. (2) Contamination of heparin preparations have recently been reported by the FDA. In February 2008, Baxter issued a recall of multi-dose and single-dose vials of injectable heparin as well as HEP-LOCK flush and some medical devices coated with heparin due to adverse reactions related to contaminants of products produced in China. (5)

Warfarin, a synthetic form of coumarin, has been a popular anticoagulant since the 1950's. Warfarin prevents the conversion of calcium-dependant clotting factors II, VII, IX and X as well as regulatory proteins C, S and Z to biologically active forms. By binding to the VKORC1 subunit of the vitamin K epoxide reductase, Warfarin prevents the recycling of vitamin K to the form needed to assist in the carboxylation of the “vitamin K dependant coagulation factors”. The elimination of Warfarin is almost entirely by hepatic cytochrome P-450 metabolism and it can have a terminal half-life of up to a week after a single dose. (6) The most serious side-effect of Warfarin is hemorrhage and is best prevented by periodic monitoring of PT/INR (4). Herbal medications including Bromelains, Danshen, Dong Quai, garlic, Ginkgo Biloba, Ginseng, and cranberry products have been associated with an increased effect of Warfarin, while Coenzyme Q10 and St. John's Wart often decrease the efficacy of warfarin. (6) Many other prescription drugs can have similar effects if they either enhance or inhibit the cytochrome P-450 system. Although warfarin has a slower onset than heparin, it has several advantages including being available in an oral form, having a longer half-life allowing once a day dosing, and doesn't cause an antibody-mediated thrombocytopenia (6). The effects of warfarin can be reversed by vitamin K or fresh frozen plasma administration (2, 7).

Low molecular weight heparins (LMWHs) were

developed when it was noted that although binding of heparin to antithrombin III (AT) is size dependent requiring at least 18 saccharide units, binding to factor Xa only required the presence of a pentasaccharide binding site (2). LMWH preparations must have at least 60% of the chains <8000 Daltons by weight but can be produced by a variety of methods including oxidative depolymerisation, deaminative cleavage and alkaline beta-eliminative cleavage (2). Drugs in this class include ardeparin (Normiflo), certoparin (Sandoparin), parnaparin (Fluxum), tizaparin (Innohep, Logiparin), dalteparin (Fragmin), reviparin (Clivarin), and nadroparin (Flaxiparin). Enoxaparin (Lovenox, Clexane) is the most commonly known of these drugs (2,6,8,9). These drugs act by preferentially inhibiting factors Xa and IIa (thrombin) without having to bind to antithrombin III like heparin (2). They have advantages over heparin including once-daily subcutaneous dosing, no need for APTT monitoring, and a lower risk of side-effects such as bleeding, osteoporosis, and heparin-induced thrombocytopenia. Unlike heparin, LMWHs cannot be reversed by protamine (2). Package inserts for these drugs includes warnings of an increased risk of spinal/epidural hematomas if neuraxial anesthesia or spinal puncture is performed on patients taking these drugs. (pdr.net Lovenox, Fagmin, Innohep)

Fondaparinux (Arixtra) is a newer drug which works by selective antithrombin-III-mediated inhibition of factor Xa without interaction with thrombin (IIa) or interacting with platelet function (2,6). It also does not affect fibrinolytic activity or bleeding time. This drug is administered subcutaneously and reaches peak concentrations in 3 hours. It is primarily eliminated in the urine unchanged and therefore can have a prolonged effect in patients with renal impairment (2). This drug has not been studied in patients with liver impairment and can have a prolonged effect in patients older than 75 years. Fondaparinux is currently being used for DVT prophylaxis in patients with hip fractures, undergoing total knee or hip replacement and those for abdominal surgery at risk for thrombotic events (6) Mild thrombocytopenia occurs in 3% of treated patients and severe thrombocytopenia (<50,000/mm<sup>3</sup>) is seen in 0.2% (6) An increased risk of spinal/epidural hematomas exists with this drug similar to that seen with LMWHs (6) Interestingly, the concomitant use of warfarin, platelet inhibitors such as aspirin, NSAIDs and digoxin did not significantly affect the pharmacokinetics/pharmacodynamics of fondaparinux. One major cautionary note is that there is no known antidote for fondaparinux (6)

Clopidogrel bisulfate (Plavix) works by an entirely different mechanism. Platelet adhesion and aggregation are dependant on the binding of ADP to a surface platelet receptor and the ADP-mediated activation of the platelet glycoprotein GPIIb/IIIa complex. Interestingly, patients who have circulating antibodies to the GPIIb/IIIa complex develop idiopathic thrombocytopenia purpura and its associated bleeding problems. (3,6). Clopidogrel works

by irreversibly modifying the ADP receptor on the platelet surface. This alteration of the ADP receptor also blocks the effects of other agonists that rely on the release of ADP to amplify platelet activation. The alteration of the platelet receptor is dose dependant and can be seen within 2 hours after a single oral dose, but steady state is usually not reached until 3-7 days of treatment when 40-60% inhibition is reached. Clopidogrel is metabolized by the liver to an inactive metabolite and is excreted into the urine and feces (6) An overdose of clopidogrel can lead to a prolonged bleeding time and subsequent bleeding problems which may require transfusion of platelets (6)

Abciximab (Reopro) is a new intravenous anticoagulant used for coronary thrombotic events. It is a monoclonal antibody that prevents binding of fibrinogen, von Willebrand factor and other molecules to activate platelets at the GPIIb/IIIa receptor (6,10). It is thought to block these large molecules by steric hindrance and/or a conformational effect rather than a direct binding to the receptor side. This drug is rapidly cleared from the blood and platelet function recovers over 48 hours (10). This drug is used as an adjuvant to percutaneous coronary intervention for the prevention of ischemia and is intended for use with aspirin and heparin (10). The effects of this drug are monitored by APTT when used with heparin and ACT during a coronary intervention (10) Currently there is no experience with an overdose situation and hence no recommendations (10).

Several new types of drugs are in the investigational stages. Ximelagatran (Exanta, Exarta, H376/95) is a direct inhibitor of thrombin (factor IIa) and had been thought to be a possible replacement for warfarin (2). Due to extensive liver toxicity investigational studies were stopped in 2006 by the FDA (2) Apixaban (BMS-562247-01), LY517717 (Lilly), and Rivaroxaban (BAY-59-739, Xarelto) are a group of anticoagulants that work through direct inhibition of Xa (2,11). These drugs have been shown to have protective effects comparable to enoxaparin (Lovenox) but have the advantage of oral administration instead of requiring subcutaneous dosing (2,11). TRA-SCH-530348 is another new antiplatelet drug under investigation that works by blocking the platelet G-protein-coupled receptors called protease activated receptors (PARS) which are part of the intracellular signaling system that participates in platelet activation and leukocyte adhesion. (1,12,13)

It should be noted that with all the above mentioned drugs the risk of epidural/spinal hematoma formation with neuraxial anesthesia is mentioned along with a caveat that the risk/benefit must be considered. Additional information can be found on coagulation and anticoagulant drugs on the web at websites such as PDR.net, en.Wikipedia.org, Medscape.com and FDA.gov. Also a summary of dosing of anticoagulants can be found at the UAB Coagulation Service website <http://coag.path.uab.edu>.

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References:

1. <http://www.med.unibs.it> King, Michael, and Marchesini, Sergio. "Blood Coagulation", Jan 17, 2008, pp 1-15.
2. <http://en.wikipedia.org/wiki/> "Antithrombin" Aug 2008, pp 1-7. "Factor VII" July 2008, pp 1-2. "Heparin", Aug 2008, pp 1-10. "Warfarin", July 2008, pp 1-8. "Low molecular weight heparin", July 2008, pp 1-3. "Enoxaprin", June 2008, pp 1-3. "Fondaparinux", May 2008, pp 1-3. "Apixaban", July 2008, p 1. "Ximelagatran", June 2008, pp 1-2. "Rivaroxaban", July 2008, pp 1-2.
3. [http://en.citizendium.org/wiki/Platelet\\_glycoprotein\\_GPIIb-IIIa\\_complex](http://en.citizendium.org/wiki/Platelet_glycoprotein_GPIIb-IIIa_complex). "Platelet glycoprotein GPIIb-IIIa complex". Jan 2008, pp 1-2.
4. [http://peir.path.uab.edu/coag/printer\\_221.shtml](http://peir.path.uab.edu/coag/printer_221.shtml) "Anticoagulant Therapy Monitoring Guidelines". pp1-5. See also: University of Alabama at Birmingham Coagulation Service. <http://coagpath.uab.edu>
5. <http://www.fda.gov/cder/drug/infopage/heparin/default.htm> "Information on Heparin" July 2008, pp 1-4.
6. <http://www.pdr.net> "Coumadin Tablets", Aug 2007, pp 1-14. "Fragmin dalteparin sodium injection for subcutaneous use only", Apr 2007, pp 1-21. "Lovenox", May 2007, pp 1-47. "Arixtra (fondaparinux sodium) injection", Oct 2005, pp 1-32. "Plavix clopidogrel bisulfate tablets Rx only", Feb 2007, pp 1-20. "Reopro (abciximab) Injection, Solution for Intravenous administration", Nov 2005, pp 1-7.
7. Ansell J, Hirsh J, et al. (2004) "The pharmacology and management of vitamin K antagonists: the Seventh ACCP Conference on Antithrombotic and Thrombolytic Therapy", Chest 126(3):204s-233s.
8. <http://www.drugs.com/pro/innohep.html> "Innohep official FDA information, side effects and uses", Apr 2008, pp 1-13.
9. [http://www.innohepusa.com/innohopus/Full\\_Prescribing\\_Information\\_For\\_Innohep.pdf](http://www.innohepusa.com/innohopus/Full_Prescribing_Information_For_Innohep.pdf)
10. <http://www.fda.gov/cder/foi/label/1997/acicen110597-lab.pdf> "Reopro Abciximab for intravenous administration", Jan 1997, pp 1-17.
11. <http://www.ncbi.nlm.nih.gov/pubmed/17408408> Agnelli G, Haas S, et al: "A phase II study of oral factor Xa inhibitor LY517717 for the prevention of venous thromboembolism after hip or knee replacement" J Thromb Haemost 2007 Apr 5(4): 746-53.
12. <http://www.medscape.com/viewarticle/555519> Hughes S, "Major phase 3 program planned for new antiplatelet drug" Apr 2007, pp 1-2.
13. [http://www.schering-plough.com/schering\\_plough/news/release.jsp?releaseID=987054](http://www.schering-plough.com/schering_plough/news/release.jsp?releaseID=987054) "Schering-Plough News Release". Apr 2007, pp 1-3.

## Politically Speaking

Once again organized medicine has been successful in preventing CMS from imposing a scheduled reduction in payments to physicians for services provided to Medicare patients. The bill enacting the latest 18-month delay also contained a significant victory for the entire anesthesia community—the elimination of the Anesthesia Teaching Rule in 2010. Under that rule, anesthesia services provided by residents were only paid at half the usual rate if the attending anesthesiologist supervised two or more residents for any amount of time. If two surgical procedures overlapped by even one minute, the total payment for each anesthetic was only half the usual fee. While this grossly unfair payment rule only applied to teaching programs directly, the entire anesthesia profession was affected.

Over the last decade a number of anesthesia training programs have closed due to their inability to sustain themselves with these extreme fee reductions. This has reduced the number of anesthesia residency positions and the number of graduating residents, making it more difficult for practices to recruit new anesthesiologists. It has also made it difficult to retain attending anesthesiologists and researchers in the remaining programs.

There are other developments in Washington that could affect physicians, both positively and negatively. CMS recently announced that Medicare fees paid to physicians who utilize e-prescribing programs will

increase. Beginning next January, physicians utilizing e-prescribing will be paid a 2% bonus over their usual fees. This will continue for two years and will then be phased out over the following few years. Beginning in 2011, however, physicians not participating in e-prescribing programs will have their fees reduced by an amount that will increase up to 2% over several years. CMS hopes this carrot-and-stick approach will significantly increase the use of e-prescribing. Other payors, including commercial plans and state Medicaid programs, are likely to also adopt programs that encourage physicians to increase their use of e-prescribing.

A recent notice in the *Federal Register* proposes a new rule that would convert the entire health care industry to the ICD-10 diagnosis and procedure code sets from the current ICD-9 code sets. This will be a major undertaking and require complete retooling of all systems that utilize the ICD-9 diagnostic codes or procedure codes. This will drain billions of dollars from the health care system, money that might otherwise be spent on actual health care. While the conversion to ICD-10 procedure codes initially only applies to hospital procedures, it is possible that CMS will also require this for Part B physician claims at some point in the future. This could eliminate the use of the CPT codes by physicians, which could have profound effects on the physician community.

Currently the American Medical Association controls the CPT code set that defines procedures performed by physicians and other health care practitioners. Thus, when the physician community decides that a new code is needed, there is a process to add that code to the CPT code set. If physician procedure codes are converted to ICD-10 codes, physicians will no longer have the ability to define for themselves the codes that describe our services. In addition, the AMA holds the licensing rights to the CPT codes. Others utilizing these code sets and associated published materials pay royalties to the AMA. These fees represent a significant portion of AMA revenues. Loss of CPT codes could markedly diminish the AMA's ability to continue its activities or necessitate a significant dues increase. Either way, practicing physicians could be detrimentally affected.

Another recent development could have negative implications for a number of physicians. One commercial plan in Minnesota now waives its usual co-pays when its members receive care in a local pharmacy clinic, but charges the co-pay if members seek care in physician offices. These clinics are often staffed by nurse practitioners. These practitioners may charge less for their services than physicians. Alternatively, they may be employed by the pharmacy and have little or no overhead. The pharmacy would then contract with the insurance company and provide the services at a lower cost because the overhead is supported by the pharmacy itself. While this does not directly affect

anesthesiologists, this model, if successful could be extended to other specialties and practice locations. In the long-term it could negatively affect many physicians.

These are just a few of the latest developments that could significantly affect the practice of medicine. Some of these may never come to fruition while others may be modified. There is little doubt, however, that other changes will be proposed, underscoring our need to remain actively involved. Only through such participation can we continue to positively affect the system or prevent negative changes.



Marc Leib, M.D., J.D.  
Chairman AzSA Legislative Committee  
Member ASA Committee on Economics

## ASA Board of Directors Meeting

The interim meeting of the ASA Board of Directors was held August 16-17, 2008 in Chicago. Arizona members in attendance included Drs. Daniel Cole, ASA Director from Arizona; Jeff Mueller, ASA Alternate Director from Arizona; Steven Barker, Director, Academic Anesthesiology; and Charles Otto, Vice-President for Scientific Affairs.

The typical structure of the Board of Director's weekend includes regional caucuses on Saturday morning, followed by the review committees (Administrative Affairs, Professional Affairs, Scientific Affairs and Finance). On Saturday afternoon there is an education session and legislative update, with the actual Board of Directors meeting on Sunday morning. I will focus my report on the issues that were before each review committee and the educational/ legislative session.

### The Review Committee on Administrative Affairs:

The key issues on the Committee for Administrative Affairs were found in the Administrative Council's Annual Report. The Board of Directors approved: the purchase of 3.015 acres of property immediately adjacent to the east and south of the ASA Park Ridge headquarters building, and development of a Quality Institute with start up funding of \$750,000.

Based on Administrative Council recommendation the dues for regular active ASA members would be increased to \$600 a year and to \$300 a year for affiliate and educational members. The increase was necessitated by the fact that the ASA has been dipping into reserves over the past few years to meet expenses and that although non-dues revenue sources will be explored over the next 3 years, the dues increase is necessary to support all the ASA programs at this time. Dues have not been increased since 2000, and ASA dues are low compared to similar organizations.

Another important area was the expert witness testimony review program and governance of this program.

One case has gone through the system, and has resulted in censure of an ASA member regarding expert witness testimony. Details of this case can be found on the members only section of the ASA website.

The Anesthesia Care Team Annual Report was approved with a new Anesthesia Care Team statement.

In the Committee for Pediatric Anesthesia Annual Report, the Review Committee recommended disapproval of the recommendation that the ASA endorse the revised application for subspecialty certification in advanced pediatric anesthesiology. However, they did refer to a committee or task force of the President's choice, the feasibility of developing an ASA educational certification program for non-anesthesiologists in procedural sedation analogous to the American Heart Association basic and advanced life support programs.

### The Review Committee on Professional Affairs:

The Committee on Performance and Outcome Measurements received approval for financial support for ASA methodologists to work with this committee for the next fiscal year to continue to develop performance measurements. The ASA methodologists will be appointed to serve as Ad Hoc advisors to the Committee on Performance and Outcome Measurements which will ensure appropriate review of the evidence when developing measures for which there are no practice parameters.

### The Review Committee on Scientific Affairs:

The Committee on Equipment and Facilities reported on activity of Dr. Jan Ehrenwerth, our liaison to the National Fire Protection Association (NFPA), in support of ASA proposals regarding NFPA standards on electrical safety. ASA members are encouraged to contact Jan Ehrenwerth for documentation and support for electrical safety in the operating room at [jan.ehrenwerth@yale.edu](mailto:jan.ehrenwerth@yale.edu).

### The Review Committee on Finance:

The Committee on Finance met and the budget was reviewed. The final budget was approved but the testimony at the Board of Directors indicated that they would need to have the increase in dues to be able to balance the budget this next year.

### Educational/Legislative Session:

The afternoon session had a candidate's forum during which the two candidates for the only contested election, the ASA First Vice-President, made presentations (Dr. Candace Keller and Dr. Mark Warner). After the candidates presentations there was a session presented by Paula Cozzi Goedert, LLP about fiduciary responsibility for the American Society of Anesthesiologists Board of Directors. She discussed topics such as anti trust laws, expert testimony, copyright law and how nonprofit organizations need to think about handling information that is placed on the internet.

In the "Washington hour" H.R. 6331 was discussed. In a historic triumph for the ASA this law has been enacted that will reverse the Medicare payment cuts for 2008, provide a 1.1% positive update for 2009 and permanently restore full Medicare payment to anesthesiology teaching pro-

grams beginning in 2010. This is a real victory for the ASA. It was a long and hard fought process. We should be proud of all in Arizona who worked tirelessly on this effort. We are grateful to our federal legislators who supported this effort, and especially thankful to Senator Jon Kyl who was the Republican lead in the Senate on the teaching rule bill (S 2056). The net outcome of this bill is \$83.7 million of increased payments to anesthesiologists in 2008 due to the SRG fix and \$500 million increased payments to anesthesiology teaching programs over 10 years.

State issues were then discussed. There are no further states that have opted out (currently 14) but Utah and Colorado are threats to possibly opt out of the requirement that CRNAs be supervised by physicians. In Louisiana, interventional pain management was not included in the scope of practice for CRNAs, and in Missouri prescriptive authority excluded CRNAs. Licensure of anesthesiology assistants has occurred in 12 states, the last one being Oklahoma and office-based regulations have now been passed in 24 states including Arizona.

Please feel free to contact me if you have any comments or need additional information regarding the ASA. My email address is: [cole.daniel@mayo.edu](mailto:cole.daniel@mayo.edu). Email works best but I welcome telephone calls.

Daniel J. Cole, M.D.  
Director for Arizona  
American Society of Anesthesiologists



## Is Healthcare a Right or a Privilege?

For the past several nights, I, like millions of Americans, am watching the Democratic National Convention. No I am not a “political junkie”, however, I am very much interested in the impact that the future Presidential Elections will have on the Healthcare system in the United States. Healthcare appears to be at the top of everyone’s list as a key item that needs to be addressed by the new President and Congress. Unfortunately, despite the need to change certain aspects of payment within the industry I am afraid that we will be throwing out the “baby with the bath water”.

There is a tremendous amount of waste generated in our current system such as: duplication of efforts, malpractice, reimbursement, insurance companies making huge profits for their stockholders, physicians refusing to take emergency room call and patients being forced to spend down to some arbitrary monetary number to qualify for government assisted plans. Add to this the issue of illegal immigration to states such as ours and it is obvious that there is a lot of pressure on the system. To me the question that must be answered is “is healthcare a right or a privilege?” This is a very thought provoking question that must be answered before any decisions regarding healthcare restructuring is considered.

Over the past few years I have had the opportunity to travel to Europe and the Scandinavian countries on several occasions. I meet some very interesting people who are not involved in delivering healthcare but are the recipients of it. Everyone I talked with felt that the healthcare provided was adequate. Some mentioned waiting for certain procedures others indicated that if you had enough money you could elect to have more “private” care. They also talked about the opportunities afforded them by the more communal system that was available in their countries. The overriding negative comment for all the individuals was that their taxes were too high. In the Scandinavian countries that I recently visited individual income taxes can range as high as 50% to 55%. In addition, the European Union has a Value Added Tax (VAT), which by law is a minimum of 15% and can be as high as 25% in some countries. This is a tax that is added to everything you purchase. Certain items are excluded but these exceptions are governed by the European Union. As a result of the high taxation many people “rent” apartments because the cost of owning a home is too expensive. “The stated goal of the tax system is to provide revenue for public services and to redistribute income between citizens. In addition, the tax system should raise revenue by means that allow labor, capital and natural resources to be used as efficiently as possible”.

Compare this to the United States where 47 million Americans are uninsured. Eight out of every ten of these individuals is working but unable to afford the cost of premiums or their employers are unable to provide coverage. Few receive “preventative” care so when they show up in the emergency room or are admitted to the hospital the cost of care is much larger because they are sicker. We have the best healthcare in the world but getting into the system can sometimes be a real challenge. The idea of a third party payer i.e. the insurance companies began in the 1940’s when salaries were frozen due to the war. In an effort to attract qualified individuals companies began offering “benefits” that included the cost of healthcare. The Federal Government became involved in the healthcare arena in the 1960’s and over time created a myriad of regulations to govern the industry.

Is nationalized healthcare the way to go in this country? I do not know! I can say from my past experience, that working in institutional facilities (Indian Health Service, the Veterans Administration Hospitals and County Hospital) it was extremely frustrating due to the inefficiencies and inflexibilities of these systems. It is hard to conceive that Washington will be more efficient.

So what do we do? I think it all comes down to deciding if healthcare is a right or a privilege.

Joseph Kryc, M.D.

## *President's Corner*

This newsletter comes at a time of many exciting and interesting occurrences for subspecialty of anesthesiology. Interesting because we as a specialty saw a congressional override of a presidential veto resulting in the passage of a legislative bill which included a fix for the anesthesiology teaching rule in the recent Medicare legislation. Exciting because this legislative victory was the result of a concerted effort at the state and national levels to establish a cooperative congressional relationship.

The next legislative year will be interesting due to the unfinished business from this session. Our society has been successful in getting legislation introduced regarding multiple issues but more support will be needed to bring them into law. It is also exciting to be in an election year which will bring new congressional faces and opportunities for new friendships and relationships. Every congressional race presents the chance for an anesthesiologist to make contact with a candidate and establish a rapport for the future. This presidential race is especially important because the result will inevitably be new healthcare policies in which we as a specialty must be engaged to effectively advocate for our patients and the practice of anesthesiology.

This excitement and interest will be evident on the Arizona election level as there will be initiatives specifically involving healthcare in our state. This is yet another reason to be active and involved in state politics and our society. On behalf of your state society I would like to thank each member who has been active in society functions, PAC contributions, political events, and any advocacy on the part of our specialty. Each anesthesiologist must be active and involved in some way in the coming year. We have seen the fruits of our labors this past year and with continued efforts there will be more exciting and interesting reports to come.

Forrest Hamon, M.D.  
President  
Arizona Society of Anesthesiologists



## **ASA Legislative Conference Update: Advocacy for Arizona Anesthesiologists**

The annual ASA Legislative Conference occurred from June 9-11 in Washington, D.C. This conference is a core component of the advocacy effort of Arizona anesthesiologists. Arizona was represented by the

following delegation: Michael Adkins, M.D., Tim Berger, M.D., Brian Cammarata, M.D., Daniel Cole, M.D., Brenda Gentz, M.D., Forrest Hamon, M.D., Marc Leib, M.D., Kelly McQueen, M.D., Jeff Mueller, M.D., Chuck Otto, M.D., Eric Cornidez, M.D.-resident, Robert McGraw, M.D.-resident, David Landrith-Arizona Medical Association

The timing of this year's meeting couldn't have been better. We were in Washington, D.C., right in the midst of the contentious congressional debate on Medicare reform. We met with the staff of Congressman Shadegg, and we met directly with:

Senator Kyl  
Congressman Renzi  
Congressman Franks  
Congressman Pastor  
Congressman Mitchell  
Congressman Flake  
Congressman Grijalva  
Congresswoman Giffords

As many of you know, anesthesiologists and their patients secured a hard fought victory when H.R. 6331 became law on July 15. This legislation: 1) replaces the 10.6 percent payment cut that went into effect on July 1 with a positive update through 2009, and 2) restores full Medicare payment to anesthesiology teaching programs in 2010.

Simply stated, this legislation would not have become law but for the hard work of your ASA, the ASA Political Action Committee (ASAPAC), and delegations from the Arizona Society of Anesthesiologists who worked together with congressional members during this crucial time period. We are especially grateful to Senator Jon Kyl for his tireless work on behalf of the anesthesiology teaching rule. Through S 2056, the Rockefeller-Kyl anesthesiology teaching rule bill, he kept the teaching rule on the table in the Senate. Co-sponsors of the teaching rule in the House include Congressman Renzi, Shadegg, Pastor, Mitchell, Grijalva and Congresswoman Giffords. If you are a constituent please call their office and give them a big thanks.

The formal program of the conference was again very well received and included updates on legislative and economic issues at the federal and state level. Of note, there was a reception for Andy Harris, M.D., an anesthesiologist at Johns Hopkins and current Senator in the Maryland state legislator. Dr. Harris is the Republican nominee for [Congress](#) representing [Maryland's 1st congressional district](#).

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Pending Election

To contact any of these individuals please contact Patrice Hand at the society headquarters.  
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## Local Meeting Calendar

Oct 2-4, 2008	Anesthesia Camp V	Montage Laguna Beach Resort	Laguna Beach, CA
Oct 10-12,2008	Difficult Airway Course	Bally' s Casino Las Vegas	Las Vegas, NV
Oct 17, 2008	American Society Critical Care	Rosen Plaza Hotel	Orlando, FL
Oct 17, 2008	International Society for Anaesthetic Pharmacology		Orlando, FL
Oct 17, 2008	Society for Ambulatory Anesthesia		Orlando, FL
Oct 17, 2008	Society for Education of Anesthesia	Rosen Centre Hotel	Orlando, FL
Oct 17, 2008	Society of Neurologic Anesthesia And Critical Care		Orlando, FL
Oct 17, 2008	Ultrasound For Every Anesthesiologist	Rosen Shingle Creek	Orlando, FL
Oct 18-22, 2008	ASA Annual Meeting		Orlando, FL
Oct 27-31, 2008	California Society of Anesthesiologists	Mauna Lani Bay Hotel	Kohala Coast, HI
Oct 29-Nov 1, 2008	Anesthesia Camp Hawaii	Four Season Resort-Maele Bay	Laina' I, HI
Nov 7-9, 2008	19th Annual Univ. California Davis Anesthesiology Update	Monterrey Plaza Hotel and Spa	Monterrey, CA
Nov 8-15, 2008	Clinical Concerns in Anesthesia	Mexican Riviera Cruise	San Diego, CA
Nov 15, 2008	Anesthesia Update 2008	Tom Bradley International Hall UCLA	Los Angeles, CA
Nov 20-23, 2008	American Society of Regional Anesthesia	Hyatt Regency Huntington Beach	Huntington Beach, CA
Nov 30, 2008	Bioterrorism	Las Vegas Wynn Casino and Resort	Las Vegas, NV
Nov 30, 2008	Medical Ethics	Las Vegas Wynn Casino and Resort	Las Vegas, NV
Dec 1, 2008	Advanced Difficult Airway Workshop	Las Vegas Wynn Casino and Resort	Las Vegas, NV
Dec 1, 2008	EKG Update: Ischemia and Dysrhythmia Workshop	Las Vegas Wynn Casino and Resort	Las Vegas, NV
Dec 1-5, 2008	Anesthesia Update	Las Vegas Wynn Casino and Resort	Las Vegas, NV
Dec 1-5, 2008	Resuscitation Series: PALS/ ACLS/ Neonatal Resuscitation	Las Vegas Wynn Casino and Resort	Las Vegas, NV

For more meeting information please see the American Society of Anesthesiology website @ [www.asahq.org](http://www.asahq.org)

**Please mark your calendars now for the 2009 Arizona Society of Anesthesiologists' Annual Meeting on Feb 13-15 at the Scottsdale Resort and Conference Center.**