



## President's Message

**Robert F. Early, M.D.**

Having attended the American Society of Anesthesiologists' Annual Meeting for the past thirteen years, I am convinced that it truly is the preeminent anesthesia conference in the world. The educational opportunities are virtually unlimited with the presentations being both timely and diverse. The relevance of a topic was never more evident than when I attended a panel discussion on Wednesday morning that offered great insight into an issue which is gaining popularity around the country—Propofol by Non-Anesthesiologists. Unfortunately, since most attendees could not stay until the last day of the meeting, the audience was rather sparse. For the benefit of the PSA members who missed this lively debate, I will briefly summarize and shed some light on this controversial subject as well as raise some significant concerns and questions that need to be addressed.

Propofol is undoubtedly one of the most important anesthetic agents added to our armamentarium in the past fifteen years. Certainly its rapid action, excellent airway relaxation, antiemetic effect,

and safety profile have led to the widespread acceptance of this drug not only for the induction of anesthesia, but also for maintenance (TIVA) and sedation (MAC). Anesthesia providers have recognized for some time that propofol is clearly the best agent for outpatient procedures, especially those where "sedation" is necessary.

### Nurse Administered Propofol Sedation

Call it what you will—MAC, TIVA, Conscious Sedation, Unconscious Sedation, Spontaneously breathing general anesthesia with supplemental oxygen (probably most accurate!)—patient and surgeon comfort and satisfaction are extremely high.

The practice where registered nurses with conscious sedation credentials give small doses of benzodiazepines and narcotics under the supervision of the operating physician has been an accepted standard in our hospitals for many years. However, a new concept has entered our emergency rooms, GI

labs, ICU's, radiology suites, and cardiac cath labs—Procedural Sedation and Analgesia. As anesthesia personnel should have anticipated, propofol has become a part of this "new" sedation protocol, being administered by all levels of non-anesthesia providers with varying degrees of sedation up to general anesthesia! There has even been a recent addition to our list of medical terms, "NAPS," or Nurse Administered Propofol Sedation.

Several factors have had a significant influence in supporting this use of propofol by non-anesthesia personnel. As is often the case, money is one of the issues. Insurance companies, wanting to keep costs to a minimum, would like to eliminate the anesthesia portion of the total charge unless our services are "medically necessary." WellPoint, one of the country's biggest health insurers, will not provide coverage for the assistance of an anesthesiologist or CRNA for routine, average-risk colonoscopies. Aetna is considering a similar policy and we must assume other large payers will follow. But these



## Sentinel

Pennsylvania Society of Anesthesiologists Newsletter

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# New Anesthesia Drugs: Are We Creating a Monster?

by Joseph F. Answine, M.D., Vice President

Representative to the Specialty Leadership Cabinet of the Pennsylvania Medical Society

Chair of the Professional Relations Committee

As we are all painfully aware, anesthesiologists and CRNAs are currently in a battle for patient safety with the use of propofol by non-anesthesia trained medical care providers. The quick but very potent sedating effect of propofol and the short duration of action has made it easier to provide heavy sedation, just on the verge of general anesthesia, to anyone regardless of their general

**We know as anesthesiologists that it is our superior clinical skills that bail us out of these tight airway situations and no medication is going to replace clinical ability.**

health, by anyone regardless of their training, just about anywhere within a hospital, even in the back corner of a busy emergency room or in the basement CT scanner, without the necessary equipment for emergency airway management.

Have we as anesthesiologists learned from this? The answer may be “NO”. Actually, it is probably not within our ability to control. We cannot stop “progress.” Currently undergoing clinical trials is a new “breakthrough” drug that quickly

binds our most commonly used neuromuscular blocking agents (NMBAs); vecuronium and rocuronium. If the clinical studies go as planned, the duration of action of our steroidal non-depolarizing NMBAs will be no longer than succinylcholine. This is obviously very exciting news in the anesthesia world. We will have the benefits of succinylcholine without the many side effects (some life-threatening). The agent, a cyclodextrin compound (ORG 25969), tightly binds the steroidal NMBAs, especially rocuronium, therefore rendering them inactive.

Fantastic news! However, maybe it is not as fantastic as you may initially think. Are we going to find ourselves in another confrontation over the safe use of ORG 25969? Are our non-anesthesia trained providers in the ER or CT scanner going to feel a little more inclined to test their airway management skills because of a new sense of security (although false)? They will not have the many side effects of succinylcholine or the longer clinical duration of the non-depolarizing agents to contend with anymore. If they get in over their heads, the “binder” will bail them out.

We know as anesthesiologists that it is our superior clinical skills that bail us out of

these tight airway situations and no medication is going to replace clinical ability. The advancements of our pharmaceutical company friends continue to improve on the agents at our disposal often making our lives easier but they create new challenges. We must advocate for safe use of these agents by trained professionals.

The rescue efforts when we are called to help out in these far away places, will place our patients in a much graver situation. The speed and expertise to salvage the situation will be demanding.

In the long term, this may benefit us, because many more individuals both medical and non-medical will realize our many talents. However, this may come at a significant risk to patients.

What are the facts: (1) this will not stop with propofol (2) we do not actually want to stop progress (3) the good news is that the PSA will be there to continue the fight to keep patient safety as the focus of our efforts.



# Nurse Anesthetists Attempt End-Run on Committee Process

by John P. Milliron, Esquire

Right before the House of Representatives adjourned for three weeks in mid March, Pennsylvania Association of Nurse Anesthetists (PANA) attempted to amend S.B.235, a bill requiring certain continuing education requirements for all registered nurses, with language eliminating physician supervision for the administration of anesthesia. They were not successful!

PANA has introduced two identical bills—H.B.1066 in the House and S.B.452 in the Senate.

These pieces of legislation would eliminate physician supervision and replace it with the following language: “A certified registered nurse anesthetist shall administer anesthesia in cooperation with a physician, dentist or podiatrist. For purposes of this section, “cooperation” shall mean a

process in which the certified registered nurse anesthetist and the physician, dentist or podiatrist work together with each contributing an area of expertise at the individual and respective level of education and training...”

If there is any confusion in its interpretation, the Board of Nursing is authorized to write more specific definitions at a later date.

Each of these bills is in the respective House and Senate Professional Licensure Committee.

Neither Committee has taken any action on either of these bills. In fact, a majority of the members of the Committees oppose the elimination of physician supervision of CRNA's. But we now know their strategy—to bypass the Committee system in the House and Senate and try to amend any legislation that deals with the Nursing Law.

To be blunt—there are bills amending the nursing law before the Legislature on a regular basis. We will have to be constantly vigilant and be prepared at any time to defeat this amendment. Although nothing needs to be done immediately, you must be ready to act on a moment's notice. Get to know your House member now. Meet with them or write them a letter expressing your view that you are opposed to the elimination of physician supervision in the administration of anesthesia. We must inform them of our views now since there may not be time if and when another amendment is introduced.

We were very successful in this battle five years ago. Many faces have changed in Harrisburg since then, plus legislators need to hear from you again! They need to hear your opinion. If you have any questions about whom your legislator is or what to say, please call our lobbyists in Harrisburg at 1-800-822-6789. John, Jim, Kenny and Andrew will be more than happy to help you out. Call them today—then your legislator!



## Call to Action Alert Be Prepared

Call 1-800-822-6789. Request your State Senator's and your State Representative's phone numbers, place them on your cell. Make a point of meeting your Senator and Representative BEFORE you are requested to call them.

The need to call them will occur in the near future. Your help is absolutely critical.

# Medicare Reimbursement Guidelines for Anesthesiology Services Performed Concurrently with Medical Direction – Q & A

by Andrew Bloschichak, M.D., M.B.A., Joseph West, M.D., and Donald Martin, M.D.

The specific duties an anesthesiologist may perform concurrently while medically directing nurse anesthetists, and still seek Medicare reimbursement as medical direction, have been the subject of questions and controversy for at least twenty years. Therefore, the following is an attempt to answer some common questions and to provide a reasonable interpretation of the existing CMS regulations regarding medical direction, consistent with current anesthesia practices in the state of Pennsylvania.

The general guidelines for concurrent services which may be performed along with medical direction are outlined in the Medicare Claims Processing Manual, Publication 100-4, Chapter 12, Section 50C:

*A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met.*

*Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.*

*However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature. Carriers may not make payment under the fee schedule.*

This section provides both general guidelines for allowable concurrent services and an illustrative list of services which, in the opinion of CMS, meet these guidelines. These general guidelines, however, do raise significant questions from anesthesiologists, including the following:

**Question: What guideline should a provider use to determine whether a specific service can or cannot be provided at the same time as medical direction?**

Answer: The above guidelines advise that a physician who is providing medical direction of anesthesia care cannot ordinarily provide additional services to other patients. However, these guidelines also describe the type of services that the physician may provide, if the services do not prevent the physician from being

immediately available to respond to the needs of the surgical patients.

**Question: May an anesthesiologist perform preoperative evaluations for patients presenting for surgery later that day, or on future days?**

Answer: Yes. As long as the area in which the evaluations are performed is easily accessible from any area of the operating suite, the patient services do not prevent the physician from being immediately available to address emergencies in the operating room, and most importantly, "do not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients," the anesthesiologist may perform pre-operative examinations concurrently while directing anesthesia care.

**Question: May an anesthesiologist perform procedures on patients presenting for surgery that day, either preoperatively or in the post anesthesia care unit?**

Answer: An anesthesiologist may perform, and if otherwise eligible seek reimbursement for, procedures (such as arterial line insertions, central venous catheter insertions, pulmonary artery catheter insertions, and epidural, spinal, and peripheral nerve

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# March ASA Board of Directors Meeting

by Paul J. Schaner, M.D., District Director

The ASA Winter Board of Directors (BOD) was held in Chicago March 4th and 5th. Testimony was heard on all items submitted to the Committees on Administrative Affairs, Legislative, Scientific Affairs, and Finance.

The Committee on Administrative Affairs approved and the BOD concurred on the following items:

- 1) A new Conflict of Interest Document was presented. The Committee requested refinement of the document for presentation to the August BOD.
- 2) The format for future BOD and Annual Meeting Handbooks Continues to be by Reference Committee with color-coding, however, recommendations will be in the body as well as at the end of the report. The Handbook will be on a CD in unalterable and alterable format with a printed version available on request. These actions are intended to facilitate the flow of business of the ASA BOD and House of Delegates (HOD).
- 3) The Executive Committee is charged to develop credentialing criteria for the privileging of health professionals to perform deep sedation. These are to be used by medical facilities for those individuals seeking deep sedation privileges.
- 4) Presidential House Committee appointments should consider the following points:
  - A) A majority of the membership of Reference Committees should be appointed from voting members of the HOD. Any other appointees should have prior HOD experience.
  - B) The chair of a Reference Committee should have served on a prior Reference Committee.
  - C) Chairperson of the committees of the BOD, Section Chairperson and vice-person should not serve on Reference Committees. Consideration should be given to consultation with the Speaker of the House in making appointments. A Resolution to have the HOD meet on

Saturday and Tuesday during the Annual Meeting was disapproved.

The Committee on Legislative approved the following items with BOD concurrence:

- 1) The ASA will provide financial support for the AMA campaigns of ASA members Dr. Head who is running for re-election to the Council on Scientific Affairs and Dr. Patchin who is running for re-election to the AMA Board of Trustees. This is in concert with established ASA Administrative Procedures.
- 2) The statement of the scope of practice for Anesthesia Assistants was approved as follows: "The policy of ASA regarding the performance of regional anesthesia is governed by the ASA Statement on Regional Anesthesia. The committee recommends that, in their practice, anesthesiologists be given the discretion to determine the extent of participation of AAs in the performance of regional anesthesia and invasive monitoring in accordance with their hospital's policies and state's regulations. In this regard, ASA encourages component societies to support this concept when helping state regulators either draft new or modify existing rules and regulations regarding AA practice."

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## PSA Members Are Invited to Attend Spring PSA Board of Directors' Meeting

Sunday, April 30, 2006

8:30 AM until 3:00 PM

JW Marriott Hotel

1331 Pennsylvania Avenue, NW

Washington, DC

Lunch will be provided

In order to guarantee space for lunch

you must RSVP by March 31

Email Dr. Donald Martin: [dmartin1@psu.edu](mailto:dmartin1@psu.edu)

# March ASA Board of Directors Meeting

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- 3) The Principles of Quality Incentive Programs was accepted. Pay for performance is here to stay and active participation will enable significant input. The alternative is to accept the direction of non-anesthesiologists.
- 4) ASA Standards are to be approved or disapproved by the HOD without amendment in the same way the HOD acts on practice parameters.
- 5) A Registry on Intraoperative Awareness will be established on a web-based basis per the Administrative Council's request. Anonymity is to be assured. The purpose is to gather relevant information to increase the knowledge of patients and events associated with intraoperative awareness.
- 6) A resolution from California regarding physician participation in executions was referred to the ASA Committee on Ethics who is to report to the August BOD.
- 3) Badges this year for the Annual Meeting will contain hospital mailing address and preferred e-mail address bar-coded as an OPTIONAL service.
- 4) If linked kiosks for registration and ticket printing are available this year at the headquarters hotels for Friday late arrivers, ASAPAC contributions will be facilitated during the kiosk registration process. The ASAPAC booth is to be visibly placed in the Registration area.

The Finance Committee approved and the BOD concurred on the following items:

- The Committee on Scientific Affairs approved and the BOD Directors concurred on the following items:
- 1) The ASA should emphasize to JCAHO their regulations should be evidence based and include a cost analysis. A recent JCAHO directive would have required that all labels be verified both verbally and visually by two qualified individuals to reduce medication errors in the OR. Dr. Guidry was able to resolve this as follows:
    - A) When a medication is prepared, immediately administered, and any remainder immediately disposed of, labeling of the syringe is not required.
    - B) When the same person prepares and administers the medication, the label (if required) does not need to be verified by a second person.
  - 2) An electronic version of the Anesthesiology Continuing Education Program will be offered in 2006.
  - 1) Accepted for information the FAER Report. While there was decrease in the number of grants funded in 2005, the total amount increased from 1.5 million in 2004 to over 1.8 million in 2005. The postponed Centennial Gala will be held at the Hyatt Regency in Chicago on 10/16/06.
  - 2) The ASA President's honorarium was increased to \$250,000 from \$200,000 and the President-Elect \$125,000 from \$100,000. These are effective for the 2005 year. The increased was based on time spent on ASA business and based on a MGMA study. The figure is equal to 75% of the MGMA mean for practicing anesthesiologists. This will serve as a benchmark for future adjustments.
  - 3) The Task Force on Hurricane Katrina Disaster Relief collected a total of \$301,243. The Anesthesia Foundation spent in grants and loans to residents \$170,000. The Foundation was reimbursed by the ASA from the collected funds. The remainder of the \$301,243 was distributed to the other agencies active in the relief process. The two anesthesiology residencies were disrupted but fortunately the residency programs in Houston, Texas offered positions to continue training for the residents. The return to a normal situation in New Orleans continues.

## President's Message

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guidelines fail to recognize an important point, the drug being administered (propofol) as well as the condition of the patient are both critical to this debate. The patients and proceduralists, however, demand propofol, and having "sedation nurses" administer the drug is their solution to the problem. Adding to the situation is the national shortage of anesthesia providers making it difficult for us to staff all the locations where sedation is required or requested.

Many state nursing boards support the practice of NAPS.



In fact, on February 7 the Oregon State Board of Nursing unanimously approved a scope of practice policy allowing RN's to "administer sedating and anesthetic agents to produce moderate and deep procedural sedation" under the direction of a Licensed Independent

Practitioner. While special education and training are required, the nursing board feels these skills are easily obtained. Propofol is viewed as a sedative at lower doses, not an anesthetic.

Because propofol has changed the nature of gastroenterologic procedures so drastically, the GI endoscopy suite is probably the major arena outside the operating room where this issue is playing out. On October 19 the American College of Gastroenterology petitioned the FDA to remove

the warning from the propofol package insert that stated the drug "should be administered only by persons trained in the administration of general anesthesia and not involved in the conduct of the surgical/ diagnostic procedure." At the Indiana University School of Medicine, Douglas Rex, M.D., a gastroenterologist, has been the leading proponent of NAPS for several years. In 2003, he wrote "state laws or local institutional policies may prohibit NAPS, but these should relax as authorities and anesthesiologists become aware of the evidence base supporting NAPS." I personally have serious reservations for patient safety if NAPS becomes widespread in routine clinical practice, not only in our hospitals but also in ambulatory centers and offices where rescue by anesthesia personnel would not be immediately available.

The anesthesia community's response to this issue has had one consistent theme—Patient Safety. The ASA House of Delegates approved a "Statement on Safe Use of Propofol" in October, 2004 which basically describes the qualifications needed to administer propofol as well as referencing other appropriate ASA documents. On a state level, the PSA and PANA have issued a "Joint Statement on the Administration of Propofol to Unintubated Patients" providing an excellent summary of the safety principles which must be followed when using propofol for sedation.

Many concerns and questions regarding NAPS remain unanswered and deserve further investigation

and resolution. First and foremost, what credentials and level of expertise are required to safely administer propofol sedation? To define proficiency and adequately demonstrate skills, especially in airway management, can prove to be difficult. Passing an ACLS course is NOT sufficient by itself! Do we as anesthesiologists have a role in education, quality assurance, or policy formation? Will we even be asked? "Rescue" is the key element of safe patient care. The practitioner must recognize not only hypoxia, but hypoventilation, correct the cardio-respiratory problem, and return the patient back to the intended level of sedation. Equally important to this process is patient selection and procedure location. Who will establish appropriate patient exclusion criteria for NAPS? How will the safety profile of NAPS compare across different centers throughout the country?

In my opinion, NAPS is not ready for "Prime Time." However, the ball is rolling and will most assuredly gain momentum as the shortage of anesthesia providers and added cost of anesthesia services continue to be perceived as an obstacle by patients and physicians demanding the positive experience of procedural sedation with propofol. We, as anesthesiologists, must stay engaged and involved in this process to ensure patient safety is not compromised. Anesthesiologists will always be the experts in the field of sedation and airway management, and we must never step back from the leadership role we are required to perform for the sake of our patients and the medical community.

# Faces in Legislature Will Change Dramatically in 2007

by John P. Milliron, Esquire

The PSA has done a tremendous job in the last ten years getting to know their state House and Senate members. That will take some additional work beginning next year.

To date, over 30 members of the House and Senate have announced their retirements. Some of them have been very good friends of anesthesiologists and supporters of quality healthcare. Brett Feese of Lycoming County and George Kenney of Philadelphia are two excellent House members who have decided they have had enough. In the Senate, Noah Wenger of Lancaster and Joe Conti of Bucks are two outstanding people who will be sorely missed. There are many other examples too numerous to list.

With all of the controversy over last year's pay raise vote, it is the general consensus in Harrisburg that approximately 10 to 20 incumbent members could be defeated in this year's elections. Many of them who have not had any opponent in recent elections are now finding themselves with both a primary fight in May and a general election battle in November.

This places two important burdens on the members of the PSA. First—it is imperative that Z-PAC help its friends who are in tough battles. Many of these incumbents have been strong

believers in the precept that the administration of anesthesia is the practice of medicine. They have helped us in our fight to maintain supervision of nurse anesthetists in hospital settings. We cannot tell them when they are in major need of our help that we do not have the funds in our PAC. PLEASE—send a personal check today to Z-PAC so we have sufficient funds to meet these needs.

Second—if you are from one of the “open seats”—that is where there is no incumbent running—get to know the candidates. Are they pro-physician? Are they employed in any healthcare field? Do you know any of them personally? We must know more about these people so we can make a determination whether we should be involved in that particular election. A classic example of what could impact us is happening with ophthalmology—an optometrist in running for an open seat in the House in Wilkes-Barre. This is not something that bodes well for physicians.

Please call our lobbyists in Harrisburg at 1-800-822-6789. Give them any information that you might have. John Milliron, Ken Brandt, Jim Mann and Andy Goodman are there to assist you.

**And finally—make sure you are registered to vote—and then go out and vote on May 16th !!!**

## Medicare Reimbursement Guidelines for Anesthesiology Services Performed Concurrently with Medical Direction – Q & A

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blocks) in an area that is immediately available to the OR, and when the performance of such services do not prevent him/her from being immediately available to respond to the needs of the surgical patients.

**Question: What constitutes the “immediate area of the operating suite”?**

Answer: Differences in the geographic design and size of facilities, differences in the severity of illness, and the complexity and demands of the particular surgical procedures make this distance impossible to universally define. This said, the

anesthesiologist must remain close enough to the operating room to return to the operating room, if/when needed, in time to meet the needs of the patient, and most importantly, emergencies that may arise.

*Dr. Bloschichak is the Vice President and Contractor Medical Director for Highmark Medicare Services, Pennsylvania's Medicare Carrier*

*Drs. West and Martin are the Representatives from Anesthesiology to Pennsylvania's Medicare Carrier Advisory Committee*



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E-Mail: vbell@pamedsoc.org

- Contact Information Changes—  
email, address, phone number
- Newsletter Articles,  
Advertisements
- Web Site – Job Postings

### **Professional Office:**

Pennsylvania Society  
of Anesthesiologists, Inc  
Department of Anesthesiology  
Penn State University  
500 University Drive  
Hershey, PA 17033  
Tel: 717-531-6140  
Fax: 717-531-5449  
E-mail: psamail@psu.edu

### **For information on:**

- Society Policies
- Board of Directors/Meetings

### **Staff:**

Donald E. Martin, M.D.,  
Secretary/Treasurer