



## President's Message

by Erin A. Sullivan, M.D.

Our primary focus as anesthesiologists is to provide excellent care to our patients and at the same time to keep them safe. For those in academic practice there is an added obligation to teach the anesthesiologists of the future. This mission sounds very straightforward and even simplistic, however, there are many obstacles that jeopardize these basic ideals.

Shortly following my inauguration as President of the Pennsylvania Society of Anesthesiologists, I was invited to be the guest speaker for the Western Pennsylvania Society of Anesthesiologists, the local organization for practicing anesthesiologists, and anesthesiology residents and fellows in the Greater Pittsburgh area. I began my talk by conducting a straw poll of the audience. I asked how many were members of PSA and ASA and approximately one-third of the audience responded in the affirmative. I then asked how many had contributed to ZPAC and ASAPAC, the political action committees of the PSA and ASA respectively. Only a few attendees raised their hand! I concluded

my survey by asking how many felt that it was important for anesthesiologists to participate in the politics of medicine at the state and national levels and I was alarmed that only a handful of the audience responded positively! The remainder of my presentation focused on why anesthesiologists should be members of PSA and ASA and why we need to participate in the politics of medicine. I would like to share some of these thoughts with you, the membership of PSA.

CMS is scheduled to release the final rule for the 2007 Physician Fee Schedule on December 1, 2006. This means that effective January 1, 2007, all physicians will incur a 5% decrease in Medicare reimbursement. These cuts stem from the unfair Sustainable Growth Rate (SGR) formula. Anesthesiologists face an additional 8.7% reduction due to changes in practice expense methodology and redistribution of physician work values. This translates into a 13.7% reduction in Medicare payments to anesthesiologists and a national average anesthesia conversion factor of \$15.34 as opposed to \$17.77 in 2006.

Since 1994, CMS has unfairly penalized anesthesiology teaching programs. If an anesthesiologist in a teaching program works with two residents on cases that overlap, CMS imposes a 50% reduction in payment per case. This is very costly to our training programs ranging from lost payments ranging from \$400,000 to \$1 million annually. This makes it very difficult for our academic centers to recruit and retain high-caliber academic anesthesiologists and continue to advance important research initiatives. If the Medicare teaching rule is not fixed, the survival of many of our valued residency and fellowship training programs will be in jeopardy! There is proposed legislation in Congress to restore Medicare payments to our academic anesthesiology training programs: H.R. 5246, H.R. 5348 and S. 2990. Although there appears to be widespread Congressional interest to support this legislation, much more work lies ahead before any reform occurs.

The issue of whom should be granted privileges to administer deep sedation remains at the forefront of controversy and

continued on page 6



## Sentinel

Pennsylvania Society of Anesthesiologists Newsletter

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## Contents

### Presidents Message

Challenges anesthesiologists encounter that impact our patients and practices PAGE 1

### 2006 Elections Bring Some Big Changes in Legislature

Numerous upsets in both the House and Senate PAGE 3

### The Preoperative Evaluation—Revisited

A letter describing the anesthesiologist's perspective PAGE 4

### Annual District Director's Report

PAGE 5

### Deadline to Meet New CME Requirements Rapidly Approaching

PAGE 8

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# 2006 Elections Bring Some Big Changes in Legislature

by John P. Milliron, Esquire, Legislative Counsel

The Primary and General elections brought numerous upsets in both the House and Senate. The House will have 51 new faces while the Senate will have 5 new members. This is a brief recap of the results.

## State Senate:

There was no change in the state Senate numbers—the Republicans continue to hold a substantial majority. However, five of most senior members of the Senate were either unseated during the primary or chose to retire.

In Bucks County, Senator Joe Conti (R) was replaced by former state Representative Chuck McIlhinney (R); Luzerne County's Charlie Lemmond (R) was replaced by his former district office staffer Lisa Baker (R); and, Lancaster's Noah Wenger (R) was replaced by Mike Brubaker (R). Conti, Lemmond and Wenger all chose to retire rather than seek re-election. Senators Jubelirer (R - Blair) and Brightbill (R - Lebanon) were unseated during the primary and those seats were filled by John Eichelberger (R) and Mike Folmer (R), respectively.

Aside from McIlhinney, all of the new Senators would be considered "conservative." The

Senate currently has 29 Republicans and 21 Democrats.

## State House:

This is where most of the excitement was on election night. Even now, it is not 100% certain which party will control the House. The Republicans hold the House by the slimmest margin of 102-101. The key to control is in a suburban Chester County legislative district, formerly held by retiring Representative E. Z. Taylor. The Republican won by only 19 votes. That number will change as the absentee ballots are counted.

The biggest surprise in the House races came from Beaver County, as Mike Veon—currently the #2 guy in the Democratic Caucus—was unseated by Republican challenger Jim Marshall. Mike was one of only two Democrats that were unseated in the General Election. Representative Shawn Flaherty (Allegheny), who won a special election to fill the Jeff Habay seat, was taken out by Republican challenger Randy Vulakovich.

The Republican Caucus lost nine seats in the House. Five incumbent Republicans were taken out by their Democratic challeng-

ers; and, four open seats that were occupied by Republicans (in Allegheny, Center, Schuylkill and Berks Counties) shifted to the D's as well. Republican representatives that lost their general election bid include Representatives Good (Erie), Diven (Allegheny), Wright (Bucks), McGill (Montgomery), and Gannon (Delaware).

The loss of the Schuylkill County seat formerly held by Bob Allen was the most surprising. Allen was unseated in the primary by "ultra-conservative" Gary Hornberger. But, Hornberger's local party leaders worked against him in the general election, urging registered Republicans to support the Democratic candidate instead.

## House Leadership:

*Editorial Note: As we go to print, the Democrats had won a close Chester County seat by 21 votes. The Republicans had won it by 19 on election day. Absentee ballots made the difference. This gives control of the House to the Democrats by a margin of 102 to 101. However, the issue is going to court for a recount as we went to press.*

continued on page 8

## Interested in Membership on an ASA committee?

In December and January of each year, the American Society of Anesthesiologists accepts nominations from interested ASA members for positions on most of its 45 standing committees. The list of the committees along with their chairs and current members is available on the ASA website at [www.ASAhq.org](http://www.ASAhq.org) in the Members Only section. The procedure, and application forms, for committee membership are also available via this website. ASA encourages members to express their interest in committee membership by completing the online application forms. Alternatively, anyone interested in a position can obtain more information from Paul J. Schaner, M.D., ASA District Director from Pennsylvania, at [pschaner1@aol.com](mailto:pschaner1@aol.com), or Donald E. Martin, M.D., Alternate Director, at [dmartin1@psu.edu](mailto:dmartin1@psu.edu), or phone 717-531-6140. The due date for applications has not yet been established, but will likely be close to January 1.

# The Preoperative Evaluation—Revisited

Joseph F. Answine, M.D., President-Elect, PSA, Representative to the Specialty Leadership Cabinet of the Pennsylvania Medical Society, and Chair of the Professional Relations Committee

Edwin C. Gillman, M.D., Ph.D, Staff Anesthesiologist, Pinnacle Health Hospitals, and Medical Director, Susquehanna Valley Surgery Center

At the Pennsylvania Medical Society House of Delegates (HOD) in October, 2006 and within my own practice, the preoperative evaluation of patients continues to be an issue of discussion and concern. The HOD decided that a universal form for the preoperative evaluation of patients to be used

by all facilities within the state was impractical, and the standards should be set by the physicians and institutions. I suggested at the reference committee handling this issue that a letter describing at least the anesthesiologist's perspective of what is required for the preoperative evaluation of patients should be drafted to be used as

a guideline for anesthesiologists, surgeons, primary care physicians and surgical institutions throughout Pennsylvania. The committee agreed. My partner, Edwin C. Gillman, M.D., Ph.D, and I wrote an article for our primary institution, Pinnacle Health Hospitals in Harrisburg. It is published below.

Dear "name of physician",

The Anesthesiologists of Riverside Anesthesia Associates are very interested in clarifying our expectations for the preoperative evaluation of patients requiring surgery. Therefore, we are sending this letter to all of our surgical, cardiology and primary care colleagues.

First of all, it is not necessary for the consulting physician to provide "medical clearance." Our request regarding "medical clearance" is to first refrain from using the term. We, surgeons and anesthesiologists, have perpetuated the use of the wording "medical clearance" by frequently using it as a synonym for a preoperative consultation. Without having an extensive understanding of the operative procedure and in what setting it is to take place (hospital versus ambulatory surgery center), it would be an impossible task anyway. In a recent New England Journal of Medicine article, the term "medical clearance" was regarded as an "oversimplification of a patient's health status and as an indication of poor communication among clinicians." It has further been suggested that this label "may impede further medical care by implying that the patient has no physical health problems".<sup>1</sup> What we request prior to surgery is a better understanding of the patient's overall health and fitness for the procedure to be performed. Questions to be answered include: (1) What is the significance as well as the extent of the patient's disease processes? (2) Is the patient optimized medically? (3) If not, what can be done to optimize the patient's medical condition prior to surgery?

Why do we differentiate between procedures to be performed in a hospital and an ambulatory surgery center (ASC)? Frequently unknown by our consultants, The Department of Health of the Commonwealth of Pennsylvania limits ASCs to the care of physical status I, II and III patients, therefore, patients with more significant disease processes cannot have their procedures performed at an ASC regardless of the anesthetic technique. This means that patients may be in their usual state of health, and in optimal medical condition, but be inappropriate for treatment at an ASC. We have summarized some of the important issues regarding patient care in Pennsylvania ASCs in the attached document "Pennsylvania Ambulatory Surgery Center Requirements."

As you know, surgical procedures can be classified as low, moderate and high risk as an indicator of the various degrees of stress to a patient. For example, the physiological stress of a cataract removal, including both surgical and anesthetic stressors, is considerably less than that for an aortic aneurysm repair. However,

<sup>1</sup> "Case 5-2005—A 53-Year-Old Man with Depression and Sudden Shortness of Breath". NEJM 352:709-716

continued on page 10

# Annual District Director's Report

by Paul J. Schaner, M.D.

The Pennsylvania Society of Anesthesiologists (PSA) has the following membership:

Active Members	1,315
Resident Members	322
Retired Members	199
Affiliate Members	21
Honorary	1
Total	1,958

The PSA Board of Directors for 2006-2007 is as follows:

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While the number of anesthesiologists has increased slightly in Pennsylvania, the retention of other physicians in the state remains a problem. A recent study by the Pennsylvania Medical Society showed a physician shortage of 5,000 physicians as of 2005 and a declining number of physicians under the age of 35 over the past decade. While Pennsylvania continues to educate physicians, these physicians are no longer remaining in the state to practice. AMA data showed in 1994 50.5% of Pennsylvania residents remained to practice in the state but in 2004 7.8%

stayed to practice in Pennsylvania. Decreasing reimbursement, rising overhead and liability exposure are the key reasons. Access problems are inevitable without a reversal of physician retention and migration.

While there has been an effort to resolve the ongoing drive for scope of practice issues with the Pennsylvania Association of Nurse Anesthetist (PANA), they continue to push for increased scope of practice. They have re-introduced their bill for co-operation versus supervision. The bill has not come out of committee. They have threatened to add it to any other bill available; this has not happened at this point. Most recently they offered a bill, which would codify same pay as an anesthesiologist by the insurance companies. The payment has been equal in Pennsylvania. In hindsight the CRNA should be paid time units only exclusive of base units but equal pay has been an established Medicare policy. The PANA continues to be active to establish increased scope of practice.

This is an election year for many seats in Pennsylvania for the house and senate. The legislature had voted itself an unpopular salary increase that was later rescinded under great public pressure. Many of the incumbents were defeated in primaries, which will alter the composition of the legislative body. It will take a continued effort to insure that patient safety remains a priority among the new members, as has been the case with the former members. The need for member support and activity is as always a demanding priority. John Milliron Associates and our legal council Robert Hoff-

continued on page 11



Five of the Representatives to the ASA Resident Component House of Delegates from Pennsylvania. Left to right: Jason Bundy, M.D., Penn State University (secretary of the Pennsylvania Resident Component), Joshua Atkins, M.D., University of Pennsylvania (president of the Pennsylvania Resident Component), David Gayeski, M.D., Drexel-Hahnemann, Antia Malhotra, M.D., University of Pennsylvania



Dr. Schaner, District Director, congratulating Dr. Martin on his receipt of the PSA Distinguished Service Award. Left to right: Donald E. Martin, M.D., Stephen R. Strelec, M.D., Cathy Martin, Paul J. Schaner, M.D.



Robert F. Early, Jr., M.D. (right) at the conclusion of his remarks to the PSA membership as the outgoing president of the Pennsylvania Society of Anesthesiologists, joined by Joseph Talarico, D.O. (left), incoming co-chair of the PSA Committee on Insurance and Legislation.

## President's Message

continued from page 1

debate. However, the resounding response from the anesthesia community has always been, "patient safety first." The 2006 ASA House of Delegates approved the following resolution: "Because of the significant risk that patients who receive deep sedation may inadvertently enter a state of general anesthesia, privileges to administer deep sedation should

be granted only to practitioners who are qualified to administer general anesthesia or to appropriately supervised anesthesia professionals."

There are some non-anesthesiologist physicians without sufficient skills in airway management and without immediate access to rescue

by anesthesia personnel who advocate using agents such as propofol to provide procedural sedation to their patients. As the nationwide shortage of anesthesia providers persists and insurers and non-anesthesiologist physicians perceive the added cost of anesthesia services as an obstacle to procedural deep sedation with agents such as propofol, we as anesthesiologists must remain engaged and involved to ensure that our patients' safety is not compromised. PSA and PANA stand firmly behind this principle and issued a "Joint Statement on the Administration of Propofol to Unintubated Patients" with the Pennsylvania Association of Nurse Anesthetists in 2004.

Once again, Hollywood will do its best to exaggerate the concerns of our patients with regard to general anesthesia. Awareness under anesthesia will hit the big screen sometime in 2007. The movie "AWAKE" is described as a psychological thriller starring Jessica Alba as the wife of a young man who is traumatized by the experience of being awake and paralyzed during open heart surgery. This film will no doubt influence the public perception of the risks of general anesthesia and perioperative management by anesthesiologists. It is our responsibility to our patients to provide accurate information and alleviate anxiety about this important concern. ASA Communications Director, Gina Steiner, has asked for our help in getting the message out. The ASA Task Force on Intraoperative Awareness issued a report in 2005 that discussed intraoperative awareness in detail and issued recommendations for perioperative management. In conjunction with the American Association of Nurse Anesthetists (AANA) the ASA Task Force on Intraoperative Awareness has also compiled an excellent patient education brochure. These documents can be viewed online: <http://www.asahq.org/news/news102505.htm> and [http://www.asahq.org/patientEducation/Awareness\\_brochure.pdf](http://www.asahq.org/patientEducation/Awareness_brochure.pdf).

These are but a few of the challenges anesthesiologists encounter that impact our patients and practices. By now you might be asking, "How can I make a difference?" Election Day has come and gone. There are many new faces as well as seasoned political figures in the State Legislature and Congress who will need our guidance on the legislative issues pertaining

to all of medicine as well as those particular to anesthesiology. Education of legislators takes precious time and costs money. Now is the perfect time for you to become more involved in PSA! I urge you to consider becoming a "key contact" for your State Representative and State Senator. This is an opportunity to get to know your State Legislators on a more personal level through written and face-to-face communication on important issues. I also urge you to attend the PSA Legislative Reception on October 1, 2007 in Harrisburg following the Fall Meeting of the PSA Board of Directors. Not only is this an important forum to meet and speak with your own legislators, it is an opportunity to meet your other Pennsylvania colleagues. Take the time to visit the PSA and ASA websites ([www.psanes.org](http://www.psanes.org); [www.asahq.org](http://www.asahq.org)) to keep abreast of the latest breaking news for legislative and professional issues and send e-mail communications to your Legislators when you notice an "Alert" message (it only takes 5 minutes to send a message). Finally, please consider donating to ZPAC! PSA has an active membership of 1,200 anesthesiologists, more than 200 resident members and almost 200 retired members but the percentage of members who donate to ZPAC is exceedingly small. We will not have our message heard by the legislators without a strong PAC and we need your help to achieve this.

I am very honored to serve you and the PSA as President for the coming year. Together we can achieve our goals to deliver excellent patient care, provide outstanding education for our residents and fellows, and continue to keep our patients safe.



# Welcome New Members

## PSA Active Members

Amanda Brown, M.D.  
Joshua Constable, D.O.  
Dana Dellapiazza, D.O.  
Barry Ewell, D.O.  
Jeffrey Feldman, M.D.  
John Fiadjoe, M.D.  
Calin Gorun-Gorunescu, M.D.  
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Sudhakar Mannam, M.D.  
Bryan Matusic, D.O.  
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Anthony Nostro, M.D.  
Uma Parekh, MB, BS  
David Provenzano, M.D.  
Gregory Pruckmayr, M.D.  
Bala Raja, M.B., B.S.  
Melissa Rosenberger, M.D.  
Huy Tieu, M.D.  
Sonia Vaida, M.D.  
Jeffrey Wilson, M.D.  
Englok Yap, M.D.  
Eric Zander, M.D.

## PSA Affiliate Members

Claudia Benkwitz, M.D.  
Trina Huwe, M.D.

## PSA Resident Members

Ashley Agerson, M.D.  
Frederick Allen, M.D.  
James Altmann, M.D.  
Jonathan Anson, M.D.  
Carlos Artime, M.D.

Shariff Attaya, M.D.  
Emily Baird, M.D.  
Kara Barnett, M.D.  
Veena Basava, M.D.  
Ellen Basile, D.O.  
Dolores Beane, M.D.  
Jason Brainard, M.D.  
William Cameron, M.D.  
Theodore Colterelli, D.O.  
Brian Daniel, D.O.  
Geraldine Daumerie, M.D.  
Gregory deCardona, D.O.  
Mathieu DeSchutter, M.D.  
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Marc Fisicaro, M.D.  
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Marc Goldberg, M.D.  
Mario Grasso, M.D.  
Anna Greshner, M.D.  
Aseem Gupta, M.D.  
Kevin Halbe, M.D.  
Timothy Hall, M.D.  
Owen Halloran, M.D.  
Kathleen Harris, M.D.  
Chris Hayes, M.D.  
Hetal Hosalkar, M.D.  
Jevere Howell, M.D.  
Mary Im, M.D.  
Neelam Kataria, M.B., B.S.  
Manivaanh Keobounnam, M.D.  
Joseph Klein, M.D.  
Christina Klufas, M.D.  
Frank Knoll, M.D.

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Phong Le, D.O.  
Esteban Lugo, M.D.  
Paul Luu, M.D.  
Julie Ma, M.D.  
Saninuj Malayaman, M.D.  
Vasil Mamaladze, M.D.  
Eileen Manabat, M.D.  
Janaki Meyappan, M.D.  
Rusel Miller, M.D.  
Aaron Mory, M.D.  
Patrick O'Connor, M.D.  
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Ronen Shehter, M.D.  
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Samara Shipon, D.O.  
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Ty Weis, M.D.  
Gregory Weller, M.D.  
Sasha Williams, M.D.  
Allison Wolford, D.O.  
Mei Wu, M.D.  
John Zepp, D.O.

# Deadline to Meet New CME Requirements Rapidly Approaching

by Steven Whitehurst, M.D., Continuing Education Committee Chair

Your PSA Continuing Education Committee is providing links to low cost web based CME, including "Risk Management" topics.

Beginning with the January 1, 2007 renewal date, 100 hours from the preceding two years (January 1, 2005 through December 31, 2006) will be required for PA Medical License renewal. Up to 80 of those credit hours can be Category 2. Twelve hours of patient safety and risk management are required, and they can be either Category 1 or 2. Category 2 hours are obtained by self-study of materials beneficial to your practice and self-recording of the actual hours spent studying.

## 2006 Elections

continued from page 3

With the handful of Republican leaders that retired and the Democrats' #2 guy taken out in the general election, there was a lot of posturing over who would lead the two caucuses in the coming session. Leadership elections were held November 14th.

John Perzel (Philadelphia) and Sam Smith (Jefferson) will continue in their roles as Speaker and Majority Leader respectively. David Argall (Schuylkill) held on to his title as Republican Whip. And, Merle Phillips went unopposed as Caucus Administrator. New leaders include Sandra Major (Susquehanna) who was elected Caucus Chairperson; Jerry Stern (Blair) as Caucus Secretary; and, Mike Turzai (Allegheny) is Republican Policy Committee.

The most contentious race for the Republican Caucus was for Majority Chair of the Appropriations Committee (effectively, the #3 position for the R's).

The PSA's Continuing Education Committee has compiled a list of internet based resources to assist its membership in attaining CME credits. While there are thousands of hours of CME available online for little or no cost, this list focuses on sites related to Anesthesia, Pain, or Patient Safety / Risk Management. The annotated list provides a brief description, the cost, and a hyperlink to the site. Almost all the sites provide Category 1 credit with the completion of a post-study quiz. The links can be reached via the member's area of the PSA web site.

Five legislators announced their intentions to run for the position. In the end, the R's selected Mario Civera (Delaware) to serve in this powerful position.

Mario, who formerly served as Policy Committee Chairman and Professional Licensure Committee Chair, has a reputation for fairness, honesty and being an accomplished negotiator. He's been a great friend to us over the years.

Democratic Leader Bill DeWeese won re-election to that position and was successful in installing his slate of candidates to the various positions. Mark Cohen and Dwight Evans will continue their tenure as Caucus Chairman and Appropriations Committee Chair. Keith McCall (Carbon) will serve as the new Democratic Whip replacing Mike Veon. Todd Eachus (Luzerne) was unopposed in his run for Democratic Policy Chair. Frank Dermody (Allegheny) will be the new Caucus Secretary and Dan Surra (Elk) will serve as Democratic Caucus Administrator.

For help in documenting your progress towards the December 31st deadline, try using the Pennsylvania Medical Society's tracking tool. Navigate to the Pennsylvania Medical Society web page and look for "Tracker" under "CME" in the "Member Resource Center" ([www.pamedsoc.org/tracker](http://www.pamedsoc.org/tracker)). Also on that site under "CME" is a detailed FAQ that answers questions such as the difference between Category 1 and 2, the documentation requirements of each, and just about any other question you might have about the CME requirements.

## Professional Licensure Committee:

The House Professional Licensure Committee will see some very dramatic changes next session. The two chairmen (Gannon and Rieger) will not be back in the next session. The new Committee chairs will likely be selected from a handful of senior members looking to "move up" from one committee chairmanship to another.

Republican Committee members Allen and Stevenson, and Democratic Committee member Roberts also will not return next session. With the current seniority list, at least six other Committee members will not be back because they were elected to leadership a leadership position (Dermody and Major) or may be selected to chair another committee (Harhart, Nailor, Saylor and Schroder).

We will need to have a key contact in each of these new Committee members' districts. When the appointments are made in late January, please be willing to help if any of them are from your area.

# 2006 Treasurer's Report

## Pennsylvania Society of Anesthesiologists, Inc.

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

So far during 2006, the Society's income has exceeded expenses, and the Society's reserves have increased by \$161,512. Eighty-nine percent of Society revenue during 2006 has been from membership dues, and the total revenue is 9% higher than last year's.

However, Society expenses are also 3% higher than last year. A large part of Society expenses this year were directed toward Governmental Affairs (42%), as well as the expenses for organizing and attending statewide and national meetings (20%).

This year, the Board of Directors voted to use 5% of our revenue to provide support to Pennsylvania and national medical, educational, and

scientific organizations including the Pennsylvania Medical Society (to help fund the effort for tort reform), Foundation for Anesthesia Education and Research (FAER), Anesthesia Patient Safety Foundation (APSF), Foundation of the Pennsylvania Medical Society, Pennsylvania Association of Perianesthesia Nurses, and the Malignant Hyperthermia Association of the United States. The work of each of these organizations is important to the growth and development of our specialty, to the future of medical practice in Pennsylvania, and the safety of our patients.

Traditionally, the Society has had a very conservative investment strategy, with most of the Society's assets invest-

ed in a pooled Cash Reserve Investment Management account with funds of other Pennsylvania medical specialties. This fund has provided maximum security and liquidity, but relatively low return. As the Society's assets have grown, however, the need for liquidity in particular has diminished. Therefore, at its September meeting the Board decided to maintain reserves equal to approximately one year's expenses in a cash equivalent fund, and invest the remainder of the Society's funds in an investment fund managed by Fulton Bank with 75% invested in fixed income securities and 25% in equities, to improve annual return on investment while maintaining a high degree of security.

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# The Preoperative Evaluation—Revisited

continued from page 4

within reason, it is best to consider all procedures to be the same because any procedure can evolve into something more invasive and stressful. Therefore, the anesthesiologist will use the consultant's information as well as the known stresses and complications of the procedure to be performed to determine the optimal anesthesia care for the patient.

Furthermore, anesthetic techniques such as general anesthesia, monitored anesthesia care with sedation, or regional anesthesia should all be considered equal from a patient's stress and risk standpoint. They each have their own inherent risks, and one type of anesthetic technique may quickly be converted to another based on unexpected intra-operative events. Therefore, a recommendation of "sedation only" or "a spinal only" by the consultant can be difficult for us to follow. It also can be confusing to the patient when an anesthetic plan has to be changed by the anesthesiologist on the day of surgery.

We would appreciate some explanation regarding the evaluation of abnormal preoperative testing results. Abnormal findings on a preoperative study such as a chest radiograph or electrocardiogram (ECG) are new to us, because we, in many cases, are meeting the patient for the first time. If a test result is abnormal, it would be helpful for us to know if it is truly a new finding or something that has been present for years or thoroughly evaluated in the past.

Lastly, statements written on prescription pads or progress notes such as "cleared for surgery" without supporting information are too vague for us to be able to put together an appropriate anesthetic plan. Furthermore, a statement such as "cleared for surgery with moderate cardiac (or pulmonary) risk" is incredibly difficult for us to interpret. Instead, a copy of the note from the patient's last office visit as well as supporting test results would be appreciated. It is essential that you provide the actual results of your evaluation in order for the anesthesiologist to optimize the anesthesia technique as well as to decide whether the patient is a candidate for an ASC or would be better served within a hospital setting.

Regarding specific preoperative testing requirements, we have included copies of the current "Preoperative Testing Requirements for Ambulatory Surgery Centers" and "Preoperative Testing Requirements for Hospitals." Furthermore, regarding the cardiac evaluation, we have adopted the approach recommended by the ACC/AHA. This guideline is enclosed for your review. All documents and this letter are also available on our website at [www.riversideanesthesia.com](http://www.riversideanesthesia.com).

Thank you for taking your valuable time to review this letter. Please direct your questions or comments to any member of Riverside Anesthesia Associates or to the Directors of Anesthesiology at the various sites where we provide care for your patients. Furthermore, questions and comments can be posted at our website ([www.riversideanesthesia.com](http://www.riversideanesthesia.com)) or addressed directly by the Chief Anesthesiologist at Harrisburg Hospital by calling 782-3538. Your help is greatly appreciated.

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Enclosures: Preoperative Testing Requirements for Ambulatory Surgery Centers  
Preoperative Testing Requirements for Hospitals  
Pennsylvania Ambulatory Surgery Center Requirements  
ACC/AHA Preoperative Cardiac Risk Assessment

## Annual District Director's Report

continued from page 5

man have been most helpful in our political pursuits in Harrisburg. The other key ingredient has been ZPAC, the PSA PAC, and PSA.

Congratulations to Dr. Donald Martin this year's recipient of the Distinguished Service Award. Don has devoted many years of service to the PSA and continues to do so as Secretary of the Society and Alternate District Director. Carol Rose, M.D. has been appointed to the Board of Medicine

by Governor Rendell. Carol has been a past president of the PSA, Pennsylvania Medical Society and active with AMA. I am sure she will perform as well in her new role as she has in her past activities. I wish her well in this new endeavor.

The challenge of providing patient safety is the job of every physician. This is no longer assured when the only activity of the physician is to practice safe medicine. The adage all politics are local still is true. Physicians MUST involve themselves in local politics. Failure to do so will ultimately work to the disadvantage of physician and patient. Why doesn't somebody do something



*Erin A. Sullivan, M.D., takes office as the incoming president of the Pennsylvania Society of Anesthesiologists.*



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# Season's Greetings

from the PSA.