



Special Legislative Update Enclosed in This Issue

You Can't Have It All!

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

In 2007, a major motion picture will be released in the United States and the storyline is based on one individual's experience of being aware and paralyzed under anesthesia. "Awake" will dramatize painful awareness during surgery secondary to inadequate anesthesia. A synopsis found at multiple movie review web sites is that Awake is "a psychological thriller that tells the story of a man (Hayden Christensen) who suffers "anesthetic awareness" and finds himself awake and aware, but paralyzed, during heart surgery."

The production and expected release of this movie has led to much anguish and concern within the anesthesia world. However, I see it a little differently. If spun correctly, it can have a positive effect on the anesthesiologists of our state. How can this be? I hear with increasing frequency that the way to stop the rising cost of health care and improve the shortage of anesthesia providers, especially in rural areas or even in remote areas within a hospital, is to allow lesser trained medical personnel to provide the medical

services traditionally performed by anesthesiologists. Currently, our governor is implementing a plan (Prescription For Pennsylvania) to have lesser trained individuals providing health care in Pennsylvania based on his belief that it will accomplish the above goals. The plan will not accomplish either goal, but that discussion should be saved for another article and another theme. I see this as an opportunity to bring the general public into the decision process as to what the citizens of Pennsylvania want when it comes to health care, especially anesthesia. Do they want the very best that is available based on level of education and training, or do they want the "budget" or "bargain basement" anesthetic?

So, what does a movie really have to do with the distribution of health care? Awareness under anesthesia can occur whenever and wherever an anesthetic is performed, and in many cases it is virtually inevitable such as with critically ill patients undergoing cardiac surgery or patients with massive trauma. However, the

cases that make the national headlines usually involve some level of negligence. Negligence in general will most likely occur with the lesser trained and experienced practitioner. It is easy to assume that the risk of significant awareness under anesthesia is no exception. So, if you actually read the "prescription" for Pennsylvania, it may say "generic" or "substitution" permissible.

We as anesthesiologists in Pennsylvania must continue to educate our legislators, non-anesthesia colleagues as well as our patients. We have to continue to stress the importance of physician involvement with the anesthesia care of all Pennsylvanians. Patient safety is at risk and we took an oath to protect our patients above all else.

Of course, this is not isolated to anesthesia but involves just about every specialty of medicine. To all other specialists out there, if you want to change the wording a little and replace anesthesia with whatever specialty that is near and dear to your heart, feel free to do so. None of us are immune.



Sentinel

Pennsylvania Society of Anesthesiologists Newsletter

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The PSA Newsletter is an official publication of the Pennsylvania Society of Anesthesiologists Inc. Opinions expressed in this newsletter do not necessarily reflect the Society's point of view. All correspondence should be directed to:

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March ASA Board of Directors Meeting Highlights

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

The ASA Board of Directors Meeting was held in Chicago on March 2-3. The wintry weather made air travel challenging but endurance carried the day. **The Committee on Administrative Affairs** commended President Mark J. Lema for his extraordinary leadership, commitment and vision on behalf of ASA. President Lema's interim report stated the reason for our 8.9% cut even though congress blocked the proposed Medicare cuts. The Medicare conversion factor decrease applies only to anesthesia codes. As a result, anesthesiologists in pain medicine may have actually had an increase in total payments when reporting visit and consult services. Likewise critical care physicians saw an increase in E/M codes. In addition acute pain management and insertion of invasive lines saw smaller cuts than general anesthesia codes. When Medicare evaluated the estimated changes in total payments, these other services offset some of the O.R. anesthesia cuts and blunted the impact on "allowed charges." E/M services are about 40% of Medicare payments to physicians. The E/M changes were estimated to cost \$4 billion and by law whenever a change in payment is more than \$20 million annually, budget neutrality must be maintained. The other issue involved was a change in the method CMS uses to calculate practice expenses. The former system was complex and had many inaccuracies, one of which appears to have been an exaggeration of the cost of clinical staff used by anesthesiologists. The new method corrected this but with a reduction for practice expenses.

The ASA last spring convinced the Relative Value Update Committee and CMS to allocate new practice expense payments to all

anesthesia codes to account for the costs of scheduling anesthesia services. This resulted in about 1% or \$18 million to the specialty. ASA fought hard to keep the planned extra 5% reduction to the conversion factor and succeeded. ASA continues the battle to improve valuation of anesthesia work. CMS has again referred this to the RUC where it will be heard this spring. It is still a tough fight since every dollar gained by anesthesia comes from another medical specialist's payment because it is a budget neutral game. With the rest of medicine, ASA has successfully argued for a phase-in of a new practice expense system. ASA is working with the rest of medicine to conduct a survey of actual practice expenses and ASA has committed funds to help conduct this survey. ASA believes that the old data currently in use by CMS underestimates actual costs. Even with correct data CMS pays much less than 100% of practice expense costs on average. The battle goes on, cutting is still the order of the day.

Insurance payments for anesthesiology in the private sector are also under assault. Endoscopy is the latest challenge. This is stimulated by the large rise in demand for the service. The initial 5 base units was based on care to some of the sickest patients. Three major GI medical societies have publicly stated anesthesia care is usually unnecessary for routine endoscopy in healthy patients. In the spring of 2006, Aetna issued a policy limiting endoscopy coverage to patients with physical status ASA 3 or greater and those older than 65 or younger than 18. Those not qualifying would be paid at the moderate sedation rate, a value significantly less than the usual, bypassing the RVS payment

system. Aetna withdrew the policy following strenuous objections by ASA and individual anesthesiologists. Aetna sought outside input including ASA but did not budge from its decision to publish a medical necessity policy on anesthesia for endoscopy. ASA made numerous suggestions to broaden the number and types of patients to be covered. Aetna accepted some but not all of the suggestions. The following resulted with ASA input:

1. Markedly broadened the number of patients eligible for anesthesia coverage with full contracted payments for their anesthesiologist.
2. Simplified administrative reporting of qualifying conditions for patents not eligible by age or ASA physical status.
3. Decreased the need for post-procedure claim review and hence the associated payment delays.
4. Retained base plus time payments for patients not covered
5. Preserved the right to direct bill the patient for anesthesia care not covered by Aetna's policy.

ASA understands Aetna will be releasing a revised medical necessity policy for endoscopy in the near future.

The committee recommended and the BOD approved that the Committee on Professional Diversity develop a formal ASA Mentoring Program for Diversity.



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The Present Law on CRNAs

by Robert B. Hoffman, Wolf Block Schorr and Solis-Cohen, L.L.P.

Other articles in this newsletter discuss the changes Governor Rendell's proposed health care legislation would make to the practice of anesthesiology in general and the role of CRNAs in particular. This article summarizes

the current law as relates to the practice of CRNAs.

Not everything below may be clear because not everything in the relevant statutes and regulations is. In particular, although it would be nice if statutes and regulations on the same subject fit together neatly, these do not.



CRNPs vs. CRNAs

CRNAs are not CRNPs. Unlike CRNPs, CRNAs have at present no express statutory authorization to practice and no authorization to practice medicine, prescribe medication, or write drug orders.

Under the Professional Nursing Law, RNs in general execute medical regimens that physicians

have ordered. The practice of nursing expressly excludes "acts of medical diagnosis or prescription of medical therapeutic or corrective measures." RNs are not, in general, independent practitioners, i.e., with decision-making authority. CRNAs are RNs with extra training in anesthesia.

CRNPs are an exception to those basic rules: they can diagnose and prescribe in accordance with rules and regulations of the Nursing Board. CRNPs work "collaboratively" with physician supervisors, generally under the terms of a written collaborative agreement (which is mandatory if the CRNP is prescribing). "Collaboration" is a carefully defined statutory term that has elements of supervision. CRNPs have formal certifications issued by the Board of Nursing in addition to their RN licenses in general and must satisfy additional requirements to obtain that certification. They may use the designation "C.R.N.P." and that designation and area of specialty are indicated on the RN's license.

CRNAs are not considered as covered by the CRNP rules. CRNAs do not have statutory

recognition as a subset of CRNPs do (akin to a CRNP specializing in pediatrics) nor do they obtain special certifications from the Nursing Board. Instead, CRNAs exist and function under a 1976 Nursing Board regulation that includes the "administration of anesthesia" as a "proper function of a registered nurse" but limit those RNs who can do so to those who have extra training and have been certified by the Council on Certification or recertified as a Nurse Anesthetist by the American Association of Nurse Anesthetists. Instead of "collaboration," the term that is applicable to CRNPs under the statute, the CRNA regulations refer to "cooperation." "Cooperation" is a process in which the nurse anesthetist and the surgeon "work together with each contributing an area of expertise, at their individual and respective levels of education and training." "Cooperation" has, in some circles, been viewed as authorizing a more independent practice than "collaboration," and "cooperation," via a 1983 amendment, replaced the term "direction" that had been in the original 1976 regulations. Unlike

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PSA to Offer Online CME to All Members

Your Education Committee is currently developing web-based CME modules that will be accessed via the "Members Only" section of the PSA web site. These modules will play in a web browser and consist of a slide presentation and linked streaming audio and/or video. Category 1 CME will be granted upon the passing of an appropriate post-test. We need your help to assist with the development of appropriate topics. Please fill out and return by fax or email the enclosed survey regarding your CME needs. In addition, we need additional volunteers who are willing to share their knowledge with the rest of the society by agreeing to produce one of these modules on your area of expertise. Please indicate your willingness in an email to the Education Committee at psa@pamedsoc.org. The modules will be available in the CME section from the PSA website www.psanes.org.

Medical Students in the OR: An Opportunity NOT a Chore!

by Anita Malhotra, M.D., CA-2 PSA Resident Delegate,
and Joshua Atkins, M.D., Ph.D., CA-3 PSA Resident Component President

We have all had these days: You're in a long case, the patient is stable, and you have to read your next journal club article or get in some studying for the imminent boards. But now they've given you a medical student to entertain. A frequent tendency is to view instructing medical students as a chore, and to fail to see the experience as window of opportunity. Educating and conveying enthusiasm for your residency training and specialty is a means to advance the professions of anesthesiology and critical care. Another great benefit of teaching is that we often best recognize our own knowledge gaps only in the process of teaching others.

The current number of medical student applicants into anesthesiology residency programs has been steadily increasing over the last few years. According to the NRMP, over 1100 medical students matched into accredited residencies, a fourteen percent increase from the previous year with a majority of students matriculating from U.S. allopathic medical schools.

To sustain such momentum, it is essential that we play a major role in mentoring medical students to choose anesthesiology as a career. In an era where there are constant scope of practice issues such as mid-level providers vying for independence as well as non-anesthesia trained personnel

administering deep sedation, it is increasingly important that we maintain a strong presence in medical education.

Aside from being taught to intubate or place an IV, the student often participates little in the administration of the anesthetic. This is where resident input will make or break a student's sole week in Anesthesia 101. With such limited exposure to the field, it is crucial to make an impression early. Instead of letting them go home early or get coffee, involve the students in intra-operative management and highlight how understanding our field can help their careers regardless of specialty. Talk for five or ten minutes on any number of topics such as: choice of induction agent, pre-operative machine checks, decision algorithm for airway management, use of neuromuscular blockers, or operating room communication.

Many students have just finished their physiology or pharmacology courses. Demonstrate how principles they have learned are applied in the operating room under general anesthesia every day. Such examples include auto-regulation of blood pressure, end organ perfusion, arterial and central pressure wave forms, and function and manipulation of the autonomic nervous system. Emphasize how these principles form the basis of patient management in all fields

and can highlight the true breadth of knowledge anesthesiologists apply daily.

Take a moment to explain the anesthesia care team model, the role of the nurse-anesthetist, and the importance of physician directed anesthesia care.

Talk about the anesthesia-teaching rule, advocate medical student membership in the ASA (it's free!), and provide information about the Anesthesia Patient Safety Foundation (www.apsf.org), the Surgical Care Improvement Project (www.medqic.org/scip), or opportunities with the Foundation for Anesthesia Education and Research (www.f aer.org).

Most medical students are eager to participate and more than willing to learn anything we can teach them. If we can show them how much we enjoy what we do, there is a good chance that they will enjoy it as well. It also gives us a chance to inform people what exactly it is that we do and make our specialty less nebulous in the eyes of the public.

We stand only to gain from spending a few extra minutes of our day with students. Knowledge of our specialty is perpetuated and we may perhaps even inspire a few to continue and choose anesthesiology as a career.



Payroll Deduction for Z-PAC

by Richard O'Flynn, M.D., Vice President, Society Hill Anesthesia Consultants

Just because you do not take an interest in politics doesn't mean that politics won't take an interest in you. - Pericles (430 B.C.)

Nearly every special interest group has a Political Action Committee. Z-PAC, the Political Action Committee of the Pennsylvania Society of Anesthesiologists, was formed in order to provide financial support to candidates who support safe anesthesia care in Pennsylvania. Z-PAC is non-partisan and contributes to candidates of both parties who are supportive of our issues regarding safe anesthesia care. Our PAC allows us to have a voice in Harrisburg in deciding how anesthesia will be delivered in the future. As we have heard many times in the past, "Either be at the table or on the menu."

Realizing the importance of supporting Z-PAC, my group started payroll deduction in May 2004. We initiated payroll deduction realizing that the reason most physicians didn't contribute to the PAC was mainly because they simply forgot

when they sent the last check. We wanted to set up an automated process that would eliminate the annual reminders and appeals. We now have 100% participation of all physicians (shareholders and non-shareholders) with an average contribution of \$20 per bi-weekly pay with a range of \$5 - \$50 per pay. Even small amounts, contributed regularly, add up over time. *Every dollar counts!*

There are now 5 groups in Pennsylvania who allow payroll deduction for Z-PAC. Approximately 160 physicians contribute to Z-PAC through their group's payroll deduction process. We have all realized the importance of the political process and have made it easy to get involved.

The process for payroll deduction is the same as for your 401K or benefits deductions; however, the PAC deduction is taken from after-tax dollars. In order to meet state reporting requirements, a list of all contributors must be on file with Z-PAC. A corporate check for the total amount is then sent to Z-PAC on either a monthly or quarterly schedule.

At this critical time for health care in Pennsylvania, the time has come for increasing our voice in Harrisburg. This is done through a strong well-funded PAC. Payroll deduction accomplishes this in an easy way. Once the voluntary decision is made to participate, the contribution continues regularly. This regular contribution also enables the Z-PAC Board to better plan financial contributions.

I would encourage all anesthesiologists to have their groups consider implementing a regular contribution process through payroll deduction. For groups that feel they are too small to participate in a payroll deduction process, Z-PAC is also able to set-up individual credit card or checking account deductions on a regular basis.

For further information on setting up a payroll deduction process, or enrolling in a scheduled checking account or credit card program, you can contact either the PSA lobbyists – John Milliron, Andy Goodman or Jim Mann at 1-800-822-6789 or myself (Roflynn@shac.cc).



Welcome New Members

PSA Active Members

Matthew Bellew, D.O.
Jason Brannen, D.O.
Marco Cantini, M.D.
Priti Dalal, M.D.
Mai-Li Dong, M.D.
Eva D. Hayden-Easley, D.O.
Michael Kentor, M.D.

Tanis Pendleton, M.D.
Brenda Raphael, M.D.
Tetsuro Sakai, M.D., Ph.D.
John Shutack, D.O.
Paul Stricker, M.D.

PSA Affiliate Member

Nabil Elkassabany, M.D.

March ASA Board of Directors Meeting Highlights

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The Committee on Professional Affairs, Asa Lockhart, M.D., had established and worked with the Business Management Certificate program 6 years ago. The success of the program has been reflected in the increasing number of participants and since it was started, produced a profit of \$500,000 to ASA. He has not received any compensation for his services. He has been instrumental in establishing a liaison with Auburn University which will accept credits from the CBA certificate program upon admission to the Auburn MBA program. Robert Johnstone, District Director from West Virginia, has also been active with the certificate program.

CPOM, the Committee on Performance and Outcomes Measurement, has the broad responsibility for oversight of ASA initiatives to measure clinical performance and outcomes. They are to create mechanisms to support practice management programs, improve communications and marketing of the specialty along with identifying and promoting professional opportunities. The committee is also to develop mechanisms for measuring performance and clinical outcomes.

Ron A. Gabel, M.D., a long standing member and past chair of CPOM, continues to represent ASA on the AMA physician consortium for performance improvement (consortium). The consortium cur-

rently uses an evidence-based approach to develop performance measurements. These measures are aimed at performance improvement and accountability. In 11/06 the consortium convened and its Anesthesiology/Critical Care workgroup considered proposed measures.

1. Maintenance of normothermia
2. Prevention of stress ulcer diseases in ventilated patients.
3. Prevention of ventilator associated pneumonia
4. Prevention of catheter related bloodstream infections.

All of these were presented to the House of Delegates in 2005 or 2006.

The Committee on CPOM recommended and the BOD approved that the ASA investigate the desirability of acting as a clearinghouse for performance data by applying the modular database design described by the "Guiding Principles for the Management of Performance Measures" by the ASA.

The Committee on Scientific Affairs recommended and the BOD approved a new Anesthesia Patient Safety (APS) CME program. The object is to offer a CME credit Web-based APS program that is based on ASA's standards, guidelines, and practice parameter. It will meet the unique practice needs of anesthesiologists. The program will also maintain the certification needs of anesthesiologists. The proposed APS Editorial Board will create a 20 CME credit, 40 case series of patient safety modules for Web-based delivery. If the 2007 ASA House of Delegates approves, the program will be available January 2008.

The Committee recommended and the BOD approved a pilot

program authored by the Task Force on Smoking Cessation. Elements include the following: asking patients about tobacco use, advising them to quit, then referring them to telephone quit lines that provide expert counseling support, available free to all in the USA. The brief tobacco interventions such as this can be reimbursed separately through Medicare for patients with smoking-related disease. The Task Force will develop member guidelines for this reimbursement. The Task Force is to report the outcomes of the pilot project at the 2008 interim BOD meeting.

A Model Policy for Organ Donation after cardiac death was referred back to the Committee on Transplant Anesthesia for further refinement.

The Committee on Finance and the Resident Component recommended with BOD approval that the Medical Student Delegation be recognized as a Medical Student Component and function as a component society with ASA separate from the Resident Component. FAER recommended an increase of \$500,000 in 2007 for two additional training grants and the growing Medical Student Anesthesia Research Fellowship Program. The Committee recommended and the BOD approved \$250,000 each from ASA and FAER.

The 2007 budget deficit is estimated to be \$278,140 at the present time. Typically by year's end this deficit is markedly narrowed.

The Present Law on CRNAs

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CRNPs, it does not appear that CRNAs have authority to write prescriptions or drug orders.

[As an aside, but one that shows the importance of an active and involved PSA, the PSA president in 1983 recently shed light on this history. He wrote, “Unfortunately, we were quite naive then—we had neither a legal counsel in Harrisburg (a lawyer from Ballard Spahr in Philadelphia had moved to a Baltimore firm and moved our account with him; that was our mistake!) nor a lobbyist.”

CRNA's Scope of Practice vs. DOH's Hospital and ASF Regulations

The Nursing Board regulates RNs, CRNPs, and CRNAs, but the Department of Health (“DOH”) establishes the standards hospitals and ASFs must meet to obtain and maintain their licenses. Even if the Nursing Board rules authorize a nurse to perform certain tasks, as a practical matter, the nurse can do so in a hospital only if the DOH hospital licensing regulations permit it.

In a **hospital**, the DOH rule is that “anesthesia care shall be

provided by a qualified physician, anesthesiologist, resident physician in training, dentist anesthetist, [or] *qualified nurse anesthetist under the supervision of the operating physician or anesthesiologist.*” The magic word is “supervision,” not “cooperation.” Similarly, every patient requiring anesthesia must have a pre-anesthesia evaluation “by a physician or by a qualified person under the *supervision* of a physician.” CRNAs (and dental anesthetists) function in hospitals under the “overall direction” of either the director of anesthesia services, when a full-time anesthesiologist heads the anesthesia service, or the surgeon or obstetrician responsible for the patient’s care when there is not. Finally, when the operating/anesthesia team consists entirely of non-physicians, DOH requires that a physician be “immediately available” in case of an emergency, such as cardiac standstill or cardiac arrhythmia.

In an **ASF**, the rules are generally similar. The same basic groups—anesthesiologists, physicians, CRNAs, dentist anesthetists, dentists or podiatrists—can administer anesthesia. When a non-physician does so, the anesthetist must be under “the *overall direction* of an anesthesiologist or a physician or dentist

who is present in the ASF.” In ASFs where an anesthesiologist is present, the anesthesiologist is to be the Director of Anesthesia Services and be responsible for directing the anesthesia services and establishing the general policies and procedures for the administration of anesthesia in the ASF. In ASFs where there is no anesthesiologist, a physician or dentist must fill that rule and have comparable responsibilities.

Medicare, Briefly

Medicare sets “conditions of participation” that hospitals must meet to receive reimbursement. Medicare requires that anesthesia services be “under the direction of a qualified doctor of medicine or osteopathy” and that anesthesia be administered only by a qualified anesthesiologist; a physician or osteopath (other than an anesthesiologist); a dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law; or a CRNA who is under the *supervision* of the surgeon or an anesthesiologist who is *immediately available* if needed. A state can waive the requirement for physician supervision of CRNAs, but Pennsylvania has not done so. The Medicare rules are quite similar to DOH’s hospital rules.



Pennsylvania Society of Anesthesiologists

Legislative Reception

Monday, October 1, 2007 • Harrisburg Hilton & Towers

8:30 a.m. - 4:00 p.m.

PSA Board Meeting

5:00 p.m.

Legislative Briefing for PSA Members

6:00 p.m. - 8:00 p.m.

Legislative Reception with Legislators

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Is Your Voice Fully Represented in the AMA House of Delegates?

by Carole E. Rose, M.D.

As a member of the ASA delegation to the AMA the following item is of interest to me and I hope will be of interest to you. Currently the ASA delegation has 9 members and could potentially increase its numbers if we have more members choosing to have the ASA represent their interests to the AMA. At this time the ASA delegation is the third largest delegation of all AMA Specialty Delegations behind the American Academy of Family Physicians and the American College of Obstetricians and Gynecologists. If you are an AMA member and have not ever placed your vote on this issue, I hope that you will go to the web site noted below and complete your ballot.

Is your voice fully represented in the AMA House of Delegates? There are 109 national medical specialty societies seated in the policy making body of the AMA—the AMA House of Delegates. Which specialty society best represents your voice?

If you are a physician member of the AMA (or in your fourth year of medical school), you are strongly encouraged to select the national medical specialty society you feel best represents you in the AMA House of Delegates. For every 1,000 AMA members who select them, national medical specialties receive one additional delegate.

This is your opportunity to help shape health care policy and the positions of medicine's most influential organization. Make your voice—and the voice of your specialty—as strong as it can be. Making your selection takes just a few moments. Visit the AMA web site <https://ssl3.ama-assn.org/ssballoting/login.jsp> to indicate your choice today.