



President's Message

Anesthesiologist or Doctor of Peri-Operative Medicine?

by Joseph F. Answine, M.D., President, Pennsylvania Society of Anesthesiologists

A recent national survey by the ASA demonstrated that there is a general lack of awareness about what an anesthesiologist does. The survey included patients and other health care professionals. I can believe it. I remember when I told my mother that I was going to be an anesthesiologist. Her initial response was that she thought that I was going to be a doctor. This, as I also found out, appears to be a common misunderstanding by mothers.

Based on the first paragraph of this article, is it more appropriate to call ourselves doctors of Peri-Operative Medicine? What is in a name? Why does it matter? It shouldn't matter at all, however in this day when our roles as health care providers have been clouded, it may. Many advanced practice nurses are choosing to complete their doctorate and appear to be quite comfortable calling themselves "doctor" while in the hospital. Whether physician versus non-physician or one specialist versus another, the lines are becoming blurred. In the future, we may need to identify ourselves more broadly and clearly. "Peri-operative physician" or "doctor of

peri-operative medicine" may then replace the title "anesthesiologist."

Hang in there with me as I try to piece this together. First of all, what makes a physician? It's not our keen business sense. Some of the worst business advice that I ever received came from my partners. It's not the way we dress, at least for anesthesiologists. We wear pajamas. Obviously it's education and experience. But all educational pursuits and all experiences are valuable. It's the difference in the education and training that makes a physician. We are trained for the "what if's." A brand new first-year anesthesia resident has a plan "A." Plan "A," however, is the easy one. It's putting together the plans after "A" that define us as physicians. We need to have a plan with an expected result. We also need plans for the unexpected results that may occur. Expect the unexpected, and adjust to the new situation. That is what makes a physician. We, as anesthesiologists, are masters of not only the art of having multiple plans for multiple scenarios, but being able to implement them quickly in the ever changing world of the operating room.

Do we provide anesthesia directly? Of course we do. Do we put together an anesthesia care plan, and then implement it either directly or while supervising a CRNA? We do it daily. When most people think of an anesthesiologist, they probably think of an individual providing anesthesia. Hopefully, they recognize that we are physicians as well. Regardless, they likely picture an individual sitting in an operating room dialing in the anesthetic and intensely watching the vital signs on the monitors. That is an important function of an anesthesiologist, but is it how we want to define ourselves for the future? Our work begins early in the pre-operative period and ends long after we leave the operating room. We are commonly involved with the work-up of our patients; especially those that are more critically ill prior to coming to the operating room, and frequently care for the patients long after surgery, whether as acute pain management specialists or intensive care physicians. We also may be caring for them long-term in chronic pain clinics.

Now, how does what we do compare to other physicians?

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Sentinel

Pennsylvania Society of Anesthesiologists Newsletter

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Specialty Leadership Cabinet Report

by Joseph W. Galassi, Jr., M.D., Representative to the Specialty Leadership Cabinet of the Pennsylvania Medical Society

On Tuesday, May 20, 2008, the Pennsylvania Medical Society Specialty Leadership Cabinet (SLC) met for its Spring Meeting. As I discussed in my last article on the SLC, this group is the venue whereby we can bring issues affecting our various specialties to the table with our other physician colleagues.

There were several legislative and regulatory priorities that were discussed at this meeting. They included a status report on proposed CRNP Practice Regulations. As you may recall, part of Governor Rendell's plan to expand health care for all Pennsylvanians included the expansion of the scope of practice of many "mid-level" allied health professionals. One law that was passed dealt with CRNP's. As of the time of the meeting, the details of the expansion of CRNP scope of practice were still not finalized. Suffice it to say that the Pennsylvania Medical Society was and is trying to limit the proposed changes that the nursing board came up with after the Pennsylvania Medical Society supported the bill.

Mr. Light, lobbyist for the Pennsylvania Medical Society, presented an update on the status of SB 1137 regarding MCARE & COVERAGE for the Uninsured. At the time of the meeting, there was still a little bit of hope that the state legislature would move on this topic before their summer recess. Again, suffice it to say that the Pennsylvania Medical Society will be addressing this issue again in the fall.

The possibility of the Certificate of Need (CON) in PA was revisited. The Pennsylvania Medical Society learned this past

spring that Governor Rendell was considering issuing an executive order to establish a commission to assure that "capital investments in health care will meet the current and projected needs of the communities they serve." As background, the CON program began in PA in 1979 and sunsetted in 1996 when the legislature did not take action to continue it. An example of the result of this law sunsetting, PA specific data shows that ambulatory surgery centers quadrupled between 1996 and 2005.

The next significant topic of discussion was the mention of Independence Blue Cross and Highmark Blue Shield's Quality Improvement Proposal Projects. The three medical conditions that they tentatively agreed to consider are pediatric asthma, colorectal cancer screening, and back pain. (As follow-up to this meeting, PSA has made it clear that we will provide input if and when asked regarding these or any other conditions that may affect our membership.)

Finally, the last topic that garnered a good deal of time during the meeting is the development of a new program offering clinical skills assessment and remediation services to physicians. The program is entitled LifeGuard and, at the time of the meeting, had already taken it's first physician. This program looks to be one that can be of significant help to the impaired physician. Of note, impaired includes not only addictions but also physical and mental conditions that can affect a physician's performance such as a stroke, depression, etc. The program includes a full assessment of the physician's current



practice situation and develops a plan that can either recommend modification of medical practice or possibly the discontinuation thereof. The program works with the individual physician through the remediation process to establish a state that is safe for both the physician and his/her patients.

The meeting ended with a request for nominations for the three specialty trustee seats on the Pennsylvania Medical Society Board of Trustees. There are three incumbents eligible for re-election, one in Psychiatry, one in OB/Gyn, and one at large, presently a neurosurgeon.

The next meeting of the Pennsylvania Medical Society SLC will be held on September 16, 2008.

Fall Board of Directors Meeting

Sunday, September 28, 2008

8:30 a.m. - 3:00 p.m.

Bedford Springs Hotel

2138 Business Route 220

Bedford, Pennsylvania

Note: All active PSA members are welcome to attend; however, if you plan to attend, please notify Dr. Vlahos via e-mail at vlahosdo@aol.com at least one week in advance to allow him to make arrangements with the hotel.

PSA: 12 Month Overview

by Joseph F. Answine, M.D., President, Pennsylvania Society of Anesthesiologists

The year has moved along very quickly. What have we accomplished? First, I would have to say that I accomplished only a small part of what I hoped to achieve during my tenure as our society president. I assume that I had “delusions of grandeur” in my quest to cure all the ills of medicine in Pennsylvania. So, what did we achieve?

- 1) The Pennsylvania Society of Anesthesiologists, due particularly to the efforts of our lobbying firm, Milliron and Associates, has been extremely successful in opposing bills which were introduced in both our State House and Senate, as part of our governor’s Comprehensive Healthcare Reform Plan, and which would have significantly diluted the supervision requirements for CRNAs.
- 2) We have embarked on some very significant discussions with the Pennsylvania Association of Nurse Anesthetists. The discussions were initiated by the PANA, and involve strengthening the anesthesia care team and keeping the administration of anesthetic agents in the hands of anesthesia providers.
- 3) The PSA mounted a successful campaign with our Medicare Carrier Medical Director, Andrew Bloschick, M.D., to oppose efforts by CRNAs to receive reimbursement for fluoroscopically guided nerve blocks, and for physician evaluation and management services associated with acute and chronic pain management.
- 4) The PSA worked both within Pennsylvania and as part of

the “GA Alliance” involving physicians across the Mid-Atlantic States to successfully retain reimbursement from private insurers, particularly Aetna, Humana, and Health America for anesthesia services provided for routine endoscopy. We recognize that this gain is only temporary, and that denial of reimbursement has just been delayed. However, on July 25th, 2008, Eisai Corporation of North America received a not approvable letter for fospropofol from the U.S. Food and Drug Administration (FDA). Approval of this drug would have given the private insurers a way to again consider not reimbursing for anesthesia services for endoscopy.

- 5) Under the leadership of Joseph Seltzer, M.D., and a committee of 10 prominent PSA members and leaders, the Society has developed a comprehensive strategic plan to guide our progress over the next 5-10 years. The plan incorporated a comprehensive mission statement and strategic priorities encompassing advocacy, enhancing the identity of our specialty, supporting member education and practice management training, and enhancing the infrastructure of our Society.
- 6) The Pennsylvania Society of Anesthesiologists engaged a Central Pennsylvania marketing firm, Cimbrian Inc., to develop a brand position, public relation strategy, and marketing plan for our specialty within Pennsylvania. Our efforts parallel those of ASA.

- 7) This year, we initiated the concept of regional membership meetings throughout the state. Successful meetings were held in Pittsburgh, Harrisburg and Philadelphia.
- 8) An effort that has been extremely important to our Society’s overall efforts is the establishment of a formal structure, by-laws, officers, and a state wide organization including a Physician’s Advisory Board for Z-PAC, our society’s political action committee. These organizational improvements will enhance Z-PAC’s ability to reach more members, increase contributions, and respond more effectively with timely contributions to state legislators.
- 9) Lastly, we are pleased to say that PSA membership continues to grow, with increases in the active membership to 1,412, resident membership to 260, retired membership to 200, and total membership to 1,887.

What has yet to be achieved?

Too much to count, however, a few things come to mind. We need to continue to work on everything positive that we started over the last year, we need to continue to work on improved reimbursement from all third party payers for anesthesia services, we need to continue to fight for MCARE abatement without ties to a state-wide health care plan, we need to continue to reach out to all PSA members throughout the state and let them know that their opinions and views count, and we need to continue to improve on access to PSA member services especially through our society web site.

ASA Board of Directors Highlights – Dues and Member Services

by Donald E. Martin, M.D., District Director, American Society of Anesthesiologists

The ASA Board of Directors met during the weekend of August 16-17, and many of the actions taken at this meeting expanded services to present and future ASA members.

Perhaps the most sweeping and potentially the most expensive action established an “**ASA Quality Institute**” with an initial cost of \$750,000. Requirements are already in place for anesthesiologists, as well as other physicians and hospitals, to report an increasing volume of quality data. ASA has been working for some time to establish a data collection and reporting infrastructure to meet this need. The “Quality Institute” is the result of these efforts, and will provide anesthesiologists and others a means to collect and report quality data related to anesthesia using a standard nomenclature and set of measures established for our specialty. The Institute is being established as an independent 501 C (3) corporation to allow it to operate as a non-profit corporation and take advantage of associated tax benefits. It will provide services to individual physicians but primarily to hospitals and health care facilities, with the associated fees providing an eventual revenue source to ASA. It will also provide a source of national quality data to help ASA establish benchmarks for the specialty, and provide a powerful research tool. However, the initial and ongoing costs of this venture are huge, and will likely reach several million dollars over the next several years. Initial market analyses will determine whether the Institute will

build its own data warehouse, will contract with one of several large corporations already in this business, or partner with other related organizations, such as the American College of Surgeons, who are undertaking similar efforts.

ASA is beginning to embrace a broader definition of health—a state of physical and mental well-being of its members, beyond the simple absence of disease, and is expanding its efforts to improve **services designed to maintain member “Wellness.”** Very specific programs are already in place to serve residents and aging members, to prevent exposure to occupational hazards in the workplace, to prevent and respond to chemical dependency. A broader approach is planned to support programs for:

1. **Promotion** of healthful lifestyles;
2. **Prevention** of unhealthy lifestyles, injury, infectious disease and other occupationally related illnesses;
3. **Detection** of injury, stress-related and substance related disease;
4. **Intervention** for psychiatric disease, stress and substance related disorders; and
5. **Rehabilitation** for disability, psychiatric and substance related disorders.

As an initial step, \$300,000 was approved to support loans and grants through the Anesthesia Foundation to assist members who experience financial need because of such things as job-related losses or even natural disasters such as hurricane Katrina. In addition, web site

resources and a “hot line” are planned to maintain member wellness and support members in time of need.

Finally, as a service to non-ASA members and another source of revenue to ASA, **courses are being designed to provide training in the administration of moderate procedural sedation** for non-anesthesiologist physicians, nurses, and other health professionals. This program, somewhat analogous to the American Heart Association’s Basic and Advanced Cardiac Life Support courses, would provide quality training to meet the needs for credentialing/certification in sedation management now being required for medical personnel by facilities and accrediting organizations.

All of these programs, as well as increased operating costs and increased value of the current “free” services now received by ASA members, will likely require the first **membership dues increase** since 2000. Inflation alone in that time period would have led to an increase in dues from our current \$450 to approximately \$575 for active members. Therefore, to include enhanced services, a dues increase from \$450 to \$600 for active members, and from \$75 to \$300 for affiliate and educational members, has been proposed. Though many of the programs which are being started will generate revenue which will be vital for ASA, and which will hold down dues in the future, this revenue is still several years away. Thus, this dues increase will represent an investment in the future.

Communications Committee Report

by Paul J. Schaner, M.D., Communications Committee Chair

This fall the PSA website will be revamped under the direction of Webmaster Ed Dench, M.D. The address is www.psanes.org in the event you have not visited the

site in recent times. You will be able to compare it to the coming renovation. An easy update is currently available for your e-mail address. This is used **ONLY** for PSA business. E-mail is the

fastest, most cost effective means of communication with you. Please make sure the PSA has your current e-mail address. Your help is greatly appreciated.

Bureau of Workers' Compensation Repricer and Provider Training Seminars

The Bureau of Workers' Compensation is holding their Repricer and Provider Training seminars in September and October. The Repricer program is strongly recommended for anyone involved in repricing Pennsylvania workers' compensation medical bills or supervising staff/venD.O.s. The seminar will cover appropriate medical billing,

understanding and correct utilization of the fee schedule, payment requirements under the Workers' Compensation Act and regulations, and several technical issues.

The Provider Training program aims to assist medical providers with accurate billing, D.O.cument charges, and payment and denial issues. Attendees will receive information on the fee review pro-

cess and utilization, as well as an overview of workers' compensation and its purpose. The seminar provides a clearer understanding of the law and requirements.

For additional information, please refer to the Bureau of Workers' Compensation website at <http://www.dli.state.pa.us/landi/cwp/view.asp?a=138&q=246151>.

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Z-PAC Update

by Richard P. O'Flynn, M.D., Z-PAC Treasurer

Over the past year, there have been many changes in Z-PAC, the Political Action Committee of the Pennsylvania Society of Anesthesiologists.

The biggest change has been the election of officers and the appointment of an advisory board. It was felt that an advisory board would bring increased geographical diversity to the committee. The role of advisory board members is that of a liaison between the PAC and the anesthesiologists and elected representatives of their area.

The PAC also holds a biennial reception in Harrisburg. Our lobbyist group does an excellent job organizing this event. The reception last year had the largest turnout of anesthesiologists and elected officials in recent memory. All of the PAC committee and PSA Board extend their thanks to the Society members who took the

time to participate in this worthwhile event.

Finally, the payroll deduction process for PAC contributions continues to expand. The following 10 groups offer the payroll deduction option to their employees:

- Allentown Anesthesia Associates
- Associates in Anesthesia
- Anesthesia Specialists of Bethlehem
- Anesthesia Associates of York
- Beaver Anesthesia Associates
- Reading Anesthesia
- Society Hill Anesthesia Consultants
- United Anesthesia Associates
- West Shore Anesthesia Associates
- Western Pennsylvania Anesthesia Associates

This ongoing support of the PAC has enabled us to remain active in Harrisburg in this important election year. We thank the

contributors to Z-PAC and ask that each of you encourage all the members of your group to participate. At this critical time for health care in Pennsylvania, the time has come for increasing our voice in Harrisburg.

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

For further information on setting up a payroll deduction process, you can contact either the PSA lobbyist (Milliron Associates) or me. Additional information can also be found on the Z-PAC page of the PSA website (www.psanes.org/Zpac.html).

Z-PAC Contributors

Thanks to the following Anesthesiologists who contributed to Z-PAC since January 1, 2008:

Please note: If you have contributed and are not listed, we may not have credited your donation within the time interval in which payments were posted.

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Brian Melamed, M.D.
Luis Mercader, M.D.

State Senator Mike Folmer and his staff visited the Hershey Medical Center in June.

*Rear, left to right:
Sheilah Borne, Kenny Brandt, Fred Sembach, State Senator Mike Folmer, Needy Beigh, and Steve Kimatian.*

*Front, left to right:
Donald E. Martin, M.D., and Joseph F. Answine, M.D.*



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—from Warren Buffett's Letter to Shareholders, February 28, 2006

...We want Medical Protective to continue to be the company that thinks like a doctor and behaves with the same integrity and individual care as a doctor....

—from Warren Buffett, April 26, 2006

**...We're proud to have
Medical Protective as part
of the Berkshire family....**

—from Warren Buffett, May 30, 2006



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Supreme Court To Decide Mcare Expert Witness Issues

by Robert B. Hoffman, PSA General Counsel

Although the Mcare Act has been in effect since 2002, one of its central reforms—raising the standards necessary for expert testimony in medical malpractice cases—is about to be interpreted and applied by the Pennsylvania Supreme Court for the first time.

Mcare requires a close alignment between the medical practices of the defendant and the expert who testifies against him. Subject to exceptions, the expert and defendant physicians must practice either in the “same specialty” or in specialties that have the same standard of care for the care at issue. Additionally, if the defendant physician is Board-certified, the expert must be as well, in the same or a similar specialty. These standards recognize that specialization and sub-specialization are the norm in medicine and that the standard of care can vary, often subtly, from specialty to specialty, even for care for a similar condition. The Supreme Court has in a prior case recognized that Mcare “raised the bar” on expert witnesses, but has not yet said what any of these requirements really mean.

The case, *Gbur v. Golio*, involves a urologist’s decision that a patient’s pros-

tate cancer was localized rather than metastatic. That decision turned out to be incorrect and the patient received various forms of treatment, such as brachytherapy, that were unnecessary, and did not get certain treatment, such as an extended course on Lupron, that would have been appropriate. Plaintiff prevailed at trial and won a substantial verdict.

Plaintiff’s expert witness was a board-certified radiation oncologist rather than a urologist. The expert testified to his familiarity with prostate cancer treatment, including reading bone scans and MRI’s and the appropriate treatment for various forms of the disease. Interpreting and applying bone scan and MRI results were important parts of Dr. Golio’s staging decision and the expert witness’s criticisms.

The central legal question is whether a radiation oncologist satisfies the “same or similar subspecialty” requirement so as to be able to testify against a urologist. At bottom, that requires a determination as to whether a radiation oncologist has the same standard of care as a urologist as to prostate treatment care.

Superior Court, Pennsylvania’s intermediate appellate court, affirmed the decision and the Supreme Court decided to review the case. The Supreme Court’s formulation of the question to be decided is: Whether the MCARE Act foreclosed a plaintiff in a medical malpractice action against a urologist from offering expert testimony from a radiation oncologist to develop the applicable standard of care for the treatment of a cancer patient, upon the urologist’s review of a bone density study indicating “multiple foci of abnormal activity involving the right and left sides of the pelvis, the lower thoracic spine, right ribs, right mandible...consistent with osseous metastatic disease.” The Pennsylvania Medical Society filed an amicus brief on behalf of the physician generally seeking a narrow and rigorous application of the expert witness qualifications. The Pennsylvania Association For Justice, formerly the Pennsylvania Trial Lawyers Association, filed an *amicus* brief for the patient taking the opposite tack.

The Supreme Court heard oral argument on September 8 and will likely rule by the Spring of 2009.

President’s Message

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During the pre-operative period, we function as internal medicine doctors; reviewing past medical history, ordering further tests as needed based on the history and physical examination, and optimizing the patient prior to surgery. However, once we begin to administer the anesthetic agents, we become intensive care physicians in every sense of the word. Our patients are rendered unable to breath on their own or maintain an adequate blood pressure without support. It is up to us to maintain these life preserving functions just as if they were in an ICU. This role as an intensivist then continues well into the

post-operative period. We also require basic surgical skills in order to place invasive monitors as well as catheters for post-operative pain management.

What is a “peri-operative physician?” It is more than just someone delivering anesthesia. Who has the greatest understanding of the overall health of the patient? It is the patient’s primary care physician. Who has the greatest understanding of the surgical procedure to be performed? It is the surgeon. Who reviews patient history and procedure to be performed to decide what further tests should be done and preoperative medications to be given and tailors an anesthetic that is the safest for that particular patient? That would be the anesthesiologist. Who addresses pre-operative, intra-

operative or post-operative problems and prescribes the appropriate remedy? You are right again; the anesthesiologist. Our role in the care of a surgical patient is even broader and more involved than we give ourselves credit for. Remember, the surgeon takes care of a particular part of a patient, whether it is the knee, heart, colon and so on. We are responsible for everything else.

What title will be on my next name tag? I presented my thoughts, and you can decide. One thing I know, being a physician and anesthesiologist has been fun and incredibly rewarding. Furthermore, being the president of the Pennsylvania Society of Anesthesiologists has been a privilege and an honor. Thanks for the help and support.



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