



## President's Message

by Joseph F. Answine, M.D., President, Pennsylvania Society of Anesthesiologists; Delegate, American Society of Anesthesiologists ; Alternate Representative, Specialty Leadership Cabinet; Alternate Delegate, Pennsylvania Medical Society

### Whatever happened to the day when medicine was practiced by physicians?

"It isn't what we say, but what we do that defines us." Very profound, isn't it. I think that I heard it while watching a BATMAN movie. Nevertheless, it is still a profound statement, and fits very well here. At our last membership meeting in San Francisco, we introduced a very extensive and challenging agenda for our society covering the next few years. We have begun to work on many of the objectives that we discussed during the meeting. Our strategic plan as well as the defining of our organization and specialty are well underway. We have hired a public relations firm to help with our branding process, to get our message out through the media especially when important issues arise, and to reorganize and put a new face to our website. The western Pennsylvania chapter of the PSA (WPSA) already has monthly membership meetings, and we are in different stages of planning for PSA membership meetings in other regions of the state. House Bill 1256 is at a standstill within committee, and we are working to keep it there.

We have also worked aggressively to keep nurse anesthetists from having independent practice while performing pain management procedures.

One of our most aggressive efforts, however, has been directed towards reversing the current policy by Aetna, Health America and Humana to refuse payment for anesthesia care during routine endoscopies. They seem to feel that anesthesia services and providing moderate to deep sedation is too expensive, and it does not provide an added benefit to the patient. Why should we care? Most endoscopies are performed without an anesthesiologist present. Most have nurse anesthetists supervised by the endoscopist if there is an anesthesia provider present at all. We are fighting to keep the decision as to what is medically necessary in the hands of the doctors. We are also fighting for patient safety. Again, those that are non-medical are dictating medical practice. Whatever happened to the day when medicine was practiced by physicians? Whatever happened to the day when physicians decided, in a collaborative effort with their patients,

on a medical regimen and it was carried out without the influence of outside forces? I am starting to think that we, the physicians, are the only ones that do not have a say in the care of our patients as well as the future of medicine. Fighting this policy change seems to be what this organization is about. Protecting the future of anesthesiology and more importantly our patients is a major part of our mission as a society.

Well, it is time we take the offensive. It is time we take back medicine. We are attacking this from multiple directions. We have written a letter, using all our resources such as our legal and legislative teams, to the insurance carriers involved. This letter mimics the sentiments of the American Society of Anesthesiologists; however, we have also stressed the risks involved with going back to conscious sedation with benzodiazepines and narcotics such as Midazolam, Fentanyl and Demerol.

At the time that we are going to press with the newsletter, Aetna has decided to delay the implementation of their policy on anesthesia coverage for endoscopies. Health American pulled their policy effective 2/29/08.



## Sentinel

Pennsylvania Society of Anesthesiologists Newsletter

### Editor

Paul J. Schaner, M.D.

### President

Joseph F. Answine, M.D.

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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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### Thanks for Making 2007 Our Most Successful Year Ever!

We wish to thank all of the anesthesiologists listed below for making a personal contribution last year to the Society's political action committee, Z-PAC. PAGE 8

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Joseph F. Answine, M.D.

**Carrier Advisory Representative**  
Joseph West, M.D.

# Tribute to PSA Past President, John C. Cwik, M.D.

John C. Cwik, M.D., a 1976 President of the PSA, died May 23, 2007. He was 82 years old and resided in Stone Harbor, NJ. John was an educator, researcher and anesthesiologist who enjoyed his entire career at Conemaugh Valley Memorial Hospital (CVMH) in Johnstown, PA.

John and his partner, Peere C. Lund M.D., pioneered much of the early research on local anesthetic drugs and techniques and authored multiple papers on regional anesthesia. He attended Pennsylvania State University and graduated from the University of Pennsylvania. He was a graduate of Jefferson Medical College.

During World War II he served as an Ensign from 1943-46 aboard the USS Denver.

John retired from CVMH in 1984 as Chairman of the Department of Anesthesiology and Director of the Anesthesia Residency Program. Some 70 anesthesiologists graduated from the program many rising to the rank of professor. He was President of the CVMH medical staff as well as a member of the Board of Managers of CVMH. He also was a Clinical Professor of Anesthesiology at West Virginia University and Temple University School of Medicine. He was a Past

President of the Cambria County Medical Society.

He is survived by his widow, Terrie, of Stone Harbor, two sons, Jason C. Cwik, an anesthesiologist of Moorestown, NJ and Timothy Cwik of Stone Harbor, a daughter, Lisa C. Mattiace of Superior, CO, and three grandchildren which includes John, a grandson who is an anesthesiologist and many residents.

## The Inside View

by Paul J. Schaner, M.D.

Endoscopic procedures for diagnosis and treatment are increasingly performed. Patient comfort and acceptance has been in large measure because of sedation. Thorough procedures are comfortably accomplished more quickly. The efficiency and comfort appeal to the patient and the endoscopist. With the steady rise of the number of procedures the associated cost has stimulated third party payers to limit reimbursement for the sedation unless a medical indication is documented. This is where patient safety and reimbursement meet the road. Current drugs are easily administered and provide sedation that can slip quickly to general anesthesia. The ability to rescue is critical. The response to critical

events must be in place. The PSA continues to respond to these issues. The PSA's response to Aetna appears in the Presidential letter. Current research by Mandel et al of the University of Pennsylvania investigates a potential approach to patient for controlled sedation for colonoscopy. They have provided a summary of their work. There are implications for you and your patient.

The potential problem of expanded scope of practice continues to loom. Vigilance is necessary. Member involvement is outlined by John Milliron Esq. our lobbyist. The member participation he requests is essential to keep the PSA effective. Z-PAC is an invaluable part of our political effectiveness; the reorganization

is designed to improve member involvement. Please note the change of address for Z-PAC. **PLEASE** supply the PSA with your current e-mail address. It is essential for a rapid response to the changing political scene in Harrisburg.



# 2008 is Even More Critical Politically Than 2007

by John P. Milliron, Esquire, PSA Legislative Council



The Society faced its biggest political challenge ever in 2007, when Governor Rendell proposed to eliminate physician supervision for the administration of anesthesia. House Bill 1256 was introduced by Representative Marc Gergely at the Governor's request. This legislation would have created a statutory requirement of "cooperation" between physicians and CRNA's, rather than supervision. The legislation, for all practical purposes, died in Committee and a vote was never taken. The issue, however, is far from over.

This is an overly simplified explanation of the physician supervision rule: The Health Care Facilities Act told the Department of Health to write regulations defining how healthcare should be delivered in a hospital setting. The law gave the Department regulation supremacy over all

other healthcare licensing Boards regulations (i.e. Medical Board, Nursing Board, Dental Board, etc.). The DOH then promulgated regulation 123.5, which states that "anesthesia care shall be provided by a qualified physician...(or) qualified nurse anesthetist under the supervision of the operating physician or anesthesiologist..." This regulation is the current law in Pennsylvania.

**This regulation could be changed by the Secretary of Health**—who works for the Governor! We are very concerned that the Governor will direct Secretary Johnson to write a new regulation which would eliminate physician supervision. This would be a major blow to the safety of patients having surgery in the Commonwealth. Because all proposed regulations must still go through a legislative review process, we would still have the opportunity for significant input —**which is why we still need your involvement!**

Every member of the PSA must continue to do two things: 1) Know your local House and Senate member, and 2) Write a

personal check to the Society's political action, Z-PAC. (The Society has created a Pac Advisory Committee and has a new address. Please read the article in this newsletter about the changes.)

If the Secretary of Health would propose a new reg, we would only have a brief 20 day window to contact our Representatives and Senators, telling them of the dangers it would present to their constituents. **Please**, make sure you know who your local legislator is—including their address and phone number. We will need everyone to make an immediate contact on a short notice. If you do not know who your House or Senate member is, go to our website: [www.psanes.org](http://www.psanes.org), e-mail us at [psagrassroots@millironassociates.com](mailto:psagrassroots@millironassociates.com) or call us in Harrisburg at 1-800-822-6789.

We have been successful in fighting for our patients because we have a great grassroots network and politically active members. This team approach will again be a winner for our patients and our profession.

PSA is now accepting Z-PAC Contributions online! Individual Membership Dues may also be paid online. Visit the PSA website at [www.psanes.org](http://www.psanes.org).

## Welcome New Members

### Active Members

David A. Burns, M.D.  
M. Theresa Fasano, M.D.  
Mary K. Hollinger-Yurick, M.D.  
Rafael E. Martinez, M.D.  
Michael Mlynarsky, M.D.  
William F. Pierce, D.O.  
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### Residents

Elie L. Basch, D.O.  
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Anthony J. Alarcon, M.D.  
Douglas S. Simon, M.D.

# Why Visit the PSA Website?

by Paul J. Schaner, M.D., Communications Committee Chair, Pennsylvania Society of Anesthesiologists

- C**ommunications Committee for the PSA
- O**n line at psanes.org
- M**ember log in, Membership on line
- M**essages from the your President
- U**pdates for the Harrisburg political arena
- N**ewsletters are posted
- I**nformation regarding your state Representative
- C**ontinuing Medical Education Credits for free, additional links on the site
- A**ctivity Calendar
- T**ell your professional friends
- I**nput your current e-mail address for urgent updates, ONLY FOR PSA COMMUNICATION\*
- O**pen practice positions list
- N**ext time your surfing go psanes.org, you won't be all wet

## Z-PAC Officers and Advisory Board Appointed

by Richard P. O'Flynn, Z-PAC Treasurer  
E-Mail Roflynn@shac.cc

The Pennsylvania Society of Anesthesiologists recently voted to bring Z-PAC more in line with the other medical society PAC's, and increase the opportunities for anesthesiologists from across the State to help set the direction of Z-PAC, by having appointed officers and an advisory board. It was felt that an advisory board would bring more diversity and participation to the committee.

Z-PAC was originally formed in the early 1980s by Paul Schaner, M.D. Dr. Schaner realized the importance of involvement in the political process and has been the guiding force since the inception. He will continue in the role of Chairman.

Members of the Advisory Board will be the local contact for their geographic area. In that role, they will assist the Officers in obtaining and distributing campaign contributions and work as key contacts for legislative offices.

Z-PAC serves the important function of helping to educate legislators to the complexities of the medical specialty of anesthesiology and how it affects patient safety.

If anyone has questions or is interested in becoming more active in Z-PAC, contact any member of the Board. Additional information can also be found on the Z-PAC page of the PSA website ([www.psanes.org](http://www.psanes.org)).

### The Officers of Z-PAC are:

Paul Schaner, M.D.  
Chairman

John Milliron, Esq.  
Vice Chairman

Richard O'Flynn, M.D.  
Treasurer

John BianRosa, M.D., J.D.  
Assistant Treasurer

### The Advisory Board Members are:

Joshua Atkins, M.D.  
Howard Hudson, M.D.  
Joshua Rhodes, M.D.  
Matthew Redcliff, M.D.  
Patrick McGannon, M.D.  
Shawn Beaman, M.D.  
Steve Neeley, M.D.  
Kevin Slenker, M.D.

# Update from Specialty Leadership Cabinet

by Joseph W. Galassi, Jr., M.D.,

Representative to the Specialty Leadership Cabinet of the Pennsylvania Medical Society

As you may know, the Pennsylvania Society of Anesthesiologists (PSA) has historically worked closely with the Pennsylvania Medical Society as well as all the other state medical specialty societies. The forum for which a significant portion of that interaction occurs is through the Specialty Leadership Cabinet (SLC). For those of you who don't have much of an idea about what the SLC is or does, I would like to give you a quick synopsis before

I tell you what's going on with the SLC. (Trust me, I didn't know much either until last year!) In a nutshell, the SLC is the group for which representatives from all the specialty societies get together to discuss issues that affect not only any one specialty, but also all of medicine

in the Commonwealth. The SLC reports directly to the Board of Trustees of the Pennsylvania Medical Society which meets immediately following the SLC meetings every quarter. The SLC has a good deal of influence on what business the Board has to conduct and has become a very effective tool for all the specialties to bring issues to the table.

Now that I've hopefully got your attention with what the SLC can do, what did we discuss at our most recent meeting you ask? The SLC met on Tuesday February 5, 2008. There were

a number of issues that were discussed at the meeting. Several of which were interesting but not directly affecting the specialty of anesthesiology, others that we brought to the table. The first issue discussed was the concept of the Medical Home in Pennsylvania. A resolution on this concept was referred from the Pennsylvania Medical Society House of Delegates to the Board of Trustees who asked for input from the SLC. Basically, this is a model to manage patients which includes the patient or his/her power of attorney playing a more active role in the patient's care. It includes a new reimbursement model to pay for all of the ancillary things that a primary care physician does in addition to face time with patients. The key with this model is to have this be a **physician-led** (as opposed to CRNP/PA-led) model. Since Governor Rendell is trying to get his Cover All Pennsylvanians (CAP) plan passed in some way shape or form, this model would allow the physicians of the Commonwealth to maintain input into the care of our patients. The Board with some modifications later passed the resolution.

The next topics for discussion were all legislative and regulatory priorities. This included a status report on the proposed CRNP practice regulations, a draft of the State Board of Medicine Regulations re: Practice of Medicine & Surgery which better defines surgery, and a request for support of HB 1093 which would grant loan forgiveness for physicians remaining in PA after residency. I presented an update on HB 1256 with reference made to the Pennsylvania Association

of Nurse Anesthetists letter to the House Professional Licensure Committee. The SLC stands ready to assist further if and when needed.

There is also an effort to get legislation passed which would require all health care practitioners to wear caregiver identification badges. These badges would be part of Pennsylvania's licensure/certification process and would clearly state who they are and what degrees/licenses, if any, they hold. Interestingly enough, the proposed CRNP Practice Regulations removes identification and notice requirements thereby preventing patients from making informed choices regarding their health care providers. There is no requirement for a name tag or limits on the use of "doctor" title. An update as to the Pennsylvania Medical Society efforts to extend the MCARE abatement was discussed. This was in follow up to a teleconference that the committee had in January. The Pennsylvania Medical Society is lobbying to phase out MCARE over either a 5 or 10 year time span. Since the MCARE fund is in essence a claims made insurance policy, The Pennsylvania Medical Society has worked with the Governor to craft a proposal to fund the inevitable tail that will come at the end of 5 or 10 years. Rather than have all physicians pay a tail, the proposal would be to increase cigarette taxes by 10 cents as well as add a 36 cent unit tax to other tobacco products (cigars & smokeless tobacco currently are not taxed) in order to "pay the tail." The Governor has made it known that he will

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# Thanks For Making 2007 Our Most Successful Year Ever!

We wish to thank all of the anesthesiologists listed below for making a personal contribution last year to the Society's political action committee, Z-PAC. These funds will be used to help our friends in the House and Senate, who have consistently supported the highest quality of healthcare in the safest possible environment. On behalf of our specialty and our patients – **Thank You!**

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## President's Message

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Risks such as prolonged respiratory depression when personnel specializing in airway management are not around as well as the rare but potentially fatal serotonin syndrome come to mind. We are using our public relations firm to take this to the patients and their employers. These are the consumers and they need to know what their insurance carriers are doing or not doing on their behalf. The patients should be made aware before they arrive in the gastroenterology suite or ambulatory surgery center for their procedure, only to find out at the last minute (after they have endured a bowel prep) that their anesthesia care is not covered by their insurance carriers.

We also realized that we could not do this alone. This has become a group effort. We have discussed this issue whether in person, by e-mail, or by phone with the gastroenterologists and general surgeons of

this state, anesthesiologists and endoscopists from other states, representatives for the state's ambulatory surgical centers, representatives from the Pennsylvania Medical Society, specialty group administrators and the Pennsylvania Association of Nurse Anesthetists. We have formed alliances with many of the organizations. We are a unified front. Democrats and Republicans may fight over an election, but later come together to pass a law to benefit all people regardless of party affiliation. Nothing is different here. We will always continue to fight over our roles in this healthcare world. Healthcare is our concern for the process and the patient. It is still what we do. We want informed decisions made. While the outcome is undecided, we will use every measure to insure the best outcome for our patients. The carriers will know we are involved.

# Anesthesia for Endoscopy – Where Are We and How Did We Get Here?

by Donald E. Martin, M.D., Secretary-Treasurer, Pennsylvania Society of Anesthesiologists

About six months ago it became apparent that private insurers were going to attempt to cut their costs by restricting, if not eliminating, reimbursement to anesthesiologists and nurse anesthetists for providing monitored anesthesia care (MAC) or general anesthesia for GI endoscopy. Why have they taken this action, why now, what changes are they actually making, and what is its significance for our medical specialty?

The new reimbursement policies by first Humana, and now more recently Aetna and Heath America, have not occurred in isolation. Endoscopy is, in many ways, the perfect target for cost cutting in 2008.

What makes endoscopy different?

- A relatively new procedure
- Rapidly growing number of procedures
- Recent large scale increase in demand for anesthesia
- Recent advances in available drugs and techniques making anesthesia or sedation safer
- Statements from GI Societies and some, though controversial, outcome data indicating that anesthesia or deep sedation is not needed for these procedures
- Demand for anesthesia is driven by patient comfort, not “medical necessity”
- The decision whether or not to have anesthesia can be separated from the decision of whether or not to have the procedure

GI endoscopy itself is actually a relatively new service. Both esophagoscopy and

sigmoidoscopy have been performed, for many years, on a very limited number of patients using rigid scopes. However, the widespread use of these procedures began only after the perfection of fiberoptic endoscopes in the 1980's and 1990's. Robertson and colleagues at the University of Alabama<sup>1</sup> found an increase of 45% and 34% respectively in the number of colonoscopies in Tricare and Medicare patients between 1999 and 2001. With the effectiveness of colonoscopies in preventing colorectal cancer quoted at perhaps 55-70%, this is recommended by some as the primary screening tool for colorectal cancer, currently the second most common cause of cancer related death in the United States.<sup>2,3</sup> With the aging of the American population, we can only expect the number of potential colonoscopies, and their costs to insurers, to continue to rise exponentially. Though we may see endoscopy as a major improvement in healthcare, insurers may see it as a huge rapidly increasing cost.

Along with the growth in the number of endoscopies, and their use as a screening procedure, has come a call for more and better anesthesia. Even though improvements in fiberoptic technology have made these procedures tolerable without anesthesia, most of the early fiberoptic procedures were performed almost exclusively awake or with mild sedation given by the endoscopist. They were, however, at the very least

uncomfortable for patients. Again technology provided the answer, this time in the form of new drugs, first midazolam and then propofol. The advent of propofol gave anesthesiologists the tool to make endoscopy comfortable for patients, technically safer and more effective for endoscopists, and provide for a rapid recovery.

Payers have been scrutinizing anesthesia for endoscopic procedures since it began to gain popularity in the late 1990's. In fact, Medicare only began covering colonoscopy for average risk individuals in 2001. Both nationally and in Pennsylvania, between 1996 and 2001 many Medicare carriers developed local carrier medical review policies regarding monitored anesthesia care, with one of their primary targets being endoscopy. In Pennsylvania, this policy (LMRPA4B) set limitations for coverage based on the documentation of full pre, intra, and postoperative anesthesia care, the type of surgical procedure, and co-existing medical conditions. Upper and lower GI endoscopic procedure were included as procedures for which “anesthesia personnel provided services (MAC) are not usually needed unless the patient had one in a specific list of co-morbid conditions.” However, under this policy, coverage for anesthesia services was not restricted for general anesthesia, or for the “administration of certain anesthetic drugs that required the expertise of an anesthesiologist/CRNA (e.g. propofol).” This policy, of course, applies to the Medicare population, with a high incidence of co-existing disease. However,

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## Table

### Comparison of Private Payor 2008 Policy Changes Regarding Endoscopy Reimbursement For Anesthesia

| Insurer   | Procedures Affected  | Patient Conditions Still Allowing Coverage  | Carrier Review Process        |
|---|--|---|-------------------------------|
| <b>Humana</b>   | “Standard upper and lower gastrointestinal endoscopic procedures (Codes 00740 and 00810)   | <b>The following may permit coverage</b> <ul style="list-style-type: none"> <li>• Prolonged or therapeutic endoscopic procedures</li> <li>• Anticipated intolerance to standard sedation</li> <li>• Increased risk for airway obstruction due to anatomic variant</li> <li>• Increased risk for complications due to severe co-morbidity (ASA Class III or greater)</li> <li>• Age less than 18</li> </ul>  | Post procedure medical review |
| <b>Aetna</b>  | Upper and lower GI endoscopy   | <b>Still allowing coverage</b> <ul style="list-style-type: none"> <li>• Pregnant</li> <li>• 18 years of age or younger</li> <li>• 65 years of age or older</li> <li>• At increased risk of complications due to certain classes of ASA physical status</li> <li>• In danger of airway compromise including those with oral, neck, or jaw abnormalities; sleep apnea; or those who are morbidly obese</li> <li>• Uncooperative or combative</li> <li>• Dependent on opioids or sedatives</li> <li>• Scheduled for certain complex or prolonged GI endoscopic procedures</li> <li>• Diagnosed with epilepsy</li> <li>• History of drug or alcohol abuse or previous problems with sedation or with an endoscopic procedure</li> </ul> | Post procedure medical review |
| <b>Health America</b>   | Average risk adult patients undergoing standard upper and/or lower gastrointestinal endoscopic procedures (CPT code 00740, 00810, and 00902) | <ul style="list-style-type: none"> <li>• Prolonged or therapeutic endoscopic procedures</li> <li>• Documented history of anticipated intolerance to standard sedatives</li> <li>• Increased risk for complications due to severe co-morbidity</li> <li>• Patients over age 70</li> <li>• Pediatric age group</li> <li>• Pregnancy</li> <li>• Documented history of drug or alcohol abuse</li> <li>• Uncooperative or acutely agitated patients</li> <li>• Increased risk for airway obstruction due to anatomic variant</li> </ul>  | Post procedure medical review |
| <b>Medicare</b><br>(Pennsylvania “MAC” policy instituted in 2001) | Approximately 40 relatively minor surgical or diagnostic procedure including most endoscopic and superficial procedures                      | Approximately 100 specific diagnoses, in addition to the following general patient conditions. <ul style="list-style-type: none"> <li>• Combative patients</li> <li>• Patients with low pain thresholds or who suffer severe pain</li> <li>• Intraoperative expansion of the procedure</li> <li>• Any condition in the pediatric patient</li> <li>• Mental retardation</li> <li>• The administration of certain anesthetic drugs that require the expertise of an anesthesiologist/CRNA (e.g. propofol)</li> </ul>  | Retrospective medical review  |

# Anesthesia for Endoscopy - Where Are We and How Did We Get Here?

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its specific recognition of the need for anesthesiologist administered propofol has set the precedent which has allowed anesthesiologists to provide the benefits of propofol sedation to endoscopy patients for the past 7 years. During this time, patients have increasingly come to expect the comfort, amnesia, and quick recovery provided by anesthesiologists using propofol, and endoscopists have come to expect the operating conditions and the patient satisfaction which have come with our services.

Over the past 5 years, however, several widely publicized articles have appeared in the GI literature concluding that propofol sedation or anesthesia could be administered, at less cost, by nurses and GI physicians who are both already present in the Endoscopy Suite. These articles, and accompanying editorials, were widely quoted. The most well known is the statement issued jointly by the American College of Gastroenterology, the American Gastroenterological Association, and the American Society of Gastrointestinal Endoscopy in 2004, stating that "the routine assistance of an anesthesiologist/anesthetist for average risk patients undergoing standard upper and lower endoscopic procedures is not warranted." All of the recent policy

revisions by private insurers prominently quote this statement. Though some of these societies are now attempting to back away from these statements to some degree, the damage may have already been done.

How do these policies restrict the use of anesthesia, and how do they compare to the Medicare "MAC" policy under which we have practiced for almost the past decade? First, these policies only apply to endoscopy, but usually deny payment for any services provided by an anesthesiologist or CRNA, no matter if it is "MAC", deep propofol sedation, or general anesthesia using an endotracheal tube. Second, they do include payment, at a much lower rate, for "conscious sedation" provided by endoscopists as part of the procedure itself. Third, they all have similar relatively poorly defined co-existing comorbidities (table) which would justify payment. However, as currently written, the policies provide only for payment after a rather lengthy individual post service review of medical necessity. Some of the policies specifically recognize the issues of patient comfort by providing that any of their insureds may indeed receive deep sedation provided by anesthesiologists, but only if they agree to pay for it themselves!

Endoscopy is indeed only perhaps the first of a growing number of less invasive diagnostic and therapeutic surgical procedures for which patient comfort and patient safety, rather than the fact that the procedure simply could not be performed without anesthesia, drives the need for anesthesiologist presence. For these procedures, the old concept of "medical necessity", as determined by diagnoses and procedure codes, is becoming inadequate, and we need to allow patients themselves, and not policies or procedures, to govern what services they actually need.

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2. Maciosek MV, Solberg LI, Coffield AB, Edwards NM, Goodman MJ: Colorectal cancer screening health impact and cost effectiveness. *J of Preventive Medicine* 2006; 31: 80-89.
3. Byrne MF: Primary screening with colonoscopy for colorectal cancer: The targeted algorithm? *Am J of Gastroenterology* 2003; 98: 2587-2589.

## Updates from Specialty Leadership Cabinet

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only sign into law an abatement plan for physicians if it is included with his CAP plan. Stay tuned!

Next, during the Forum for Specialty Concerns/Issues, we discussed the Payer Policy Changes regarding Anesthesia services for Gastrointestinal Endoscopic Procedures. Dr. Darrell Reed from gastroenterology and I presented a unified message about

our dissatisfaction with Aetna and HealthAmerica and why we felt that anesthesia services should be covered for all endoscopies when felt medically appropriate. Since this topic is being discussed elsewhere in this Newsletter, suffice it to say that the Pennsylvania Medical Society will provide assistance to our two specialties in our efforts to continue to provide safe, comfortable,

and state of the art care to all of our patients.

In conclusion, the SLC serves as a forum for our specialty to interact with all the other specialties in the Commonwealth. If there are any issues that you would like to have addressed in this venue, please feel free to contact me at [Joseph.Galassi@lvh.com](mailto:Joseph.Galassi@lvh.com).

# Patient Controlled Sedation for Colonoscopy - Implications for the Anesthesia Community

by Jeff E. Mandel, MD, MS

Clinical Associate Professor of Anesthesiology at the Hospital of the University of Pennsylvania

Our study “A Randomized Controlled Double-blind Trial of Patient Controlled Sedation with Propofol / Remifentanyl vs. Midazolam / Fentanyl for Colonoscopy” appeared in the February 2008 issue of *Anesthesia and Analgesia*. The study has garnered a fair amount of interest because of controversy over the use of propofol for colonoscopy. I’d like to clarify what the study demonstrated, what it didn’t demonstrate, and what impact it holds for those who have a stake in the delivery of sedation for colonoscopy.

The study was a randomized, controlled trial of 50 patients, and was blinded for endoscopist, nurse, and postoperative observer. An unblinded anesthesiologist was physically present for the entire procedure. The study was designed to detect differences in facility utilization between patients receiving midazolam/fentanyl (MF) vs. propofol/remifentanyl (PR) via PCS. The most striking difference was in recovery; group PR patients were able to ambulate without assistance significantly sooner than group MF, and in significantly less time than required for the procedure. This suggests that the PACU capacity required to buffer the egress of patients from the procedure rooms could be reduced from the 3-4 PACU slots recommended to avoid bottlenecks. The extremely rapid recovery from propofol/remifentanyl coupled with the tendency towards decreased demands during withdrawal of the colonoscope explain this result.

The study was not designed to address the safety of the technique, but we had two PR patients

who met the criteria for anesthesiologist intervention—a saturation < 85% for 60 seconds. These events both occurred immediately following cecal intubation when stimulus dramatically decreased, and both were resolved by two breaths of 100% oxygen. The only conclusion that can be drawn from this is not to give propofol/remifentanyl for sedation unless you are prepared to deliver more oxygen than a 2 LPM nasal canula.

What was left out of the current paper? In January 2008 I presented a poster at the Society for Technology in Anesthesia on the mathematical analysis of PCS. This work promises to improve design of Patient Controlled Sedation (PCS), and provide prediction of respiratory events based on patterns of demand. A study to confirm this is under review by the IRB.

Why would anyone want to use PCS for colonoscopy? I still periodically use the Graseby PCA pump to sedate colonoscopies. It diminishes the work of sedation, but since I can’t leave the room, it doesn’t make a big difference. It would if I could simultaneously sedate multiple patients. While such suggestions usually lead to lighting of torches and melting of tar, I’m old enough to remember the debates over continuous epidural infusions. If we were not able to safely administer infusions of bupivacaine (a truly dangerous drug) simultaneously to multiple parturients (a truly high-risk population), very few women could afford effective analgesia during labor. Approximately 80% of colonoscopies are done without anesthesiologists; if all 14.5 million colonoscopies

done in 2003 had anesthesiologists reimbursed at Medicare rates, this would have cost \$7 billion, and required 10% of the ASA membership working full time. PCS may make it possible for a significantly larger proportion of patients undergoing colonoscopy

to have an anesthesiologist involved in their care, which in my book means greater patient safety.

Colon cancer is the second most common cause of cancer death in the US. Compliance with screening regimens will save lives at a rate several orders of magnitude greater than the number of lives lost to sedation. As physicians, we should look for ways to find the optimal balance between access to care and risk. Patients, gastroenterologists, anesthesiologists, CRNAs, and third party payers all have a stake in this issue, but no one’s interest is served by fewer patients having access to safe, painless colonoscopy.



**Mandel JE, Tanner JW, Lichtenstein GR, Metz DC, Katzka DA, Ginsberg GG, Kochman MK: A Randomized, Controlled, Double-Blind Trial of Patient-Controlled Sedation with Propofol/Remifentanyl Versus Midazolam/Fentanyl for Colonoscopy. *Anesthesia and Analgesia* 2008; 106:434-439.**

# The Use of Simulators in Anesthesiology Training

by Anita Malhotra, MD, CA-3 Resident

Department of Anesthesiology and Critical Care, University of Pennsylvania

Simulators have long been in use for training purposes. For example, airline pilots undergo extensive time in flight simulators before actually flying commercial aircraft. Emergency situations are rehearsed over and over until responses are perfected and become second nature. In health care, a common scenario using simulation is during Advanced Cardiac Life Support training. After instruction and reading the manual, participants are required to go through a "code" situation and appropriately resuscitate a simulated patient. Simulators are powerful learning tools that are increasingly utilized in medical training. A familiar example for many is the "standardized patient" that undergoes a history and physical exam from a medical student.

More recently, simulation modules have been applied to anesthesiology training. Several academic centers are using programs such as Anesoft, GasMan, and the virtual anesthesia machine

among others. The simulators often display monitors that are the same as in the operating room and a case is attached to each simulation. The simulators are interactive and require real time input from the student. Often, the cases which are presented are unusual such as intraoperative development of malignant hyperthermia. However, this is a clinical condition which every anesthesiologist must be able to recognize and treat appropriately. Practicing cases like this several times before they actually happen allows the anesthesiologist to be fully prepared if the situation should arise. The programs also have more "routine" emergencies such as myocardial ischemia, difficult airway, and anaphylaxis. Preparing for these types of occurrences is invaluable for the physician and patient alike.

Another option available for trainees includes an internet program which displays a virtual anesthesia machine and allows the clinician to troubleshoot

problems which may occur with the machine. It also demonstrates basic functions of integral anesthesia machine components. Yet a third program which is available is called GasMan. It was developed by an anesthesiologist named James Philip and is used to aid understanding of inhaled anesthetic uptake and distribution. The trainee has the ability to manipulate several clinical parameters such as gas flow, anesthetic agent, and time.

Regardless of which program is used, all provide beneficial experiences for the clinician. Residents and medical students have rated simulator based training modules favorably. They have found them to be especially useful for emergencies which occur relatively rarely such as amniotic fluid embolism or pheochromocytoma. The number of training programs which utilize simulators is increasing and perhaps will soon be a standard of medical education. Is your institution ready?

## Classified

**West Chester Anesthesia Associates (WCAA)**, a well established and respected private group of 9 BC anesthesiologists located 30 miles west of Philadelphia is seeking an associate with a specific interest in adult cardiothoracic anesthesiology. The successful candidate for this position will be BE/BC in Anesthesiology; training and certification in Adult Cardiothoracic anesthesiology is preferred. Partnership track, a guarantee income, malpractice and an attractive benefit package is offered. WCAA provides anesthesiology services for the 10,000 surgical cases and 200 open-heart cases performed at The Chester County Hospital (TCCH) annually, and the 4,000 outpatient surgical cases performed at the Turk's Head Surgery Center. TCCH is a 238-bed not-for-profit, acute care hospital offering an array of inpatient and outpatient medical/surgical services. Centers of excellence include The Orthopedic Center, Women's Health, The Cancer Center of Chester County which is affiliated with the Abramson Cancer Center of the University of Pennsylvania, and The CardioVascular Center. The Cleveland Clinic recently recognized the excellence of the hospital's cardiovascular program by creating a partnership between the Cleveland Clinic's Department of Thoracic and Cardiac Surgery and the cardiac surgery program of The CardioVascular Center at The Chester County Hospital. For further information please contact Esty Collet, Search Consultant, 410-745-5191, estycollet@msn.com



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