



President's Message

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

The following is the incoming President's speech given at the PSA Annual Meeting on October 18, 2008, in Orlando, Florida.

First of all, I want to thank all of you for electing me to be your society president. I especially want to thank those on the Nominating Committee for seeing the leadership potential in me several years ago when you put me on track to assume the reins of this most vibrant organization.

Thanks too to the members of the PSA board. Your hard work and dedication to the society is nothing short of remarkable. I especially want to thank Sean Kennedy. Sean was one of my Professors at the University of Pennsylvania and I always loved working with him. It was he, who when President of PSA approximately six years ago, got me involved with the society.

I want to share a quick story with you. When I saw that Sean was PSA President, I asked him to come up to Allentown and speak to my group on the then current state of affairs of the society. He most graciously accepted but he also asked me

to be become involved. Before I knew it, I was a PSA Board Member and an ASA Alternate Delegate. In the few years since then, I stand before you now as your President.

Thanks to all my partners in Allentown Anesthesia Associates for giving me the time and support to be involved with PSA. Unfortunately, most of them are all hard at work back home while we are here enjoying this wonderful meeting. Without their support, I would obviously not be here today.

I have one last thank you. I want to publicly thank my wife Francine and my four children. Between school and all their after school activities, they were unable to join us today. They have been very supportive of my efforts with PSA.

Speaking of the society, where have we been? Where are we going? Well, I know that our society is strong, vibrant, and growing. We have had very capable leadership. In fact, I have some very large shoes to fill with our past several presidents. Joe, you're a size 22, right? I'll be swimming in those!

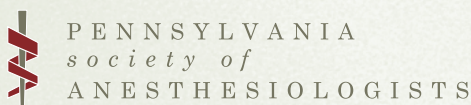
This past year has been an extremely productive one for the society. We have been

active both at the political level as well as working towards improving our services for you, the members.

Our Fall 2008 issue of the Sentinel had a great overview of the past year written by Joe Answine. In brief, we achieved the following:

- 1) Victory over legislation that would have significantly diminished supervision requirements for CRNAs— thanks to our lobbyist in Harrisburg, John Milliron and his associates and thanks to you for all your efforts in defeating the bills that would have diminished patient safety in the Commonwealth
- 2) Victory over efforts by CRNAs to receive reimbursement from Medicare for physician E&M services for acute and chronic pain management and for fluoroscopically guided nerve blocks
- 3) Victory over private insurers—Aetna, Humana, and Health America—to retain reimbursement for anesthesia services for routine endoscopy. Here we worked both in the

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Pennsylvania Society of Anesthesiologists Newsletter

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The New Logo and Tagline of the Pennsylvania Society of Anesthesiologists

by Joseph F. Answine, M.D., Immediate Past President

I am pleased to be the one formally presenting the new face of the Pennsylvania Society of Anesthesiologists. The new logo of the PSA is a modern version of the Staff of Asclepius (which is, by the way, the “correct” and traditional symbol of medicine). Asclepius is the (Greek) god of Healing, and the “Staff of Asclepius” depicts a single serpent encircling a staff, classically a rough-hewn knotty tree limb.



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ANESTHESIOLOGISTS

What is the significance of our new logo? Well, first of all, it is “new”, an image which reflects our “new” Society and always evolving medical specialty. The PSA is always finding “new” ways to help the

anesthesiologists as well as our patients in Pennsylvania. A “modern” look is important and appropriate because with the ever changing face and direction of medicine, we want to convey our dedication to keeping our society “modern thinking” and in line with the changes in medical practice. Use of the Staff of Asclepius itself demonstrates that even though as anesthesiologists we are specialists, we are physicians first with all of the knowledge and dedication associated with the title.

Similarly, the Society’s new “tagline”, a statement of what we stand for that is designed to often accompany the logo, is:

Physicians Protecting Patients

This statement is also meant to reflect our role as the physicians responsible for assuring the safety of patients before, during, and after surgery. Of all of our roles in the care of perioperative patients, this single



role has emerged, over the last several years, as the primary role with which we now are associated—by ourselves, our physician colleagues, and our patients.

What do our new logo and tagline say in just a few words? They say that the Pennsylvania Society of Anesthesiologists is a modern, forward-thinking society that represents a group of dedicated physicians who practice and continually improve the art and science of anesthesiology in Pennsylvania, for the benefit of all the patients we serve.

Communications Committee Report

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

The PSA website psanes.org is undergoing renovation. Ed Dench, M.D., webmaster, is directing this renovation. In the coming months, the changes will be implemented to improve the site for member use. The current site will continue to be active. Please go to

psanes.org and enter or update your email address. The address is used **ONLY** by PSA to contact you; it is not shared with any other entity. This provides PSA with the most rapid economical means to keep you informed on current critical issues. Thank you in advance for your help.



Back to PAC History

by Paul J. Schaner, M.D., Z-PAC Chair



President Joe Answine, M.D., presents Paul Schaner M.D., founder and Chairman of Z-PAC, with a plaque honoring 25 years of service to the PAC at the PSA Annual Meeting.

I had the pleasant surprise of receiving a plaque as founder of Z-PAC, marking its 25th anniversary at the Annual Meeting of the PSA in Orlando, FL. The PSA meeting was held during the ASA Annual Meeting. While the PAC has become more widely supported, in 1984, the idea of starting a pac was not warmly

received by all the members. I was asked "Why, would you give money to a politician?" Some members walked away shaking their heads in disbelief and just wanted me to pack-up. Fortunately, most members agreed with me and the PAC was established. With the approval of the PSA membership obtained, I needed to select a name for the PAC. I wanted a name which would be recognized as the anesthesiologist's PSA PAC with the legislators. ZZ-PAC was strongly considered to link the sleep aspect of the specialty, which most patients and legislators associate with anesthesiology. Ultimately, I

deleted one of the Z's and felt it would stand out just as well if I used Z-PAC, and still provide the desired name recognition. I was vindicated for the choice by the Philadelphia Inquirer, who noted the choice of the PAC's name as unique. The formal filing with the IRS was done in July of 1984. It was necessary, because unlike other state PACs, I decided to place funds in an interest bearing account. I felt every dollar was important. I would deposit funds within days of receipt and used free checking.

I performed functions as the Secretary-treasurer. In the

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Nominations are Open for Committee Appointments for 2009-2010 American Society of Anesthesiologists

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

Again this year the ASA President-Elect, Alexander Hanenberg, MD, will appoint active ASA members from across the country to fill open positions on the Committees of the American Society of Anesthesiologists for 2009-2010. A complete listing of ASA Committees, with their current members and chairs, is available on the ASA website at www.asahq.org/aboutasa/asa-committeelisting.htm.

If you would be interested in serving your medical specialty and being nominated for membership on any of these Committees, simply complete the on-line "Self Nomination Form" on the "Members Only" section of the ASA website, to provide information about yourself and to inform ASA of your interest.

If you would also like the support of PSA for your nomina-

tion, or would have any questions about either the Committees themselves or the nomination process, please contact either one of us at the addresses below. In order for us to provide the most effective Society support for your nomination, please include an abbreviated CV, or some background information about yourself that is particularly relevant to the Committee(s) in which you are interested. Also, confirm for us that you have completed the on-line self nomination form and listed PSA on this form as an "ASA member" from whom they may be receiving a recommendation on your behalf. We will be happy to work with all interested PSA members to secure Committee positions which best fulfill your desire for service, the needs of ASA, and our state society as well.

The deadline for submission of all self and colleague nomination forms is January 15, 2009. Therefore, for Society support, please contact one of us by January 7, 2009.

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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

The most recent meeting of the Pennsylvania Medical Society Specialty Leadership Cabinet was held September 16, 2008. As of that date, there was still some hope that MCARE relief would occur. The Pennsylvania Medical Society's staff provided an update to the SLC as to the status of MCARE. As you are well aware, Governor Rendell's priorities for the uninsured and reauthorization for PHC4 were two issues that he decided to tie to MCARE. The medical society and the legislature are in agreement that all three issues must be addressed. Unfortunately, the Pennsylvania Medical Society's vision for solving the MCARE issue differs from that of the Governor. The Pennsylvania Medical Society wants the monies in the Health Care Provider Retention Account to be used to pay off the unfunded liability, while the Governor wants to use it to fund health care coverage for the uninsured. The Pennsylvania Medical Society planned to go back to the basics to try to get the issue resolved.

The Pennsylvania Medical Society's staff also provided an update on the Scope of Practice of CRNP's. The Pennsylvania Medical Society is concerned with the proposed regulations in several areas. The Pennsylvania Medical Society seeks clarification of the collaborative agreement, criteria for use of Schedule II drugs, and the ratio of 4:1 CRNP's collaborating to physicians. As of the meeting, the regulations were still not out for public comment. They will be forwarded to the legislative oversight committees while the General Assembly is in session either this year or when the new legislative session begins in

January 2009 (see page 17 for related article). Upon publication, there is a 30 day period for public comment. The specialty societies were encouraged to comment regarding the Pennsylvania Medical Society's concerns.

The nurse midwife regulations are much more limited and will be proposed as final if they go to the legislature before it adjourns for the year. The Pennsylvania Medical Society is pleased with these regulations.

The State Board of Medicine has been working on draft regulations to clarify the practice of medicine and surgery. The specialties of Dermatology and Ophthalmology are particularly interested in the outcome of this process and we won't see the regulations until January 2009. These two specialties are concerned about the possibility of other health care providers performing surgery.

Several other issues were discussed including a bill to provide relief of medical education debt, potential legislation for direct billing of pathology services, requiring referral information from long term care facilities, possibility of fellowship training licenses in the Commonwealth, development of a notice of compensation payable poster for workers compensation claims, and a resolution regarding primary care and the medical home in Pennsylvania.

Two other issues pertinent to anesthesiology were discussed. The first issue was the AMA Scope of Practice—Update on AMA Truth in Advertising Campaign. Basically, AMA is concerned, just as we are in Pennsylvania, with consumer confusion about health care



professionals' titles, education and training. The Pennsylvania Medical Society and Pennsylvania Orthopedic Society were to testify at a public hearing in October regarding caregiver ID badge legislation.

The second issue was the potential creation of a Pain Management Work Group to improve Pain Policy in Pennsylvania. A resolution was introduced into the State House on Pain Management directing the Joint State Government Commission to create a chronic pain task force and advisory campaign. They are to promote professional and public education and awareness and to improve the quality of care for chronic pain patients. The task force will be composed of legislators and is required for the Joint State Government Committee to function. Physicians and any special interest stakeholders will be on an advisory committee. The Pennsylvania Medical Society and the American Cancer Society have requested change to the legislation. The Pennsylvania Medical Society's Patient Advocacy Executive Council is providing assistance on this issue. Dr. Galassi

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For the Residents and Students:

What is the Best Preoperative Sedative; Midazolam or a Bad Joke?

by Joseph F. Answine, M.D., Immediate Past President

As anesthesiologists, we have little time to spend with our patients prior to the operating room. In that short period, we have the difficult task of understanding the medical history, developing a risk assessment and finally providing a more relaxed atmosphere during an incredibly stressful time in that individual's life. It is easy to forget the importance of each of these goals; and many times, it is the easing of preoperative anxiety that we overlook as young physicians. Why? Because our attendings want to know anything and everything (appropriately of course) about the patient history in order to avoid any unforeseen or unexpected events while under anesthesia. The paperwork has to be in order and the IV must be running well. Furthermore, many patients put up a "strong front"

and appear "un-phased" by their situation. Let me help you out. Their "phased" and even a little "freaked out." We can always blast them into sedation oblivion with increasing doses of midazolam until we achieve a general anesthetic. It has a high success rate; but there is another technique that is less likely to have significant hemodynamic changes, will have fewer episodes of respiratory depression, is less expensive and is much more memorable in a positive way. It actually is an old technology. It is the art of the funny or minimally funny joke. As our jobs become more and more hectic and we strive to do more cases, we sometimes forget the personal touch. After you have successfully frightened your patient with the risks of MI, stroke and death, take a few seconds and touch their hand and hit them with a one-liner.

It doesn't even have to be that funny. You are not a comedian. Take my word for it, I have been told that many times. You just want to let them know that there is a person under that paper OR hat. I am not saying to look silly; just human. You can convey intelligence and humanity at the same time. Furthermore, ask them about their life, their kids, and their job. Acknowledge their family members if they are around the bedside and ask them about their concerns and fears with the procedure and anesthesia. Furthermore, tell them a little about yourself. I like to tell my patients about the trials and tribulations of being the parent of teenagers. This only takes a minute or two, and you can do many of the other necessary jobs at the same time. Add just a little midazolam (you don't need much) and you have the perfect sedative. All your work should not be in vein.

Welcome New Members

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Valerie Armstead, M.D.
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Elia Elia, M.D.
John Ferrari, M.D.
Adam Fleckser, M.D.
Iskra Ivanova, M.D.
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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.

Erratum: An incomplete list of Z-PAC contributors was published in the fall issue of Sentinel. PSA would like to apologize to those deserving of recognition whose names were inadvertently omitted.

Raymond Adams, M.D.	Richard Denovan, M.D.	Charles Kingsley, M.D.
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Specialty Leadership Cabinet Report

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volunteered our specialty's expertise to help. EM, Oncology, Pediatrics, Psychiatry, and Rheumatology also indicated willingness to participate. Of note, the legislation did not pass this session and will be introduced in the new legislative session in 2009. Our society will be actively involved as this

evolves over the next several months.

On a personal note, it was a pleasure serving as your representative to the The Pennsylvania Medical Society's SLC. I will remain the alternate representative and turn the reins back to our immediate past president, Joe Answine. If there

are issues that any member feels should be addressed by the Pennsylvania Medical Society in a forum where all specialties are represented, please forward your comments/questions/concerns to Dr. Answine. The next SLC meeting is scheduled for February 3, 2009.

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Going more places

Practice Management Controversies Resolved by the 2008 ASA House of Delegates

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

The position of the American Society of Anesthesiologists on several practice management issues, important to the daily practice of anesthesiology, were resolved at the 2008 ASA House of Delegates meeting in Orlando during October.

Are student nurse anesthetists “qualified anesthesia personnel” capable of providing anesthesia alone in an operating room?

The answer approved by the House of Delegates, in the form of a revised “Anesthesia Care Team Statement” is a qualified “no.” The revised statement was approved after several years of work and compromise on the part of the Board of Directors, the Anesthesia Care Team Committee, and its Chair, Jeffrey Plagenhoff, M.D., defines qualified anesthesia personnel as “anesthesiologists, anesthesiology fellows, anesthesiology residents, oral surgery residents, anesthesiologist assistants, and nurse anesthetists.” However, the statement does include room for an exception made by some clinical training sites for non-physician anesthetist students. It distinguishes brief interruptions of 1:1 in-person supervision from actually scheduling students as primary providers in a room, and establishes conditions for the latter practice.

1. The delegating anesthesiologist and the department chair must both deem the non-physician student nurse anesthetist fully capable of performing all the duties delegated to them, and the

student must also express agreement with accepting any responsibility.

2. The privileging process must precede this practice to officially and individually designate each student as qualified to be supervised 1:2.
3. Students must be supervised on a 1:1 or a 1:2 ratio.
4. Backup support must be continually available if an anesthesiologist is currently supervising two non-physician anesthetist students.
5. The Chief of Anesthesia must assure that every patient understands, by means of a standardized departmental informed consent process, that they may be cared for by only a non-physician student being physically present.
6. The Chief of Anesthesia must notify the responsible professional liability carrier of the facts of allowing non-physician anesthesia students to provide care without continuous direct supervision by a fully credentialed and qualified anesthesia provider.

The importance of the definition of “qualified anesthesia personnel” is established by the ASA standard for basic anesthesia monitoring, which requires that “qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics, and monitored anesthesia care.” Therefore,



programs which do use non-physician students, primarily nurse anesthetist students, alone in operating rooms must reconsider this practice, or follow the conditions described in the new statement.

Does the ASA recommend sub-specialty certification in “Advanced Pediatric Anesthesiology”?

ACGME-certified training programs in Pediatric Anesthesiology have been established at many programs across the country. As a step toward the recognition of the graduates of these training programs, the Committee on Pediatric Anesthesiology and the Society for Pediatric Anesthesia initially proposed ABA Certification in the Sub-Specialty of Pediatric Anesthesiology. We note the proposal was initially disapproved by the ASA Board of Directors, because of concerns that it would be interpreted too broadly. The Committee on Pediatric Anesthesia and Society for Pediatric Anesthesiology then revised their proposal to recommend Board Certification in “Advanced Pediatric

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PSA Annual Membership Meeting Report

2007-2008: A Year of Building and Consolidation for PSA

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

In 2007, PSA mounted a very intense, and very successful, political effort to maintain the high standards of anesthesia care in the face of challenges from PANA and the Rendell administration. In 2008, largely because of these political successes, under the leadership of Joseph Answine, M.D., PSA was able to embark on perhaps the largest and most comprehensive effort in its history to plan and build Society infrastructure and member services. During 2007-2008, the Society has:

- Approved a comprehensive strategic plan with priorities including:
 - Maintain advocacy for patient safety
 - Brand Anesthesiology as a medical specialty with broad-based expertise
 - Represent the medical specialty of Anesthesiology to legislators and executive agencies within Pennsylvania
 - Support member education
 - Provide practice management advice to members
 - Maintain more inclusive governance
- Increase membership involvement
- Develop Society infrastructure
- Initiated regional PSA membership meetings throughout the State, beginning in Pittsburgh, Harrisburg, and Philadelphia.
- Using Cimbrion, Inc. as our public relations consultant, developed a comprehensive image and message for the Society to convey to patients, referring physicians, legislators, and the media.
- Started to redesign, expand, and improve the PSA web site for the benefit of all members.
- Initiated, over the course of the year, very useful and practical discussions with PANA leaders regarding first our areas of common interest, and then even areas such as scope of practice, where we still largely disagree, to understand each other's fundamental positions and improve the working relationships between the two groups.
- Fighting, along with ASA, to rescind the federal Medicare "Teaching Rule" — and we have prevailed at the national level!
- Preventing CRNA reimbursement by Medicare for medical evaluation and management services and medical procedural services associated with pain management!
- Petitioning the Pennsylvania Medicaid program and the Department of Public Welfare to increase anesthesia reimbursement under Medicaid to keep pace with increases in Medicare reimbursement rates to anesthesiologists over the past year. The Medicaid program was quick to decrease anesthesia reimbursement when Medicare rates fell, using Medicare as a standard. They should be just as responsive now, in increasing anesthesiologist reimbursement rates, as Medicare rates rise.

At the same time, PSA has maintained a strong presence advocating on behalf of our members on issues regarding practice management and reimbursement:

- Fighting for continued reimbursement from private insurers including Aetna, for anesthesia services during endoscopy. So far, we have won at least a delay in any limitation of our reimbursement for these procedures!

PSA has had an extremely busy and successful year in 2008. Dr. Answine, as president, has certainly broken new ground in several areas, and the Society stands to become much stronger in future years because of the foresight, planning, and efforts of Dr. Answine, the officers, Board of Directors, and especially the committed members of the Society. Our advocacy efforts this year were successful, too, to a large extent, because of our Society's excellent legal and governmental affairs consultants, Robert Hoffman, Esq. and John Milliron, Esq.



PSA President, Joe Answine, M.D., delivers Presidential address at the PSA Annual Meeting at the Peabody Hotel in Orlando, FL, on October 18, 2008.

PSA Annual Membership Meeting Report

PSA Officers and Representatives Installed

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

At its membership meeting in Orlando, the PSA membership also elected its officers for 2008-2009:

President

Joseph W. Galassi, Jr., M.D.,
Allentown Anesthesia Associates

President Elect

Stephen J. Kimatian, M.D.,
Penn State, Hershey

Vice President

Steven Neeley, M.D.,
Beaver Anesthesia Associates

Immediate Past President

Joseph F. Answine, M.D.,
Riverside Anesthesia Associates
in Harrisburg

Secretary/Treasurer

Patrick J. Vlahos, D.O.,
Pittsburgh, PA

Assistant Secretary/Treasurer

Donald E. Martin, M.D.,
Penn State, Hershey

District Director

Donald E. Martin, M.D.,
Penn State, Hershey

Alternate District Director

Erin A. Sullivan, M.D.,
University of Pittsburgh

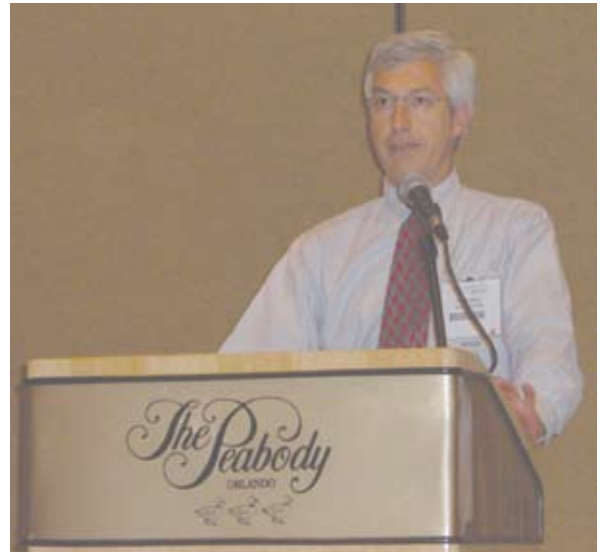
The PSA elected the following physicians, who previously had been members of the PSA Board, to positions as delegates to the ASA House of Delegates:

Steven Neeley, M.D., from Beaver Anesthesia Associates, Richard O'Flynn, M.D., from Pennsylvania Hospital in Philadelphia, and Steven Whitehurst, M.D., from the University of Pittsburgh.

Alternate delegates who joined the PSA Board for the first time this year are Michael Ashburn, M.D., from the University of Pennsylvania, James Cain, M.D., from the University of Pittsburgh, Scott Helsley, M.D., Ph.D., from Erie, PA, and Andrew Herlich, M.D., from Mercy Hospital in Pittsburgh.

Finally, the PSA members and Board of Directors recognized three members of the Board of Directors, who will be leaving the Board, for their exemplary service:

- Sean Kennedy, M.D., who has been a PSA Board mem-



Rich O'Flynn, M.D., presents the annual Z-PAC Report at the PSA Annual Meeting.

ber since 1994, has served as PSA President, and has made significant contributions to both PSA and ASA

- Mary Bolden, M.D., who has been a PSA Board member since 2003
- Barbara DeRiso, M.D., who has been a Board member since 2001.

Mark Your Calendars!

ASA Annual Meeting

October 17-21, 2009

Ernest N. Morial Convention Center
New Orleans, LA



President's Message

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- state, with the "GA Alliance"—a group of anesthesiologists & gastroenterologists in several MidAtlantic states, and with ASA. We realize that this is likely just temporary and that we need to continue to be vigilant when it comes to insurers trying to limit their costs at our and our patients' expense
- 4) Instituted regional membership meetings. This year, meetings were held in Philadelphia, Pittsburg and Harrisburg. I would like to continue this in the year to come
 - 5) Established a formal structure to Z-PAC, our society's political action committee. Before I briefly describe some of the changes, I want to personally thank Paul Schaner for his 25 years of excellent service to the society in running Z-PAC. Z-PAC now has by-laws, officers, and a Physician's Advisory Board comprised of anesthesiologists from across the state. With these organizational improvements, the PAC will be able to reach more members, increase contributions, and respond in a more timely fashion with donations to our state legislators.
 - 6) Under the capable leadership of Joe Seltzer, a committee of 10 PSA members has developed a comprehensive strategic plan to guide our progress over the next 5-10 years. It included a comprehensive mission statement and strategic priorities covering advocacy, society identity/branding, CME, practice management education, and infrastructure enhancement. It happened to coincide with work being done by ASA this past year as well. We hope to be able to benefit from some of the changes ASA has and is undertaking at this time.
 - 7) In follow-up to the strategic plan, we have engaged a Central PA based marketing firm, Cimbrian, Inc., to help us develop a brand position, public marketing strategy and marketing plan for you, the anesthesiologists of PA. Some of our efforts will parallel that of ASA and as a consequence will hopefully allow for some cost savings. We expect you to be able to see some changes on our website if not by the end of this year, then early next year.
 - 8) Despite our differences with the CRNAs over earlier legislation the past two years, we've embarked on discussions with their leadership to strengthen the anesthesia care team and solidify the present state of anesthesia administration in the state, that being physician supervision of CRNA's in the hospital & ASC settings. You can go to our website to see the joint statement that PSA & PANA issued in this regard.

SO, where are we going?

We have MANY things to complete this upcoming year as well as several new issues that have recently come to the forefront.

 - 1) We need to continue to fight aggressively for the safety of our patients. We will ensure that there is not a diminution in the provision of anesthesia care in the Commonwealth. This will be accomplished via our recently formed PAC Board as well as our lobbyists in Harrisburg. You may be called upon to act as well.
 - 2) We will continue to find common areas with which we can work with PANA. We hope to be able to jointly develop legislation which will ensure continued anesthesiologist or at least physician supervision of anesthesia care in the hospital & ASC settings in PA.
 - 3) If our efforts with PANA fail to produce a satisfactory piece of legislation, we will continue to explore the possibility of other anesthesia providers working under anesthesiologist supervision
 - 4) We will continue to work with the Pennsylvania Medical Society, AMA, and ASA to ensure our patients are not confused by others who call themselves "doctor." We feel it is grossly confusing to our patients already as they themselves often refer to CRNAs, CRNPs, and PAs as "doctor."
 - 5) We will continue to implement our strategic plan with the use of our consultant, Cimbrian. We anticipate our image to the public to be significantly improved as a consequence of these efforts. We also anticipate our services to be more readily accessible to you via our website. Again, you will be able to see the first fruits of our labor in the near future.
 - 6) We will continue with regional meetings which will allow us to update you on the current issues facing our society. It will allow you to give us feedback on our efforts, ask questions about what we are doing or what you are doing, and let us know where you think we need to focus our attention. Your opinions and views count! On a related note, I personally feel that the anesthesiologists in this state need to communicate more freely with one another. I have noticed that if you invite anesthesia practice administrators to a meeting to discuss common interests, they are more than happy to get together. One example is the Tri-state

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President's Message

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Anesthesia Administrators Group (TAAG for short). They have been active in the Philadelphia area this past year, especially in light of the endoscopy reimbursement issue. Anesthesiologists on the other hand, I find, are much more resistant to getting together to talk. If you continue to stick your head in the sand, you may end up finding yourself buried 6 feet under with no way out! The PSA board has discussed the possibility of developing a web-based discussion group. For now, please feel free to contact us via email or telephone. At the very least, if you don't already receive email from PSA, please provide us with an updated email address for important timely communications.

- 7) We have initiated contact with Medicaid officials in an attempt to increase reimbursement for those patients. Since Medicaid has based their rates on Medicare, we feel that it is only appropriate for them to give us an increase as Medicare has done this past year.
- 8) We will remain vigilant for other insurers attempting to cut costs to our and our patients' detriment. We will work against the formation of insurance monopolies which will ratchet down reimbursements. We will work with the AMA, Pennsylvania Medical Society, and especially ASA over the next year or so to avert the 21 percent Medicare pay cut looming for 1/1/2010.
- 9) While it looks bleak, we will continue to work with the Pennsylvania Medical Society in an attempt to fix the malpractice situation in PA. You will

undoubtedly be called upon to act on this matter.

- 10) We will work with the Pennsylvania Medical Society and the PA Chronic Pain Coalition (which is a group of industry representatives, patient advocacy groups including the American Cancer Society, and physicians) to improve the care patients with pain get in the commonwealth. I have initiated discussions with the Pennsylvania Medical Society as well as two of our members, Bob Campbell, PSA Pain Management Committee Chair, and Michael Ashburn, PSA PM Committee Member on this issue. We hope to have some constructive meetings with members of both the state house and senate in developing a Pain Task Force & Committee. The committee, on which I hope to have at least two anesthesiologists, will globally assess the current state of pain management in the commonwealth & develop strategies to improve the care of acute, chronic and cancer pain patients.
- 11) We will continue to educate our resident members on the issues that affect our society and encourage them to get involved early on in their careers. We must nurture them now as they will ultimately be the ones getting involved and leading our organization in the future.
- 12) We will encourage both our private practice and academic anesthesiologists to realize that we are all one society. A perfect example is our recent victory in Washington with the academic teaching rule. I was one of many

private practice anesthesiologists educating our federal legislators on this issue that INDIRECTLY affects my private practice of anesthesiology. Why indirect? Because I don't benefit financially now by increased reimbursement. I don't supervise two residents simultaneously. I will benefit later when we have more residents trained who want to work in private practice in PA. We lobby for issues that may affect one subset of anesthesiologists more than others, knowing that ultimately, it is for the common good of all.

- 13) Lastly, while PSA does not endorse candidates for office, nor does Z-PAC contribute to federal elections, I encourage all of you to exercise your freedom to vote. There will be change. It may not be the change everyone wants, but you will factor into that because your future vote counts!

In conclusion, I hope you can see that we are in fact, a very busy society, committed to our patients and committed to serving our membership. I strongly encourage you all to get involved! Perhaps letting me know that you have an interest in one of our committees or setting up payroll deduction in your practice for Z-PAC. Please feel free to email or call us with issues. Perhaps you have a question as to how to handle a particularly difficult hospital situation or hospital administrator. In either event, please let us know how you can help the society and how we can help you. It is in this manner that we can learn from and help one another. Finally, I hope that I can serve you this year in a way that benefits us all!

PSA Annual Membership Meeting Report

Joseph L. Seltzer, M.D., Named PSA Distinguished Service Award Recipient

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

Joseph L. Seltzer, M.D., was named the 21st recipient of the Distinguished Service Award of the Pennsylvania Society of Anesthesiologists at the Society's Membership Meeting on October 18th in Orlando. He was recognized for his outstanding service to not only the Society itself, but also the entire specialty of anesthesiology; particularly the many residents and medical students that he has introduced to our specialty. Nationally, Dr. Seltzer has played a large part in developing the specialty of anesthesiology and establishing residency training standards for the past 30 years. He became an Examiner for the American Board of Anesthesiology in 1985, and was promoted to a Senior Examiner in 1989. In addition, he served as a site visitor for the Residency Review

Committee in Anesthesiology and was president of the Society of Academic Anesthesia Chairs from 1996 to 1998.

Finally, Dr. Seltzer has been an invaluable leader within the Pennsylvania Society of Anesthesiologists itself. He has been a member of our Society's Board of Directors since 1985, has served as our Vice President, President Elect, and then President between 1992 and 1996. Over the past 3 years, Dr. Seltzer has initiated, and then saw through to completion, a tremendous effort to establish our Society's very effective strategic planning process, setting our direction for the next 5-10 years. We are already seeing the fruits of his labors.

Dr. Seltzer has truly been one of the central figures in the specialty of Anesthesiology in Pennsylvania and richly deserves this award. Dr.

Seltzer's family, particularly his wife Susan, his daughter Wendy, and his son Dr. Greg Weller, an anesthesiology resident at the University of Pennsylvania, were with him when he received the award.



PSA District Director, Donald Martin, M.D. (pictured on right), presents PSA Distinguished Service Award to Joseph Seltzer, M.D.

Back to PAC History

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years after 2001, I did have some welcomed secretarial support. The addition of credit card contributions and payroll deductions from groups was very beneficial. I continued to write all the checks, attend multiple functions, deliver money to legislators and mail checks for members who were constituents, to deliver them to their legislators. It is clearly best for the constituent to deliver or mail the check with a personal note. The key is to begin a dialogue with the legislator. I have encouraged the membership to know their legislators on a first-name basis. I recommended they offer assistance in the legislator's election by holding functions for them, working the polls and letting them know if any input was needed in regards to health

legislation, as they would act as a resource. I filed the tax returns to conserve money until December of 2007, at which time Rich O'Flynn took over as treasurer.

In the early days of the PAC, my wife and children were a great support team for the fund appeals. The family joined in folding, sealing, stamping and mailing appeals. Slowly, the concept took hold and contributors firmly established Z-PAC. We became a player in the Harrisburg scene. We had a seat at the table. The PAC grew slowly, and without the PAC our political successes would have been fewer. One regret I have is that Z-PAC has not had 100 percent participation by the membership. All members received and continue to receive the

benefit of increased revenue, following the successful Workers Compensation update. The amendment which was placed into the legislation that permitted this, was through the efforts of yours truly, John Milliron, our lobbyist, and of course Z-PAC. **This resulted in per anesthesiologist per year \$20,000+ depending on practice mix.** In fairness, a \$500 contribution is small compared to the return. In addition, the patient safety banner has been successfully held high for continued quality patient care. The PAC has benefited ALL members of PSA. It is my hope that the future holds a year in which I can proudly report PSA has reached 100 percent participation. Please do your part.

Proposed CRNP Regulations Summary

Joe Galassi, PSA president, recently submitted comments regarding proposed regulations regarding Certified Registered Nurse Practitioners (“CRNPs”). The regulations were published in the Pennsylvania Bulletin on November 8. They would substantially expand CRNP’s scope of practice. PSA’s letter focused on pain medicine issues. Dr. Galassi made the following points:

Anesthesiologists interact with CRNPs in preoperative evaluation clinics...and as members of the patient care team in an outpatient setting. Separately, anesthesiologists have a long history of working with CRNAs, as part of an anesthesia care team. When the Legislature considered a bill to expand a CRNA’s scope of practice from working under an anesthesiologist’s “supervision” to “collaboration” with non-anesthesiologist physicians, a concept that was akin to independent practice for CRNAs, we strongly and successfully expressed our opposition.

These experiences lead to PSA’s central position: CRNPs should practice only under established relationships with physicians who know the area in which the CRNP is practicing and in ways that permit and facilitate active supervision at important points. We believe that the regulations weaken the present rules in many areas pertinent to that concern.:

Pain management in general, and the use of opioid medications for pain relief in particular, require more training and knowledge than CRNPs typically have or can be expected to have. Pain management is rarely an established subject area for CRNP specialized training. CRNPs have a constructive role to play as physician extenders in pain management, but doing so successfully requires physician involvement of a kind the regulations do not now require.

We believe that the expansion of a CRNP’s authority to prescribe Schedule II medications should be more gradual than is currently proposed; that it should be limited to maintenance prescribing rather than the initiation of treatment; and that physician involvement throughout the patient’s treatment with these medications is necessary. The proposed expansion in

Schedule II prescriptive authority—from 72 hours to 30 days—is substantial, particularly so for a new prescription, and particularly when the requirement to provide notice to the collaborating physician is being deleted and physician oversight substantially reduced.

Schedule II drugs...have a high potential for addiction or dependence, are highly susceptible to patient abuse and illegal diversion, and can result in severe adverse reactions and other complications affecting major body systems, even when prescribed appropriately.

For cancer patients, pain management typically implies end-of-life care with an advanced cancer. Dosage escalations for pain relief in that context are expected and predictable based upon disease progression; a patient’s complaint of breakthrough pain and a request for additional medication are relatively easy to assess as legitimate, not a sign of addiction.

Treatment of non-cancer patients is quite different. The condition causing the pain is typically not life-threatening, and the disease’s progression is neither inevitable nor easy to determine. Distinguishing between genuine requests of breakthrough pain, whether from progression of the disease or from patient tolerance to the medication, from requests that are indicative of an addiction, can be difficult. Management of dosing schedules is both more difficult and has more implications in this group than in non-cancer patients.

As the population ages, pain patients more commonly have multiple health care problems that complicate medication management. There are also the issues of dependence, addiction, and diversion. These issues require insight,

judgment, and experience. The most challenging aspect of prescribing opioids for non-malignant conditions is the threshold decision as to which patients are good candidates for that course of treatment and which are not.

Pain medicine requires use of very powerful drugs that pose substantial risks of harm, both in terms of side effects but more so in terms of addiction and its sequella. Prescribing opioids successfully for other than a short-term basis for an acute episode of pain (e.g., post surgery) must be done carefully and with a sophisticated understanding of the risks, benefits, and alternatives. This is particularly true in treating chronic non-cancer pain.

With that extensive background, we offer the following specific recommendations:

- The expanded 30 day prescription period is acceptable for drug maintenance but not for initial diagnosis and prescription. The initial prescription of a Schedule II medication is, in many instances, an important medical event, with potentially serious consequences. It should be made by a physician.
- For these same reasons, any meaningful increases in dosing should be made only by a physician or by a CRNP in consultation with a physician. This is particularly so for treatment of chronic non-cancer pain patients. ...
- CRNPs should be required to advise their collaborating physicians promptly of all prescription refills.
- CRNPs should not be permitted to issue “do not fill before” prescriptions for Schedule II drugs. These allow CRNPs to write prescriptions for longer periods of time that the sensible limitations discussed in this letter.

ASA Updates

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Anesthesiology.” Although this change goes a long way toward addressing the ASA’s concerns, the fact remains that sub-specialty board certification, once established, is no longer under control of the ABA or ASA, and may be required by accrediting agencies, states, or insurers, regardless of ASA or ABA desires. Therefore, the House of Delegates re-affirmed the position that ASA does not support sub-specialty certification for Pediatric Anesthesia, distinguishing it from Critical Care and from Chronic Pain Management, which occur outside of the operating room and for which sub-specialty certification exists in other specialties.

Should ASA enter the “quality improvement arena?”

The broad recommendation of the Board of Directors was to establish an “ASA Quality Institute,” with an initial cost of \$750,000. This Institute will be designed to meet the needs of ASA members, other physicians, and hospitals to provide quality improvement data regarding anesthesiology services to payers, accrediting agencies, and the

government at all levels. The Federal requirements for such data are already on the horizon, and some are even already in place. Therefore, the ASA feels it can best serve the needs of its members, and also gain a wealth of statistical data which will support the ASA’s practice management and political efforts, by establishing the Quality Institute as an independent 501c(3) corporation. This institute will establish a comprehensive nationwide data base of anesthesia related data. The Institute will help to compliment related data currently being collected by the American College of Surgeons and other organizations, to provide a comprehensive source of perioperative patient care and practice management information. In addition to meeting regulatory requirements, this data will help ASA members to improve and streamline their practices. Although this is a large undertaking, which will eventually probably cost more than 7 million dollars, the dividends which it can pay are also huge.

Which of the new Practice Guidelines will be endorsed by the Society?

The House of Delegates approved three newly prepared practice guidelines, which will be available on the ASA web site:

1. The Practice Guideline for Neuraxial Opioids Associated with Respiratory Depression
2. The Practice Advisory on Anesthetic Care for Magnetic Resonance Imaging
3. The Practice Alert for Perioperative Management for Patients with Coronary Artery Stents

The Practice Guidelines for Perioperative Transesophageal Echocardiography were not approved at this time, almost entirely because of insufficient evidence to support the recommendation that TEE should be used for all cardiac or thoracic surgery patients.

Finally, in other House action, the issue of the perioperative evaluation and management of cardiac rhythm management devices was referred to the Committee on Equipment and Facilities for action and recommendation.

The American Society of Anesthesiologists House of Delegates elected the following officers to lead ASA during the upcoming year:

President	Roger A. Moore, M.D., Moorestown, NJ
President Elect	Alex A. Hannenberg, M.D., Newton, MA
Immediate Past President	Jeffrey L. Apfelbaum, M.D., Northbrook, IL
First Vice President	Mark A. Warner, M.D., Rochester, MN
Vice President for Scientific Affairs	Charles W. Otto, M.D., Tucson, AZ
Vice President for Professional Affairs	Robert E. Johnstone, M.D., Morgantown, WV
Secretary	Gregory K. Unruh, M.D., Kansas City, KS
Treasurer	John M. Zerwas, M.D., Houston, TX
Assistant Secretary	Arthur M. Boudreaux, M.D., Hoover, AL
Assistant Treasurer	James D. Grant, M.D., Bloomfield Hills, MI
Speaker House of Delegates	John P. Abenstein, M.D., Oronoco, MN
Vice Speaker House of Delegates	Steven L. Sween, M.D., Atlanta, GA

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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

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—from Warren Buffett, May 30, 2006



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