



President's Message

Make Your Voice Heard

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

It's the middle of August and Congress is in recess and so am I. I'm used to getting up early in the morning so I am awake even though I am on vacation. Rather than lie in bed and wait for my teenagers to get up in about four hours, I figured I would let my creative juices flow a bit.

I'm in a hotel room at the beach and my youngest son is complaining about his older brother with whom he's shared a bed. He's been up for about two minutes and he's already listed five problems about his night.

1. The cover doesn't do anything
2. My brother takes all the covers
3. The cover makes you cold
4. The bed hurts your back
5. I kept whacking my head on the armrest

To me, it was obvious what he was talking about. The room was too cold so he didn't get a good night's sleep on the pull-out sofa bed.

I haven't been sleeping well either lately, but for other reasons. I am gravely concerned about how the media has been portraying our democratic process, especially as it relates to health care reform. As you are well aware, and hopefully have participated in personally,

many congressmen and women are holding town hall meetings in their home districts on health care reform.

Many people are going out to these meetings to have their voices heard. It seems that the majority of people who have been attending these meetings are individuals who are gravely concerned about drastic changes in health care that may negatively impact them personally. Many of them have been quite vocal about their feelings. Many of them don't want drastic changes that will intrude on their personal lives, may take away their health care decision-making ability, will allow the government access to their finances, etc.

The media is portraying these individuals as angry mobs, sent there by conservative talk radio hosts or local community organizers (Gee, this sounds familiar doesn't it? Last year it was admirable to be a community organizer, now it isn't – unless you belong to ACORN!) who don't represent the majority of people's opinions on health care.

What is wrong with that you might ask? Well, when you have congressmen the likes of Michigan Democrat John Conyers who was

quoted as saying that he wouldn't read the 1,018 page health care bill he was going to vote on and actually poked fun at those who do, you better start getting gravely concerned too! It is up to all of us to have our voices heard! This is the democratic process!

We cannot have individuals, specifically the media and some members of Congress, tell us that we cannot voice our opinions! The time to act is now! (Hopefully by the time this gets to print it still will be!)

There are a number of issues with health care reform and I am by no means able to address all of them in this forum. As such, I will briefly address the one that is common to all anesthesiologists.

Reimbursement in these health care reform bills originally linked physician payment to Medicare reimbursement rates. If this were to survive in the final bill, this will be devastating to anesthesia.

There has been some talk that physician rates will be negotiable in the proposed public plan. Personally, I think this is nothing more than window dressing because our specialty is the only one that gets reimbursed so poorly from

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Sentinel

Pennsylvania Society of Anesthesiologists Newsletter

Editor

Paul J. Schaner, M.D.

President

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

Association Director

Maria B. Elias

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PSA Newsletter
777 East Park Drive,
P.O. Box 8820
Harrisburg, PA 17105-8820
717/558-7750 ext. 1596
www.psanes.org

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New Effort Underway by PANA for Independent Practice

HB 1866 Calls for “Overall Direction” and “Electronic Communication”

by John Milliron, President, Milliron Associates

It has a different bill number and slightly different language, but the nurse anesthetist’s newest attempt to expand their scope of practice through legislation has the same objective – elimination of physician supervision!

Past PANA legislation replaced physician supervision with the term “cooperation with a physician.” The language in HB 1866 now uses the phrase “under the overall direction of a physician.” Both phrases are unacceptable since they would erode the current high standards for patient safety in the operating suite.

Why do we feel so strongly about using “overall direction” rather than supervision? Simply put – it is an undefined term and the legislation gives the Board of Nursing the authority to define it. Not the hospitals, not the Board of Medicine, not the physicians – **the Board of Nursing would now have the authority to decide how anesthesia would be administered in hospitals and ASF’s!!**

The members of PSA have successfully defeated this legislation in the past, but this new effort by PANA must be answered as

strongly as ever. Every anesthesiologist in the Commonwealth must do his/her part. Call and write your legislator today.

There are several things that every anesthesiologist in Pennsylvania must do immediately:

1. Know who your state representative is. Either go to www.legis.state.pa.us and put your address and zip code in the upper right hand corner box, or call our PSA legislative office in Harrisburg at 1-800-822-6789.
2. While at that website, put HB 1866 into the “Find legislation box.” See if your member is a sponsor. If he/she is a sponsor, write immediately and express your opposition to any lowering of safety standards for your patients. Ask him/her to reconsider his/her support for this legislation. You have received specific points from the PSA to raise in your letter.
3. If your local legislator is not a sponsor, call or e-mail him/her and ask that him/her oppose HB 1866. Mention several of the points you have received in the mail.
4. Attend the Legislative Reception in Harrisburg on Tuesday, October 6. First call us at our 800 number (800-822-6789) so we know you are attending, then call your house member and tell him/her that you will be in town that evening and ask that he/she also attend. We are expecting over 100 members of the Legislature to join us on the 6th.



Now, More than Ever Be Active

by Steven W. Neeley, M.D., President-Elect

Now, more than ever, we need to be active as a society in the political arena. Health care as we have known it is changing rapidly and we need to have a say in how it changes. There are many principles we can adopt and adapt to help us affect the political landscape.

First, it is not enough to simply be in the right. Lawmakers

enact laws based on what they perceive either to be best and most popular or best for them and a portion of their constituents. We need to educate our individual lawmakers on issues that are of importance to the PSA and organized medicine.

We believe we are in the right on issues of patient safety, fair reimbursement, and tort reform.

We want our legislators to have that same perception.

How can we be effective with lawmakers? The most important part of good influence with them is to develop a personal relationship. We can do this by calling the home office of our local state representatives, senators, and

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Silence Is Not Golden

by Joseph F. Answine, M.D., Immediate Past President, Representative, Pennsylvania Medical Society SLC, Delegate, Pennsylvania Medical Society House of Delegates, Delegate, ASA House of Delegates

After listening to numerous health care town hall meetings, it has become quite obvious that physicians are politically silent. Big business, especially insurance carriers and pharmaceutical companies, are well heard and represented.

Whether supported or not, they have the ear of the legislature and executive office. They also have, based on aggressive grass roots efforts, many of the American citizens fighting for them even though they may not necessarily know what they are fighting for. But, except for weak shouts for tort reform, not much is heard in defense of physicians.

Why is this? Aren't we the final step; the direct providers of health care?

First, we cannot decide amongst ourselves as to what we want and the path we need to take to achieve our political goals. The American Medical Association proved this with its basically blind approval of a truly unknown House Bill 3200, leaving most physicians – even those that are members of its organization – in absolute disbelief.

Furthermore, multiple medical specialty organizations have signed on while others such as the American Society of Anesthesiologists are opposing it. Others over the years have recognized this pattern and that is why, for example, we have Health Maintenance Organizations (HMOs).

HMOs convinced primary care physicians that they can get their due at the expense of the specialists. Divide and conquer. Until we can agree amongst ourselves, no one else will listen.

Second, as a group, we don't have the sympathy of our patients. In the patients' eyes, doctors make good money so reimbursement issues shouldn't be a concern. We do a poor job demonstrating to the general public our dedication to our field and patients. As physicians, we fail to showcase the required intelligence required to maintain competency in our complex evolving specialty. We have not publicized the commitment of time and money essential to this process.

Lastly, we usually take a lackadaisical approach when it comes time to contact our legislators, as well as being sporadic at best contributors to our political action committees and campaigns. Everyone has a bad taste in their mouths when it comes to lobbyists and contributing to politicians and political parties. It seems "dirty" at times but its power is well established. Money and votes talk loudly to a legislator.

So what do we do? How do we move forward? First, we need to begin to speak with one voice. Second the specialties need to put aside their differences for the common good. This, in my opinion, is the most difficult part of the plan but absolutely necessary. Third, educate our patients that physician knowledge and dedication are essential components of health care and encourage our patients to lobby in this regard. Whether through the media or direct conversations, we need to prove our value to those benefiting from our expertise.

Money doesn't have to be mentioned; just value for the dollar. Finally, we have to bite our



lips, pull out our checkbooks and open up a few minutes of our precious time to visit our legislators. We are not politicians, not even close; however, we need to have the guts to fight this battle on their battlefield.

It is time to be
"politically loud."
It is time to be the
"squeaky wheel."



Should We Be Afraid For The Future of Our Health Care System?

Let Me Tell You About Fear...

by Joseph F. Answine, M.D., Immediate Past President, Representative, Pennsylvania Medical Society SLC, Delegate, Pennsylvania Medical Society House of Delegates, Delegate, ASA House of Delegates

I had many fears growing up. I was hounded by bullies all through high school, college and medical school.

But it wasn't the big guy after my lunch money who scared me. It was the 150-pound guy with the broken glasses who scored a 1,600 on his Scholastic Aptitude Test – as a sophomore. And the girl who would have gotten a perfect score on her Medical College Aptitude Test except for one question only to find out later that she was right and the examiner was wrong.

These were the people who kept me from sleeping at night. Why? They were separating me from being the best in college and medical school. We all looked around the auditorium the first day of undergraduate and medical school scoping out the competition. In college, they were my competition for medical school; and then in medical school, they were the ones keeping me from the best residency position. I was always surrounded by the scary smart and they all became physicians.

In the August 3 edition of Time Magazine, there was an article entitled "If a Health-Care Bill Passes, Nurse Practitioners Could Be Key." Here is a quote from the article: "In the recently released House health-reform bill, nurse practitioners...are listed

alongside doctors as primary-care providers." And another: "Nurse practitioners, on the other hand, require fewer years of training and can therefore bump up their ranks faster."

I have nothing against nurse practitioners. The Certified Registered Nurse Practitioner (CRNP) is a valuable asset for a physician, but the initial plan was to use a CRNP as a health care extender under the supervision of a doctor, not as a replacement.

As a patient, I just don't want a provider. Remember, the early stages of bacterial meningitis look very similar to those of the common cold, however 12 hours later the patient is dead. So, when I come in with my "cold" symptoms, I want the "ultimate provider."

I want the guy who used textbooks as a blanket in medical school, and the girl who put her hair up in a ponytail instead of curling it so that she could spend an extra 15 minutes dissecting out the pancreas of her cadaver. I want my provider to have so much medical knowledge stuffed in his brain that there isn't any room left to learn how to tie his shoes.

I want my doctor to be one of those individuals who were the source of my nightmares as a student. Medicine has improved steadily and dramatically over the years because of these "ultimate

providers”; these amazing minds who have worked feverishly to control AIDS with a flurry of high-tech medications and to allow us to put one person’s liver into another (and then have them go home and lead a normal life). We need to keep these geniuses in direct charge of each and every patient.

So am I afraid for the future of our “broken” health care system? First, let me clarify that this broken health care system is truly the best in the world. I won’t argue that the financing of health care has problems, but not the care given to our citizens as well as many others from around the world.

The best minds with the best resources available are there to make patients comfortable and well. If we need money to pay for health care, find it! But don’t destroy our greatest asset as United States citizens under the guise of repairing it. And don’t push away the best and the brightest by devaluing the role of a physician by promoting non-physicians to physicians, making a medical education cost prohibitive, or cutting provider reimbursement (which has already been stagnant or falling over the last decade or two).

Remember,
our health care
system isn’t
truly broken, but
we can break
it if we try hard
enough.

If the government wants to “fix” health care, here are some suggestions:

1. **Praise, not devalue the medical profession.**
2. **Help with tuition reduction or repayment.** The education of a physician can easily cost \$400,000 or more. Furthermore, a physician cannot secure his/her first real job until well past 30 years of age. Tuition aid by itself will increase the numbers of much needed physicians, especially in primary care where salaries are the lowest.
3. **Raise or at least maintain physician reimbursement.** We are already plagued by government-controlled Medicare and Medicaid rates that are a small percentage of a doctor’s usual fee, and are continuously being reduced further. The majority of the currently proposed health care plans use Medicare rates as the benchmark for reimbursement. Improving reimbursement will increase job satisfaction and continue to be an incentive for the better students to fill up the health care ranks.
4. **Tort reform!** Yes, I said it. Speaking about tort reform is like uttering the name “Lord Voldemort.” But billions would be saved if we can avoid defensive medicine. This has always been an uphill battle, because trial lawyers have a much larger presence in politics than physicians.
5. **Strengthen the relationship and the oversight of a physician and healthcare extenders** such as RNs, CRNPs and physician’s assistants. The needs of all the patients will be met without significantly diminishing the doctor/patient relationship.
6. **Don’t be afraid to hold patients responsible for their health.** Emphasize the patient’s role in smoking-related morbidity, curbing obesity and its related illnesses, and the need to understand the dangers of alcohol and drugs. Even consider making them at least partially financially responsible for controlling habits that lead to poor health. Again, billions will be saved by an overall decreased utilization of health care services related to treating advanced disease caused by the above mentioned poor habits.
7. **Provide more, not less, funding for medical research.** The spread of illness keeps marching on. Continuously striving to improve the health of our citizens can only make our society stronger, more productive and more economically advanced in the future.
8. **Further define who the uninsured are.** The 46 million number cited by Obama and others comes from the Census Bureau’s annual Current Population Survey for 2007. However, there are many questions as to the accuracy of this number with many feeling that it is grossly inflated and includes a large group with the means to have coverage but choose not to. By having a better understanding of the actual numbers and groups involved, the appropriate funding and care can be given to those who truly need it.
9. **Patients need to be directly involved in some way, shape or form with payment of health care services** in order to curb inappropriate utilization such as unnecessary emergency room visits.
10. **Keep the government out of the health care business.** It has been proven time and time again that government-run health care is less efficient, less likely to provide comprehensive care and much more expensive to the population as a whole.

Editorial

Health Care Reform

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

The evolution of the government's health care plan continues. What is in the plan will be anybody's guess.

President Obama does not appear to know the details, nor do many members of congress. The details will be devilishly important. The 1,000-plus pages of legalese in this bill have already had at least three versions.

The bill references and amends other laws that must be read, meaning it is more like 4,000 pages. This appears to be a stimulus-style scenario. Rush through and pass a huge bill that must be done yesterday for trillions of dollars for salvation of economy and country.

As of this writing only 18 percent of the stimulus bill has been spent and the economy appears to be on the initial upswing. It was to cap unemployment at 8 percent, but many states are at 9.5 percent and rising; some states are in the high teens.

The presidential promise was a line-by-line review of legislation with no earmarks. The stimulus bill had more than 9,000 earmarks.

The presidential promise was no signed bill until it was available on the Internet for five days. It was signed immediately and unread by congressional members let alone the president.

This health care bill must not be a repeat. Your health care, your family's and your patients' are too important. The ballooning national debt demands a careful, thoughtful and open process. This bill will change the landscape for years to come.

It is an entitlement that will not go away. Insist your congressional representative and senators adhere to a frank, open legislative process. If members of congress were to also be covered under the same health care plan that they pass, it would be carefully crafted.

The congress, however, is excluded from this plan. If the congress were under Social Security, instead of their own re-

tirement program, I suspect either term limits would not be an issue or it would be a solvent program.

Phone calls, e-mails, personal visits and attendance at town hall meetings are essential components of legislative input for the health care bill. You need to make it clear a repeat of the stimulus bill will not be tolerated. It will take a dedicated effort to keep abreast of the proposals and what ultimately comes out of the house and the senate.

The conference committee will be a closely monitored event. The conference committee must produce a single bill for passage by the house and the senate. This bill will be the final version prior to passage.

This is crunch time. It is time to insist the president keep his promise of five days on the Internet prior to his signing this bill.

The presidential desire to pass the health care bill, however, is likely to overpower any campaign promise. IT is clearly imperative to try for worthy health care legislation...your health will depend on it!



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The National Scene

Summer of 2009: ASA Report

by Donald E. Martin, M.D., District Director ASA

The impact of pending national health care reform legislation on the specialty of anesthesiology has dominated our society's attention on a national level. However, several regulatory issues, including implementation of changes in the resident teaching rule, classification of fospropofol and propofol as controlled substances, and infection control in the operating room have also been important for our specialty.

Internally, ASA has added two new subspecialty committees, and the wellness of anesthesiologists will play a prominent role at the ASA annual meeting.

President Obama has outlined a very aggressive, far reaching plan for health care reform that would include multiple changes in the way that health care would be delivered and financed, and has included health benefits for uninsured Americans.

Proposals for financing this health care plan include a so-called "public option," which would be provided by the federal government and made available to any Americans who chose it. This option would be designed to "compete" with private insurance.

However, many feel that it would become a de-facto single-payer system. The major problem for anesthesiologists with any of

the reform proposals comes when any of the proposals use Medicare rates as the basis for physician reimbursement for the so-called "public option."

Since Medicare pays anesthesiologists only roughly one-third of what they are paid by private insurers, a national health insurance plan based on Medicare rates would be unaffordable for our specialty. Therefore, ASA has launched a comprehensive legislative offensive to remove connections between the public option and Medicare rates.

In the Senate, the Health, Education, Labor and Pensions (HELP) Committee has drafted the "Affordable Health Choices Act," which includes a "public plan" option with negotiated rates rather than a "public plan" option based on Medicare payment rates.

The Senate Finance Committee, which actually has jurisdiction over health care issues, is expected to release its version of a health care reform bill in the coming weeks.

In the House of Representatives, there are three committees responsible for health care legislation: the Energy and Commerce, Ways and Means, and Education and Labor committees.

Two of these committees, the Ways and Means Committee and

the Education and Labor Committee, have adopted the House version of the health care reform proposal, HR 3200, the "America's Affordable Health Choices Act." This bill contains a public plan option based on Medicare rates.

On Friday, July 31, however, the House Energy and Commerce Committee adopted an amended version of HR 3200 that allows physicians and hospitals to negotiate payments under the public plan option. This amendment, which was strongly supported by the "Blue Dog Democratic Coalition," was applauded by ASA.

However, the position of the final House version of HR 3200 on the linking of Medicare rates to the public option remains uncertain. Negotiations between all three House committees will determine the final bill.

Congress is currently in recess, and during this time ASA will work hard, with the support of all ASA members, to assure that Medicare rates are not adopted in the final version of the Health Care Reform Bill. It is now expected that the final bill will be considered in September, and possibly after the House-Senate Conference Committee, be sent to President Obama in October.

On the regulatory side, in July CMS released its 2010 Physician

Fee Schedule that includes the proposed implementation of the Medicare anesthesiology teaching rule change. In this rule, CMS proposes to “narrowly interpret the law” and require that only one individual teaching anesthesiologist be present during all of the key or critical portions of an anesthesia procedure in order to receive full reimbursement.

This interpretation would not allow full reimbursement if more than one anesthesiologist supervised a resident during any particular case. It is obvious to those of us who work in the operating room that this interpretation would severely restrict full reimbursement for teaching anesthesiologists, since it would not permit “handoffs” of supervision, which are considered essential to promote operating room efficiency.

This interpretation does not seem to be consistent with congressional intent, and would surely represent an arbitrary restriction, in the face of legislation that ASA has worked hard to get passed. Therefore, all anesthesiologists are urged to submit comments to CMS, using the sample letter and instructions available on the ASA website at <http://www.ASAHq.org/news/ASAnews070209.htm>.

Almost coincident with Michael Jackson’s death associated with the administration of propofol, the DEA recommended that fospropofol be classified as a schedule IV controlled substance under the Controlled Substances Act. ASA, in a letter carefully considered by the Committee on Occupational Health, had recommended this course of action to the DEA based on the pharmacological effects of fospropofol, and its increasing, though still relatively low, potential for abuse, particularly in anesthesiologists and other anesthesia practitioners.

Since propofol and fospropofol present a limited risk for abuse to the general public, and since

dependence is mostly psychological, ASA recommended the classification of the drug at the level of schedule IV, rather than the more restrictive schedule II. This recommendation is also consistent with the fact that many similar sedative medications are also classified as schedule IV.

Because of the similarity between fospropofol and propofol, the DEA is very likely to also recommend the schedule IV designation for propofol. The Committee on Occupational Health and ASA recognize the administrative burden that will be placed on anesthesiologists who could be faced with tracking propofol and fospropofol if the scheduling recommendations go into effect.

However, in the interest of the health and welfare of our own specialty, it seems that this approach is almost inevitable.

Finally in the regulatory realm, the Center for Disease Control has made recommendations that would prohibit the refilling and reuse of any sterile syringe, even to administer the same medication to the same patient. Because of the lack of good data that could substantiate or refute this recommendation, significant controversy still exists and the ASA has not taken a position on whether to support this recommendation, which would require extra time, extra money, and perhaps have unintended consequences regarding labeling and medication identification errors.

Over the last six months, ASA has also made several important internal changes.

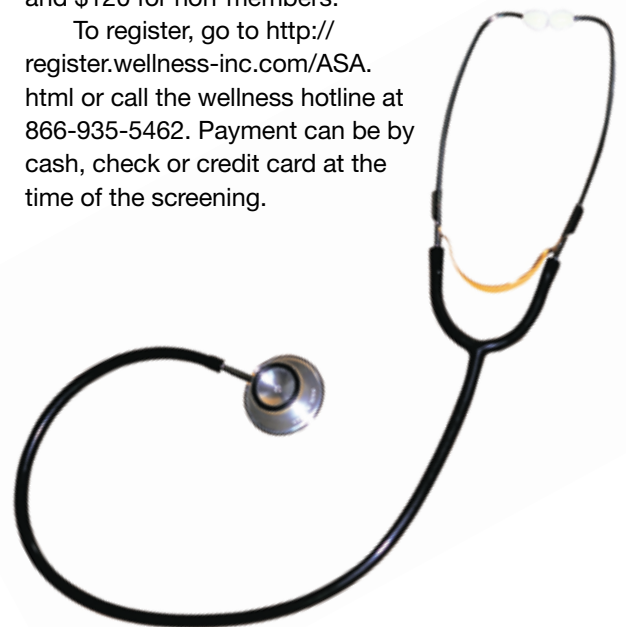
In March, the ASA Board of Directors approved a recommendation to create two new committees in the Section on Society Subspecialties, one for cardiovascular and thoracic anesthesia, and the other for neuroanesthesia. Final approval would come at the House of Delegates in October.

Finally, a comprehensive wellness initiative for anesthesiologists has been crafted over several years by current ASA President, Roger A. Moore, MD. This initiative includes a loan program sponsored by the Anesthesia Foundation for anesthesiologists suffering professional and financial setbacks, a wellness website, “Healthy Anesthesiologists,” that is currently under construction, a summary of research on health and wellness issues for physicians, as well as video presentations and annual meeting panels.

At this year’s ASA Annual Meeting in New Orleans, there will be an onsite screening program, or wellness booth, on Monday and Tuesday from 9 a.m. to 4 p.m. in the exhibit hall. This screening program will include a health history, blood pressure readings, BMI calculation, and comprehensive blood chemistry profile.

Additional, more specialized blood tests – including PSA, hemoglobin A1C, hepatitis B immunoassay, RAST allergy testing, and others – are available for a small fee for anesthesiologists who may have known or suspected disorders. The cost of basic screening for ASA members is \$50, which is lower than the cost of a workshop, and \$120 for non-members.

To register, go to <http://register.wellness-inc.com/ASA.html> or call the wellness hotline at 866-935-5462. Payment can be by cash, check or credit card at the time of the screening.



Cooperative Quality Care Initiative with PA Patient Safety Authority

by Joshua H. Atkins M.D., Ph.D.



Comparative effectiveness research, pay for performance (P4P) and “never-events” are the health care buzzwords of today. The evolving paradigm of health care quality measured by codified, external metrics increasingly impacts the daily practice of medicine. Forward-looking physicians appreciate that self-assessment and preemptive corrective action are as, and perhaps even more, likely to improve patient care than legislatively imposed mandates and directives.

Our day-to-day work is extremely taxing. We are all stressed and seemingly pushed to our limits; the last thing anyone wants to experience is the added anxiety and concern associated with an adverse event. Fortunately, anesthesiologists in many hospitals and practices across the state are working hard to analyze the causes of unexpected events and errors and alert us to underappreciated hazards.

Wouldn't it be even better if providers in a community hospital in Altoona, large Pittsburgh aca-

demically centered center and a Philadelphia area private practice could derive mutual benefit from QA/QI efforts? In this way, anesthesiologists across the state, working together, could be PROSPECTIVELY alerted to quality and safety issues discovered in other hospitals.

The PSA Board aims to accomplish this goal through the establishment of QA/QI Working Group of the Membership and a collaborative partnership with the PA Patient Safety Authority.

The PA Patient Safety Authority (<http://www.patientsafetyauthority.org>) was created by the Mcare Act of 2002 and subsequently created the PA Patient Safety Reporting System (PA-PSRS). Pennsylvania is the only state in the nation with mandatory reporting of medical errors and near misses. Nearly 120 hospitals and a significant number of ambulatory facilities report their medical errors and participate in patient safety surveys.

The Authority analyzes the collected data to identify trends and recommend changes in health care practices and procedures that may be instituted to reduce the number and severity of future serious events and incidents. The PA-PSRS is an enormous database with a utility to practitioners and patients that is only as good as the data provided and the interrogation and analysis performed.

Rather than wait for catastrophic events to emerge from the dataset, we propose to proactively work with Safety Authority and our members who are interested in local QA/QI activities

to guide the analysis of available data in a clinically relevant fashion. The groups can work cooperatively to develop high-impact communication tools, CME programs, and alerting systems that will affect changes in practice based on the insight gained through collaborative analysis.

In keeping with our vested professional interest in patient safety and quality, the PSA will be one of the first specialty societies in the state to develop a collaborative, on-going relationship with the Safety Authority toward the goal of perfection in the level of care we provide our patients. Orthopedic surgeons are working with the Authority in a similar fashion.

The PSA is forming the Quality And Safety Working Group to function as a sounding board for and facilitator of QA/QI activities within the Society and with the Safety Authority on issues related to patient safety. This is a grassroots, team effort.

We depend on the input and participation of members of academic and private practice groups across the state to make this venture successful. If you are interested in working on this project in any way or are involved in QA/QI projects for your group or hospital please, contact me so that we may solicit your expertise and local experience to jump start these efforts and develop a shared perspective on these critical issues. Please e-mail your name, contact information, and the name of your group and primary hospital affiliation and we will be in touch!

Secretary/Treasurer's Report

Is My Membership in the PSA Important?

by Patrick Vlahos, D.O., Secretary/Treasurer

Due to the economic decline, state and federal governments are looking for ways to reduce costs and that includes health care costs. The state governments are not as focused on patient outcomes as we, the anesthesiologists who care for their patients, are.

We have recently completed another annual billing cycle, and I am concerned.

This year is the first in recent memory that the enrollment for PSA has declined. Although you may feel that this is of no importance to you, maybe you should reconsider.

Yes, the cost of the annual membership is low to join the PSA. You might ask yourself how much will my contribution help the PSA, and, more importantly, how much will this help my patients?

As you can see this is a very critical time for the PSA and the ASA's survival. Again this year the AANA and the PANA have chosen to re-introduce bills that will allow nurse anesthetists to practice independently of physicians. There is a bill that was presented to the Pennsylvania Legislature that would decrease physician involvement while supervising nurse anesthetists.

We have been through this fight before, and we have been

successful. Today the story and the fight have changed.

As we all know, the state of California has chosen to permit nurse anesthetists to practice independent of physician supervision. Which state will be next?

Your dues allow us to support our lobbyist in Harrisburg. The dues support visits to your local state legislators by members of our board of directors.

Most importantly, the dues that you pay allow PSA to host a Legislative Reception on Oct. 6 this year and every other year in Harrisburg. This is an opportunity for you to speak directly to your state representative and/or your state senator about your concerns.

Yes, your dues are important and beneficial to both you and your patients. Fellow anesthesiologists, please support your society by paying or renewing your PSA dues.

Also, encourage your associates to join the PSA. This is the only state society that is here working directly for you.

Join our society through the ASA website at <http://www.asahq.org/joinASA.htm>. The enrollment process is fast, free and easy. The price of membership will go a long way toward helping us achieve our goals.

2009

Legislative Reception

Tuesday, October 6, 2009

5:00 pm – 6:00 pm
Legislative Briefing & Dinner

6:00 – 8:00 pm
Legislative Reception

Harrisburg Hilton & Towers

(Corner of Second and Chestnut Streets)

Harrisburg, PA

You are cordially invited to attend the 2009 PSA Legislative Reception in support of your Society and its mission of patient safety. Please be sure to attend both the Briefing and Buffet Dinner at 5:00 pm and the Legislative Reception at 6:00 pm.

One hundred plus members of the Pennsylvania House of Representatives and Senate are planning to attend the reception. Some are newly elected, and may not be aware of our work or mission. It is important that we take this time to reacquaint ourselves with those who have not only supported us in the past, but who will support us this year.

In May, legislation was introduced (HB1866) that will essentially expand the nurse anesthetists' (CRNAs) scope of practice in Pennsylvania. Showing our interest and our concern as a group at this event will speak volumes to legislators who have the opportunity to support our issue this fall.

We would like to notify your Representative and Senator in advance that you plan to attend, so please RSVP today by calling PSA at (800) 822-6789.



President's Message

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Medicare. All the rest of medicine will have rates that will be 80-plus percent compared to private commercial insurance, so negotiating a rate that pays a couple percent more than Medicare isn't that big a deal.

For us, we need to ask the government to pay three times what it currently pays us for Medicare services! I believe there is virtually no way the federal government will agree to that, but we must try. Call your Congressman and Senators. Let them know who you are and what you think about health care reform, especially as it pertains to the specialty of anesthesiology.

Here in the Commonwealth, our state legislators are still trying to come up with a budget that doesn't have tax increases. (I'm afraid we will see one soon.) We don't know the fate of Mcare as it is tied to the Health Care Provider Retention Account (HCPRA) and the current budget impasse, but if I had to guess, we will be seeing that phased out starting in 2010. If this happens, you will be paying more for malpractice insurance next year.

The Pennsylvania Medical Society and Hospital and Health-system Association of Pennsylvania (HAP) filed suit against the state in December 2008 to preserve the funds in the HCPRA. At the present time, the Pennsylvania Commonwealth Court has unanimously rejected a motion to dismiss the suit. Pennsylvania Medical Society & HAP are trying to determine their next course of action.

I would like to touch briefly on the PSA website. Your PSA Board Members are diligently working on providing quality material for the new website. It is slow going, but I am confident that we will see it start to materialize in the near future.

Those members who are pain practitioners will be glad to know that PSA is still actively involved with the Pennsylvania Pain Coalition (PPC). PSA Board Member, Michael Ashburn, MD, has been elected Chair of the PPC. Through his efforts, Governor Rendell has recognized September as Pain Awareness Month in the Commonwealth. See <http://www.pac3.org/Files/PainAwarenessMonthProclamation.pdf> for the Governor's proclamation.

Efforts are underway to improve the C+ pain grade given to Pennsylvania from the University of Wisconsin Pain & Policies Study Group.

Finally, the President's message would not be complete without some discussion of the latest CRNA Scope of Practice bill, HB 1866, this legislative session's CRNA Scope of Practice Bill, takes on some new language.

CRNAs wish to practice under the "overall direction" of a physician or dentist. The bill does not attempt to define what this means, nor is it defined anywhere else in statute or regulation. The bill goes on to state that when there are no anesthesiologists or physicians involved in the care of a patient under anesthesia, the CRNA can choose a physician to contact who may be physically present or available via electronic communication.

Obviously in an emergency situation, this jeopardizes patient safety. We must let our legislators know what this could mean to them, their families, friends, and constituents. I am your community organizer! Pick up the phone and call your state representative, e-mail him or her. Let him/her know how you feel about this bill. Show up in Harrisburg at the PSA Legislative Reception on Oct. 6. I look forward to seeing you there!

Welcome New Members

Active Members

Ali R. Ekbatani, D.O.

Barry O. Pinkus, M.D.

Steven Schrenzel, M.D.

Mark Slywka, D.O.

Residents

Andrea G. Fanelli, M.D.

Daniela Elena Francesca Ghisi, M.D.



Now, More than Ever

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U.S. Congressmen and setting up an appointment to discuss issues with which we may have expertise.

We can do this by attending a fundraising event. We can do this by inviting them personally to our PSA legislative reception and then being there to greet them. These steps will help us “get face time” with our representatives, but then it is up to each of us to cultivate that relationship.

I have many friends in the legislative ranks, and there is not one of them who agree with me on every issue (or even most of the issues). We cannot be critical of votes that we disagree with. We must do our best to inform and educate the lawmaker and/or the legislative aides.

Our lobbyist (John Milliron) can be of great assistance with state lawmakers and how we can best help them. Please treat them

and their offices as friends, not opponents and allies. The political gain for us will follow.

Other than being friends, lawmakers are always looking toward that next election, so your help will be greatly needed and appreciated. Obviously money donations are of great importance, but also your personal help in an election or fundraiser is perhaps even more important.

You may not feel that it is true, but lawmakers do think physicians are important people – especially if they feel you are on their side. I admit some may treat us rudely and have no time for us, but even then it will not help to make enemies.

So remember a few of these do’s and do not’s when approaching your lawmakers. Be a friend, do not be critical, help both with time and money, and always include John Milliron in your

planning and then report to him information on any contacts.

We need all of our society members to understand how crucial it is to be friends with our legislators and how important it will be to be their “key” contact for our society. Best of luck to us all in our political endeavors, and wishing us successful and fruitful relationships. Now, more than ever, we need to be active in the political arena. Educate ourselves on the issues, educate our lawmakers, and report our encounters. Now, more than ever.

Pennsylvania Society of Anesthesiologists

Annual Membership Luncheon Meeting

(As part of the ASA Annual Meeting in New Orleans)

Sunday, October 18, 2009

12:00 - 1:30 PM

La Galerie 1 (second floor)

New Orleans Marriott Hotel

The deadline for online registration and ticket purchases for the ASA Annual Meeting is October 7.

See <http://www2.asahq.org/web/index.asp> for more details.

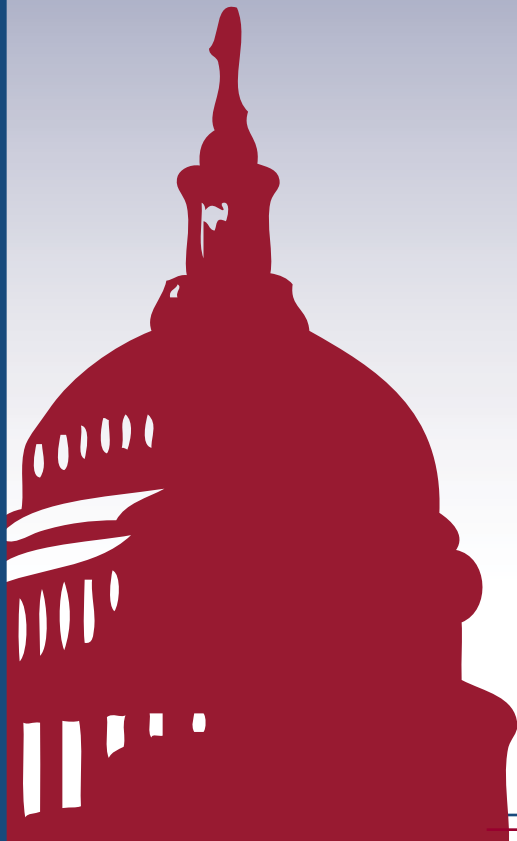




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Annual PSA Legislative Reception

Tuesday, October 6, 2009
5:00 pm to 8:00 pm

Harrisburg Hilton

**Please make every attempt to attend
RSVP today by calling PSA at (800) 822-6789**