



President's Message

Is Change Really Good?

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

Undoubtedly, you heard a lot about change this past election cycle. Now that we have our new U.S. President sworn into office, millions of people around the world are looking to him to solve many crises from helping to pay the bills to pulling our troops out of harms way to revamping our health care system. Certainly there will be significant discussion in the upcoming weeks and months regarding how the majority of US citizens can obtain and/or maintain health care coverage at a reasonable cost. One of President Obama's campaign statements that I heard a number of times was that everyone could get the same health insurance coverage that he got as a US Senator. What he was not as forthcoming with was the fine print: AT A PRICE. We will see Congress grappling with the issue of cost. Every US citizen and even the undocumented immigrants want easy access to health care. Perhaps they will throw millions of dollars at it as they are doing with the economic stimulus package. It's too early to tell, especially now that Tom Daschle will no longer head the Department of Health and Human Services.

So, where does that leave us? It's difficult to say. The economic stimulus bill HR 1 includes some aspects of what the new Democratic Administration would like to see in their vision for the future of health care. Betsy McCaughey, former Lieutenant Governor of New York, wrote in a commentary on Bloomberg.com (<http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aLzfDxfbwhzs>) about how you can "Ruin Your Health with the Obama Stimulus Plan." Her opinion was rather pessimistic in that she believes that the Health Care funding in the economic stimulus bill will ultimately be used to limit costs by rationing health care.

How does that 1434 page bill stimulate health care? Personally, I don't think it does, but was included in the bill without much chance for discussion. Basically, the bill provides for money to fund Health Information Technology (HIT) and more importantly, outcomes research. It has been estimated that physicians may receive anywhere from \$44,000 to \$64,000 for implementation of an electronic health record as a result. (However, anesthesiology and other hospital-based special-

ties were apparently deliberately excluded from this stimulus money.) These advances in HIT will, in theory, be used to increase patient safety through the increased use of standard treatment protocols that are developed as a result of outcomes research.

The bill includes at least "\$700,000,000 for comparative clinical effectiveness research" to be spent by the Agency for Healthcare Research and Quality or the Office or the Director of the National Institutes of Health. (HR 1, Pg. 806) "In addition, \$400,000,000 shall be available for comparative clinical effectiveness research to be allocated at the discretion of the Secretary of Health and Human Services and shall remain available through September 30, 2010: Provided, that the funding appropriated in this paragraph shall be used to accelerate the development and dissemination of research assessing the comparative clinical effectiveness of health care treatments and strategies, including through efforts that: (1) conduct, support, or synthesize research that compares the clinical outcomes, effectiveness,

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PENNSYLVANIA
society of
ANESTHESIOLOGISTS

Sentinel

Pennsylvania Society of Anesthesiologists Newsletter

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Update on CRNP Regulations

by Robert Hoffman, WolfBlock LLC

The winter 2008 issue included a lengthy article summarizing the mostly critical comments, focusing on pain management, that PSA had submitted concerning proposed CRNP regulations. The regulations, proposed by the Board of Nursing, will, if implemented as written, substantially expand CRNP's scope of practice, all but allowing independent practice. PSA sent its comments to the Independent Regulatory Review Commission ("IRRC"), which reviews and comments on all state regulations. This article provides an update on the positive developments since. .

Simply put, IRRC substantially agreed with the comments of PSA and other medical groups, including the Medical Society and the Psychiatric Society. IRRC made numerous comments and asked many questions that the Nursing Board must consider and address before it finalizes the regulations. The regulatory process is complex; suffice it to say that IRRC's comments will likely have a substantial impact on what the final regulations will look like.

To read the full IRRC comments, go to <http://www.irrc.state.pa.us/Regulations/RegInfo.cfm?IRRCNo=2729> and follow the link for "Proposed IRRC Comments." The remainder of this article summarizes the high points in IRRC's comments.

Initially and generally, IRRC noted that "while increased access to quality, affordable health care is a necessity, . . . it must be balanced with adequate protection of the public health, safety and welfare." IRRC's concern was that the regulations and accompanying materials "did not adequately explain the rationale" for the changes nor demonstrate

that they balanced access and affordability with quality of care. It then turned to specific items.

- The proposed regulations would delete the requirement that if a collaborating physician determines that a CRNP was prescribing inappropriately, the collaborating physician was to take prompt corrective action. IRRC noted that "commenters representing the physician community believe this provision is needed to protect patient safety" and continued: "We agree...and recommend that it either be retained or a similar provision be mandated for any prescriptive authority collaborative agreements."
- The proposed regulations would substantially expand a CRNP's ability to prescribe Schedule II-IV drugs. PSA and other medical associations had particularly objected to that provision, and IRRC agreed: "we ask the Board to further explain why these amendments will not put the health of patients at risk. In particular, the Board should explain why it believes CRNPs have the appropriate education and training to administer these provisions, especially without oversight of a physician." IRRC specifically asked the Board to consider the alternative recommendation offered by PSA, Pennsylvania Medical Society, and others.
- The proposed regulations deleted the requirement that collaborating physicians have knowledge and experience with any drug CRNPs will prescribe. Again, IRRC asked why this made any sense,



particularly given the proposed expansion of authority to prescribe Scheduled Drugs.

- The proposed regulations would delete various provisions that would identify CRNPs as CRNPs and avoid any inference that they were physicians. IRRC thought that was inappropriate. "We believe the current regulations of the Board provide more protection to the public and recommend that they be retained. Of particular concern are [proposed deleted provisions] which currently requires patients to be notified of the fact that they will be seen by a CRNP and... requires CRNPs with a doctorate degree to inform patients that they are not medical doctors."

PSA is quite optimistic that the final regulations will be a substantial improvement over the proposed regulations and believes the participation of PSA and organized medicine generally played an important role in IRRC reaching the positions it did.

Getting Involved: Is It Worth Doing While Still In Residency?

by James Rossignol, MD, PSA Resident Representative



Residency is a time of personal and professional growth that is unmatched almost anywhere else. There is often little time to pursue outside interests as we attempt to balance work, education, and family while focusing on becoming competent anesthesiologists. Every now and then it becomes necessary to step back and examine the bigger picture in order to maintain the motivation that is needed to complete four years of residency training. We will eventually need to answer questions such as academic or private practice? Do I see a fellowship, or a research career, in my future? Other questions, which we do not routinely think about, are: What aspects of our specialty define who we are, and what sets us apart? What do we expect the future of anesthesiology to look like? We have chosen a subspecialty of medicine that demands an intense focus, concentration, and understanding of our patients' needs during a time when they are most vulnerable and residency does a great job of preparing us for this challenge. It does not, necessarily, prepare us to enter into practice with an adequate awareness of how organized medicine functions, on both a national and a state level.

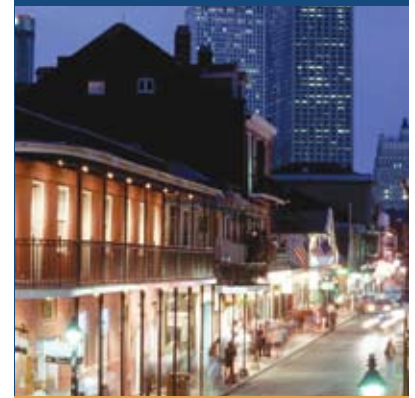
With the recent change in the political climate and the growing concern over the state of our current healthcare system, it is more important now than ever to become aware of the challenges that we face as physicians, and as a specialty. It's crucial that residents do not sit by the sidelines,

but instead take an active role in structuring the future practice of anesthesiology. The Resident House of Delegates during the annual ASA meeting and the ASA Legislative meeting each summer in Washington are both excellent opportunities for residents to get involved. Last June during the ASA Legislative meeting, I joined with anesthesiologists from around the state and met with legislators to discuss stopping the Medicare reimbursement cuts, restoring the academic teaching rule, as well as legislation pertaining to improving funding for pain research and education and legislation that will strengthen enforcement against limited-licensed healthcare providers who misrepresent their skills, training, and education. It was only because of anesthesiologists that came together on a national level, that Congress overrode a presidential veto and later restored full Medicare payments to anesthesiology teaching programs. This unfair 50% payment penalty had only affected the medical specialty of anesthesiology, and was costing residency programs approximately \$30-40 million per year. Last year the PSA faced a tough battle with House Bill 1256, which would have expanded the scope of practice for nurse anesthetists practicing in Pennsylvania. Due to the grassroots efforts of PSA members contacting their state legislators, this bill was stopped before it made it to the governor's desk. With the nation's attention now on a struggling economy and an uncertain future for our healthcare system, legislators are under more pressure than ever to cut costs within an already flawed

system. We all need to be aware of how legislation is affecting, and will affect, how we practice in the future.

It's up to us to make sure that our voices are heard, and that we will be able to continue being physicians protecting patients. If you are unable to attend one of these PSA or ASA meetings, donating to both the ASA political action committee (ASA PAC) and the PSA political action committee (Z-PAC) will help to ensure that your voice is heard on a national and state level. Even on a resident's income, a small donation of \$20 to each PAC is an investment well worth making. If you have an interest in determining what our practice will look like after residency, please let me know, at jrossignol@hmc.psu.edu.

Save the Date!



ASA Annual Meeting

October 17-21, 2009

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Convention Center
New Orleans, LA

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You—R Politics

by Paul J. Schaner, M.D.

Most consider Politics a dirty business. Politics, however, govern almost every aspect of our daily lives. The quality of the air we breathe, the quality of what we consume and drink milk, meat, water and food are dependent on the vigilance of the government agencies. The rates we pay to warm, cool and light our homes are regulated by government. Phone rates, health insurance, auto insurance, and life insurance come under government control.



Licensure of almost all involved in our lives from physicians, pharmacists, nurses, dentists, electricians, beauticians to lawyers are under the government in multiple ways. The quality of the roads that we drive on, the assurance that the pumps used to fill your car with fuel are accurate is under supervision of the government. Since there is such a daily effect on your life, why are so many reticent to be involved in the process? With the government growing larger each day can we afford not to be involved?

The daily routine permits a finite time for extra activities. Demands of work and family often leave little time for other endeavors. In the current economic environment, however, it has become very apparent that the attention spent in political action is critical. "We're from the government and we are here to help you" is scarier than ever. The very foundations of everyday life are under assault. The assump-

tions that government agencies are effective, active and directed by competent people are increasingly in doubt. It is essential that intelligent and knowledgeable politicians honestly fulfill their duties in representing their constituents. This oxymoronic statement must become reality. It is no longer acceptable to elect along party lines. Knowing your candidate is imperative. Knowing what your elected government officials are doing is essential. Ben Franklin's admonition to guard your wallet while the legislature is in session is spot on.

Every politician must gain the support of their electorate. Vetting of the candidates can no longer be the domain only of political bosses in a smoky back room. We can no longer assume proper vetting has occurred by anybody. Primary elections become an important starting point because when voters do not show up, the political machine elects the candidate of THEIR choice. We the voters need to encourage the talented to seek political jobs. It should not be a second choice. In large measure the future direction of the country, your family's future is in the process. How well do you know your state representative, state senator and their federal counterparts? Do you know their names or how to contact them? Have you ever contacted any of them? Have you made your desires known to them or held them accountable for their vote(s). Make sure that tomorrow you can answer yes. Your future and your family's hang in the balance. Be political!



Welcome New Members

Active Members

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Basavana Gouda Bharamana
Goudra, M.D.
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Gregory H. Pharo, D.O.
Laura Schleelein, M.D.
Daniel Weil, M.D.
Laura N. Zeigler, M.D.

Residents

Mahwish Raza, M.D.

Recruiting Foreign Anesthesiologists: A Delicate Balance All the Way Around

by Valentine Brown, Esq.

Worldwide demand for anesthesiologists and other types of physicians remains high. Like other countries, the United States is facing a critical shortage of physicians and health workers in the coming decades. The reasons for this shortage are numerous: we are under-producing new health care workers to meet demand. Many health care workers who train in the U.S. leave the profession mid-career for non-health care occupations. Over the next 10 years, a large number of health care professionals will retire. During the same period, consumer demand for health services will continue to rise due to an aging population and increased demand

for specialized services. These factors combined with normal population growth of somewhere between 14-18% by 2020, (approximately 50 million additional people) place the problem in stark relief.

Recruitment of foreign physicians is one way to address increased demand, but as in the past the political ramifications and difficult immigration process require a constant balancing of societal, political and practical considerations. Beth Schlachter, a program officer in the Office of Population and International Migration at the Department's Bureau of Population, Refugees

and Migration, in a recent Department of State blog post explains that, "we have a complex international phenomenon that isn't easily addressed.

For example, some countries, such as the Philippines and Pakistan, produce excess health workers for overseas employment because they value the remittances these workers provide, and the Philippines has set up an effective mechanism to monitor the companies which recruit there. Other countries, such as Ghana,



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ASA Updates

ASA 2009 Winter Update

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

Over the past several months, the Federal government has been preoccupied with the elections, particularly the election for President. Now, interest in Washington has turned to President Obama's economic stimulus package, and most new federal initiatives regarding healthcare are tied, in one way or another, into this inclusive stimulus package. Significant healthcare provisions include funding for health information technology, along with a significant bureaucracy, additional Medicaid funding and expanded health insurance benefits for the jobless, as well as over 1 billion for clinical research, comparing the effectiveness of various treatment protocols.

The ASA spring Board of Director's Meeting is still almost a week away, so that the Society has taken no official action since the October annual meeting in Orlando.

However, several issues are being discussed by ASA committees, and one has particular relevance to practicing anesthesiologists. The role and responsibilities of anesthesiologists in the pre and postoperative management of patients with indwelling pacers and AICD's is being debated. In particular, the question has been raised whether anesthesiologists should assume responsibility for the pre and postoperative interrogating and/or reprogramming of these

devices. In some larger facilities, technicians and physicians are available to perform these functions 24 hours a day and 7 days a week. In other hospitals, anesthesiologists may be the most qualified physicians available. However, the technology required to perform these functions, as well as the changing pacer and AICD technology which requires specific expertise, and perhaps even certification by the Board of Heart Rhythm Examiners, would be hurdles for anesthesiologists to overcome. This debate is ongoing. If you have opinions on either side of the controversy, please feel free to contact me by email at dmartin1@psu.edu.

Specialty Leadership Cabinet Report

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



As is done 3 times yearly, the Pennsylvania Medical Society Specialty Leadership Cabinet met on February 3, 2009. This forum allows Pennsylvania Medical Society to gather the insights from and the support of the various state medical specialty organizations. The meeting started with a presentation on Primary Care and the Medical Home. Once again, Pennsylvania Medical Society is supportive of this concept that will hopefully allow patients to become more empowered and responsible for their own health and will result in less health care expenditures.

The meeting then turned to what was the most pertinent issue for all of medicine, MCARE. The group was informed that unless something is done to change what is already in statute, MCARE will be phased out in two steps. The first step will be in 2010 when private insurance will be required to cover 3/4th of the required 1M/3M malpractice while the remaining 1/4th is MCARE. The second step will occur in 2013 when all malpractice will be private and MCARE is phased out. If it were that simple, we would have nothing to talk about. Unfortunately,

it is anticipated that there will be a 25-35% increase in malpractice rates with each of these two changes. In addition, since MCARE is a pay as you go system, there will still be unfunded liability for claims that have yet to be filed that will need to be paid for by you and me. In essence, it's a tail that won't go away completely until around 2030. The Pennsylvania Medical Society will likely seek a more gradual phase out of MCARE in order to lessen the financial burden on physicians.

Next, the PA Academy of Family Practice asked the SLC to consider supporting them in their request to amend the Medical Practice Act of 1985. They would like IMG's to be able to obtain an unrestricted medical license in PA after 2 years of postgraduate training (just as US grads can do) as opposed to the current 3 years. Their rationale is that many residents moonlight during their third year of residency and by excluding IMG's from doing so limits access to care. It was cautioned by the SLC Committee that opening the Medical Practice Act could open other areas to change that were not anticipated or intended. A CRNP update was presented. (See separate article.)

The PA ER doctors gave a presentation regarding hospital overcrowding. They are working on a project that will move patients waiting for hospital beds from the ER to other areas that have not traditionally held patients waiting for beds. Such places include the endoscopy unit after they are done for the day, the preop surgical areas later in the day, and the hospital hallways amongst other areas.

A request was made from Pennsylvania Medical Society to

the specialty societies as to how they envision a reformed health care system. It is the society's goal to use the comments to develop a framework from which organized medicine can utilize in its advocacy efforts as the debate over health care evolves. PSA will be formulating a statement for Pennsylvania Medical Society in the next few months.

Next, a discussion was held regarding assessing clinical competency. In light of the requirements by ABMS, JCAHO, and ACCME, Pennsylvania Medical Society would like to be in the position of assisting individual physicians with clinical competency assessment programs. Interested parties were asked to volunteer their thoughts with the Practice Advocacy Executive Council Work Group on this topic.

Lastly, an update regarding the work of the Pennsylvania Pain Coalition (PPC) and the Pennsylvania Medical Society Pain Work Group was presented. Dr. Galassi has been appointed chair of the Pennsylvania Medical Society Pain Work Group. The PPC has been meeting monthly to work on a proposed resolution to be introduced this legislative session by Rep. Jennifer Mann and Sen. Pat Browne. At this point, the PPC has finalized the wording of the resolution and which organizations would be included in the proposed advisory committee. (Author's note: Special thanks again to Michael Ashburn, MD, and Bob Campbell, MD, for their work on this topic. Dr. Ashburn has contributed significantly to the current version of this proposed resolution.)

The Future of Health Care: You Must Be Kidding!

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

I asked a group of Steeler fans a few days prior to the Super Bowl if they spend more time thinking about football or their healthcare coverage. The unanimous answer was football. Then I asked the same question with a little twist. While I asked the question, I had them imagine that they were having crushing chest pain radiating down their left arm and into their jaw. Again, it was unanimous; healthcare. A ticket to a professional sporting event or a rock concert seems so much more important and necessary than paying the co-pay for our health insurance when we are healthy. We tend to forget that our health is our most important asset until we don't have it. I assume that is why our government can make major decisions that will negatively impact the healthcare system, and have them go virtually unnoticed by the majority of us.

In a recent Bloomberg article: *Ruin Your Health With the Obama Stimulus Plan*: Betsy McCaughey, the author describes how major healthcare legislation was placed in the stimulus bill virtually unnoticed by most including the legislators. Since the bill (now law) makes "War and Peace" look like a postcard, it is understandable. In one paragraph, the author wrote: "One new bureaucracy, the National Coordinator of Health Information Technology, will monitor treatments to make sure your doctor is doing what the federal government deems appropriate and cost effective. The goal is to reduce costs and "guide" your doctor's decisions." She describes how the legislation seems to follow Ex-senator and one-time

Obama cabinet nominee Tom Daschle's healthcare plan in his book; *Critical: What We Can Do About the Health-Care Crisis*. So, I read the book (after paying \$23.95 plus tax). Mr. Daschle outlines the formation of a government agency, "The Federal Health Board" which will dictate not only fees but medical research and clinical decision making. His initial points are reasonable. Automated record keeping should be implemented to allow healthcare providers easier and quicker access to health records and to possibly reduce duplication of costly testing. Also, Mr. Daschle states that we should compare newer and more expensive technology to already existing and probably less expensive treatment plans for various diseases. I jumped off the bandwagon, however, when he describes the "pay-for-performance" plan which isn't designed to pay for better outcomes, but to pay for treatment decisions which are in line with those the government feels are appropriate. The Federal Health Board will not necessarily dictate what a physician must do, but he states that there should be a reduced fee or no payment if their algorithms are not followed. He states that "They will have to learn to operate less like solo practitioners and more like team members,..." (pg 166) All aspects of medicine will be directly or indirectly controlled by the government. Mr. Daschle envisions the Federal Health Board functioning in a similar fashion as the National Institute of Health and Clinical Excellence in Great Britain and the Federal Joint Committee in Germany. What he doesn't tell you is that many Euro-

pean nations including the UK and Germany have the highest cancer death rates among industrialized countries. I am willing to give up some funding for a high speed railway or a new bridge for a cancer

survivor. Another quote from the book does mention medical liability: "Fear of malpractice suits may induce interventions of limited value." (pg. 126), however, nothing in the plan addresses this issue any further. My guess is that he felt attacking the costly medical liability issue would be the kiss of death for any plan requiring passage by a congress made up mostly of lawyers.

So, are we really that inept that we cannot manage our industry? Are we at the same level as the CEOs of our financial institutions generating monstrous paychecks while their companies spiral into financial ruin or the leaders of our auto industry that can't seem to make a car that can stay on the road for more than 80,000 miles? Are we the same as a government that pays \$45 for screws and \$200 for a hammer to keep our fighters in the air? I don't think so. Technology is changing and we are aging. It makes sense that our industry is requiring an influx of more money.



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President's Message

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and appropriateness of items, services, and procedures that are used to prevent, diagnose, or treat diseases, disorders, and other health conditions and (2) encourage the development and use of clinical registries, clinical data networks, and other forms of electronic health data that can be used to generate or obtain outcomes data: Provided further, That the Secretary shall enter into a contract with the Institute of Medicine, for which no more than \$1,500,000 shall be made available from funds provided in this paragraph, to produce and submit a report to the Congress and the Secretary by not later than June 30, 2009 that includes recommendations on the national priorities for comparative clinical effectiveness research to be conducted or supported with the funds provided in this paragraph.” (HR 1, Pgs. 807-808)

Under the legislation, researchers will receive \$1.1 billion to compare drugs, devices, surgery and other ways of treating specific medical conditions. What specific conditions you ask? The bill creates a council of up to 15 federal employees to coordinate the research and to advise Congress and the President on how to spend the money. That is the long-winded way of saying that there may be an opportunity for our specialty to obtain government funding for outcomes based research.

What else is blowing with the winds of change? Well, while some things change, others stay the same. PANA is looking to expand CRNA scope of practice yet again. I met in good faith with current PANA President, Joe D'Amico and PANA President-Elect Diana Davidson on 2/2/09. We discussed renewed efforts on

the part of our society and their association to get a bill passed that would accomplish both our organizations goals, statutory recognition of CRNA's and preservation of physician supervision of anesthesia care in hospitals and ambulatory surgery centers in the Commonwealth of Pennsylvania. Unfortunately, that very same day, H.B. 212 was introduced which is this legislative session's version of the CRNA scope of practice bill. While PANA states that HB 212 “has language PANA doesn't even agree with,” they refuse to pull the bill. Rather, “PANA will draft language to address entitlement that includes scope of practice” without further discussion with our society. Once again, instead of working with PANA to protect the specialty of anesthesiology, we are forced to defend what our society feels is in the best interest of patient safety, physician involvement in anesthesia care. As a direct consequence of the inability of PANA to refuse to acknowledge the benefits of the anesthesia care team as well as the continued need for anesthesia providers in the Commonwealth, PSA will continue to explore the possibility of other anesthesia providers under the supervision of anesthesiologists.

Other things are changing as well. The PSA Web Site is still in the formative stage of a significant facelift. A small group of dedicated individuals have been working with Cimbrion, a Lancaster PA based company, and the Pennsylvania Medical Society to radically change the PSA web site. We have developed a new Site Map that may likely be the envy of ASA. We will have individuals from the PSA Board and PSA Committees who will be designated to coordinate content

for the various sections of the web site. At this point in time, we have gathered the bones to make a skeleton, if you will. Now we need to put the meat on the bones. If you have a special area of expertise you can write on or have already written on, please let us know. For example, if you have written on pediatric preoperative fasting guidelines, please include that in your email so we can direct your efforts in the proper direction. Of course, any work that you provide for PSA will be appropriately recognized on the web site. I would like to publicly ask for those individuals who have an interest in writing web site material, those who would be willing to share material they have already written for their own web sites or their own groups, and those interested in web site development to contact Maria Elias at PSA. Her email address is melias@pamed-soc.org. Your help will be much appreciated by the PSA board.

Can we discuss change? Joe Answine is working on an interesting format for our second annual Central PA Regional PSA Meeting. Once the content is finalized, PSA will announce more details regarding speakers, date, and time. If this meeting proves successful, we will hold at least two more in Pittsburgh and Philadelphia.

Can we change our reimbursement in a positive direction? Hopefully! Last November, Joe Answine wrote to Michael Nardone, Deputy Secretary, Office of Medical Assistance Programs, Department of Public Welfare. He asked DPW for an increase in the Anesthesia Conversion Factor to mirror the positive change we received from Medicare. This was followed up with a letter of sup-

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13.7%

ATTN: Dues Paying PSA Members

The percentage of your PSA membership dues for 2008 which has been devoted to lobbying expenses and is therefore not deductible on your 2008 Federal Income Tax Return is 13.7%. This percentage has been updated, and should be used instead of any prior percentage included as part of your 2008 Membership dues statement which you received last year.

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port from Pennsylvania Medical Society. To date, we have not received any reply. PSA will follow up on this matter, knowing full well that the Commonwealth is facing a budget crisis and we face an uphill battle. Our immediate goal is to have DPW acknowledge that they significantly underpay anesthesia services relative to Medicare and to remind them that when money does become available, they send some our way.

One last note about change. It is with great sadness that I announce that the PSA Board is

losing one of its great members. Steve Kimatian has announced that he is resigning from his positions as President Elect, ASA Delegate, and Chair, Bylaws Committee. He has taken a position at the Cleveland Clinic effective March 20, 2009. Steve has provided tremendous insights over the years and has done it with a dry sense of humor that few others rival. He will be sorely missed. PSA Bylaws allow for the PSA Board to elect replacements for Executive Committee Members should they resign during their term of office.

As a consequence, Steve Neeley has been elected by the PSA Board to become President Elect (moving up from his VP Position) effective March 20, 2009. Joe Talarico has been elected to the office of Vice President effective March 20, 2009. I have appointed Joe Talarico to move from ASA Alternate Delegate to fill the vacancy of ASA Delegate. Josh Atkins has graciously accepted the position of Bylaws Committee Chair. Please join me in wishing Steve, Joe, and Josh well in their new positions.

Recruiting Foreign Anesthesiologists

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have been devastated by an exodus of health workers in the past decade, while still others, such as South Africa, are both migration "source" and "destination" countries for health workers."

Factors that push foreign health care workers into the US market include poor economic conditions in their countries of origin, low job satisfaction, unsatisfactory or even dangerous working conditions, and inadequate career opportunities. While addressing the shortage in the United States through various visa programs, Ms. Schlachter explains that United States, through various aid programs is also addressing the "push factors that cause people to want to migrate

in the first place. For example, since 2004 one quarter of the \$18 billion President's Emergency Plan for AIDS Relief (PEPFAR) program has gone to build hospitals and clinics and train nearly 2.6 million doctors and nurses[abroad]."

Balancing brain drain, the U.S. shortage of physicians as well as protection for the integrity of the profession in the United States continue to be key elements of U.S. visa policy for foreign physicians. The complexity of addressing these diverse considerations, however, has caused U.S. visa processing to be long, uncertain and often onerous for employers of foreign physicians and especially for the physicians themselves.

Both the J-1 and H-1B visa categories, primarily used by physicians, involve detailed regulations and multi-step processes which often require approval by three or more government agencies. When deciding whether to undertake such a long and difficult journey, medical facilities and the physicians they are sponsoring should start early and map out a clear strategy with several alternative routes in the event that unexpected roadblocks appear along the way.

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The Future of Health Care

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Not everything new is better; however without a continued attempt to improve our ability to treat illness and keep our citizens well, we will be thrown into the medical “dark ages”. Again, our health, not our homes or cars, is our most important asset. Without our health, everything else that we are so desperately trying to fix will be rendered useless. Furthermore, without our health, our productivity and our ability to contribute to the workforce will falter. Our healthcare system is expensive not broken. We don’t even need a bailout. We just need a “cost-of-living” raise, or should I say a “keep-us-living” raise. Some of the brightest individuals that I have ever met were healthcare providers, so if the healthcare industry would get just a small percentage of the “bailout” money and the clinical decision making was

left to the physicians, we could increase the life expectancy of our citizens rather than watch it decline as it has in the recent past.

We as a nation are working feverishly to save our financial institutions and our automobile manufacturers, but at the same time considering allowing our healthcare system, our most valuable institution without exception, to be rationed into oblivion. So we will still have cars to drive and banks for our money, but the only living creatures that will be around to use them (as the joke goes) are cockroaches and Keith Richards.

As physicians and patient advocates, we are again asked to take the forefront and work to educate our leaders, legislators and patients as to the importance of healthcare, medical

advancement, clinical decision making and the physician-patient relationship. I could never be President of the United States, a senator or a congressman; but if we are all in a room together and you feel that elephant sitting on your chest, your best bet would be to find me.