



President's Message

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

As I begin my year of service to the Society as your president, I hope I can be of help to us in these uncertain, politically explosive times.

I am a private practice anesthesiologist in Beaver, Pa., and have been in Beaver since I finished residency in 1986. I have been on the PSA Board for seven years and have also served in local politics in Beaver. So my strengths will be in helping to increase our Society's grassroots efforts in the political arena and educating both our public and lawmakers about anesthesiologists.

As I start, I also need to thank our Immediate Past President, Joe Galassi, for his hard work and dedication. I also want to thank Paul Schaner and Rich O'Flynn for their continuing work with Z-PAC (PSA's Political Action Committee).

We also need to thank Don Martin and Erin Sullivan for functioning as our Directors to the ASA. And not lastly, we need to thank and acknowledge our lobbyist, John Milliron. I hope we take advantage of his help in how best to help and educate our individual representatives to state government.

I hesitate to comment on any political activities, either on the state or national level, because the

delay between when I write this and when you read this will most likely mean much of what I am reporting to you will have changed. But I figure it is my duty to keep us up to date as best I can.

Some good news to the Society is that CMS has finally interpreted the Medicare teaching rule as we all believed was intended by the lawmakers. I never cease to be amazed how our government can take the simplest language and decide it means something else. Funny, their misinterpretations always seem to benefit themselves—never the public. I guess it depends what the definition of "is" is.

On a more somber note, the Congress continues to debate health care reform. Although I am sure the majority of our members feel some reform is needed, we all can agree that any steps leading toward anesthesia reimbursements tied to Medicare would be a disaster for our specialty.

Presently the many bills on the table are being debated. If the "Public Option" is indeed in the final bill, we can only hope it is defeated or that the House amendment preventing our fees from being Medicare rates is included.

Please write to your Congressman/Congresswoman

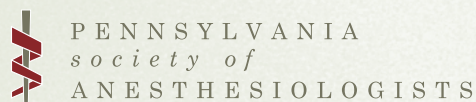
and Senators to let them know how much these measures could negatively impact patient safety. You can put down this newsletter now and go do that.

Now that you are back, we can discuss some state issues. Recently we learned the governor's budget robbed our MCare monies and that will certainly mean increased insurance rates and assessments. The Pennsylvania Medical Society has initiated lawsuits to attempt to prevent this, but it is always an uphill fight to undo what the government has done. Let's pay attention to this—anything the PSA Board discovers will be reported to you.

The PANA has again introduced legislation to change its scope of practice to independent. A constant need to educate our State House and Senate members was painfully shown to us when about 50 legislators signed on as sponsors of the PANA's bill.

When the truth of how this measure would affect patient safety in the Commonwealth was made known to these legislators, many removed their names from sponsorship. Although this scare seems to be a little less likely, it does underscore the idea that

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I Thought There Was No ‘I’ in Team

by Joseph F. Answine, Representative to the Pennsylvania Medical Society’s Specialty Leadership Cabinet

(DISCLAIMER: I am not the best dressed anesthesiologist, usually coming into the hospital with a T-shirt obtained with a lot of sweat during a race that I had run, or a Lower Dauphin Falcons sweatshirt stolen from one of my kids (I am sure that I paid for it, anyway). I do change into appropriate OR attire, however, prior to meeting my first patient. Furthermore, I have an excellent sense of humor, even though I am frequently the only one laughing.)

It is not uncommon for our nurse anesthetist friends to tell patients that they will be the ones there for the whole case, watching the blood pressure and heart rate closely, and directly providing the anesthetic. Wow, that is pretty powerful stuff. So, how do we “trump” that?

I am the anesthesiologist, and I will be supervising the CRNA. That’s true, but pretty weak.

I am the anesthesiologist, and I will develop the anesthetic plan, prescribe it, and be there for the crucial parts of its implementation. That’s true, but pretty technical and dry.

I am the anesthesiologist, and I will pull you from the brink of death when the education and skills of the CRNA become inferior to your needs. That’s true, but harsh—especially since the CRNAs actually may not think that they are intentionally trying to bash the anesthesiologists, and they are likely good personal friends.

The truth is, however, that the individuals making decisions within the AANA knew exactly what they were doing when they promoted this method of introduction. Inflate their role in the anesthesia care and belittle ours; confuse our roles; make our job

seem useless to the patient. Pure genius!

Yea, I know. We don’t help our cause when we forget to talk directly to the patient or appear rushed as we move from one to the other, or when we hold a novel in one hand and coffee in the other. No, I am not knocking reading, especially if it’s big print and less than two syllables per word.

I wrote previously about the benefit of a touch of the hand and an appropriately timed joke to alleviate pre-operative stress. Because no one else will explain our crucial role in their care we must do so in a concise diplomatic manner.

So what can we do?

- Introduce ourselves as “physicians and anesthesiologists.” “Hi, I am Dr. Joe Answine, your anesthesiologist (or something similar).” If they call me Dr. Joe or Joe after that, I don’t usually correct them. Everyone present now knows who I am, and this may be the way the patient keeps some feeling of control during a very difficult time. Furthermore, hopefully, everyone is wearing a name badge clearly demonstrating their appropriate titles.
- Explain your role in their care. “The surgeon will be doing the knee replacement and I am responsible for everything else, such as your brain, heart and lungs.” I will be there when you go to sleep and wake up, and won’t be far away if any problems arise.” Or you can say: “My job is to think about the ‘weird stuff’ that rarely can happen while under anesthesia ... and then fix it.” If you happen to



be providing the anesthetic directly, you can add: “I will be the one there for the whole case watching the blood pressure and heart rate closely and directly providing the anesthetic.” It seems to work well for the CRNAs. Also, describe the part you play, not just during the procedure, but pre-operatively getting the patient fit to handle the stresses of surgery, and, more importantly, post-operatively within the recovery room (and beyond) by controlling the blood pressure, heart rhythm and oxygen level as well as treating nausea and pain. We need to let it be known that we are their “primary doctors” during the post-operative period.

- Go over their allergies, medications and laboratory results with them. It lets them know that you are more than just the “sleep doctor” but a “whole body doctor,” and it provides valuable information to the patient as well. They may learn that a fast heart

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Physicians ‘Contribute’ More Than Their Share to Balance the Budget

by Robert Hoffman, Esq., Eckert Seamans Cherin & Mellott, PSA Outside Legal Counsel to PSA



If the Mcare fund is fair that everyone should contribute to resolving a budget impasse, physicians should get a big “thank

you” note from the legislature and public for being fairer than fair. The reality is that the legislature balanced the budget at the expense of physicians to the tune of between

\$500 and \$750 million.

First, the legislature transferred \$100 million from the Mcare Fund to the General Fund. Mcare, as you likely know, is funded almost completely by assessment payments from health care providers.

All the funds in it were required by the Mcare statute to be used for

purposes related to the insurance coverage Mcare provided.

Furthermore, the Commonwealth has woefully underfunded its obligation to fully fund the Mcare abatements it granted.

Finally, there is a strong argument that the pot of money that proved irresistible to legislators should not have existed, but should have been used to reduce Mcare assessments.

How, you wonder, on these facts could the legislature lawfully raid those funds? Stay tuned. The Pennsylvania Medical Society and the Hospital & Healthsystem Association of Pennsylvania (HAP) have filed lawsuits in Commonwealth Court challenging the action.

They are hoping to have the merits of the case argued in Commonwealth Court in February

of 2010; if that happens (and it is uncertain as of press time), the Court would likely rule within a few months. For updated information on the Mcare case, and on a related case discussed below involving the Health Care Providers Retention Program, go to www.pamedsoc.org/mcare.

The second physician “contribution” to the budget is even bigger—\$708 million! This is the amount the legislature transferred from the Health Care Providers Retention Fund, again to the General Fund.

That fund was set up in 2003 to pay for the Mcare abatement program and was funded by a targeted increase in the cigarette tax. Instead of using the money to fund the abatements, the Commonwealth allowed the funds to accumulate.

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The Three Basic Elements Needed for Ongoing Political Success: Good Lobbyists, Good Grassroots, Good Political Action Committee

by John Milliron, Esq., President, Milliron Associates

A group can have the greatest issue in the world, but if nobody explains it to a legislator, it will probably fail. Actually, it needs to be explained to the legislator by several people, starting with the local constituent, then the Harrisburg lobbyist does a follow up, and finally the local constituent does an additional follow up.

We have one of the best issues ever: the safety of our patients.

But guess what—there are almost 100 members of the Pennsylvania House and Senate who are new and haven’t heard a single word from a local anesthesiologist about how anesthesia should be administered to their spouse, their kids, their parents or their constituents.

In the meantime, they have been hearing from local nurses about how important their role is

and how unnecessary you are! That has to change.

House Bill 1866 is this session’s version of independent practice for CRNAs. It is the seventh, eighth or maybe ninth time that it has been introduced since the beginning of this decade. They all have the same theme—eliminate physician supervision.

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stability matters.

If there is one thing to learn from the recent financial turmoil, knowing who to trust is paramount.

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PSA Past President Sean Kennedy Testifies Before House Committee on Issue of Proper Identification of Health Care Providers

by John Milliron, Esq., President, Milliron Associates



The Pennsylvania House Committee on Professional Licensure recently held a hearing on the subject of proper identification of health care workers. The legislation would apply in both hospitals and office settings.

Past President Sean Kennedy, M.D., spoke in favor of house bills 1482 and 1879 at the Committee's Nov. 6 hearing in Radnor, Pa.

Dr. Kennedy's testimony began "from the basic principle that patients have the right to know who is treating them and what are they trained and qualified to do. Patients grant health care workers extraordinary access to the most personal aspects of their lives...and there is no room for ambiguity."

The two bills were introduced by Representative Jennifer Mann (D-Allentown) and Representative Tom Killion (R-Media) in response to constituent complaints about confusion over knowing who was treating them when they were ill or needed surgery. Both Representatives said the confusion is heightened by the fact that many providers use the title "doctor" after receiving doctorate degrees in their academic field.

Both pieces of legislation would require identification badges with the name of the certificate or license issued by the Commonwealth displayed prominently. For instance, if your state license says "Physician," "Registered Nurse" or "Physician Assistant," that is the displayed designation. The patient would then have a clear understanding of which licensee is providing the care.

Dr. Kennedy used several excellent examples to explain the need to eliminate all ambiguity in the use of titles in health care settings. He told the panel that "According to the Oxford English Dictionary, a doctor is 1) a person who is qualified to practice medicine, or 2) a person who holds the highest university degree.

When attending a university class in English Literature, it is accepted that Dr. Jones is an acknowledgement of his or her academic achievement, but when an announcement is made on an airplane we need a doctor in the back of the plane" no one expects a PhD in English to respond!

The Society and the Pennsylvania Medical Society are pushing for consideration of these bills in early 2010.

Editorial

Health Care Reform?

by Paul J. Schaner, M.D.

The ongoing saga of health care reform continues to be a major concern for America. The promise of a bipartisan effort is but one of the broken pledges along the troubled pathway to reform. The bill has grown another 1,000 pages, crafted by the Democrats behind locked doors for an unbelievable total of nearly 2,000 pages.

The pledge of transparency has also been cast aside. The pledge of clear, concise language is out the window, requiring a

minimum of a law degree to comprehend the changes assuming one could read the bill prior to its signing.

Given 72 hours to read this bill, which is really like 5,000 pages because the reader must reference the bills it amends, it will require a dedicated effort to know what is in the bill. The members of Congress who actually read the bill for the stimulus package was next to none. I personally believe a similarly low number will read the

health care bill that is ultimately passed.

The pledge that everyone could keep their insurance if they were content with their policy is also gone. Tell this to Medicare Advantage participants who doubt favorable changes or cost savings to their coverage is in progress. The proposed cuts of \$400-500 billion to Medicare only bolster seniors' distrust of the health care reformation.

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The PSA Annual Meeting in New Orleans

by Patrick Vlahos, D.O.

The PSA had a wonderful gathering at its annual meeting in New Orleans. The Marriott New Orleans provided the meeting room and food. The venue permitted about 75 PSA members and anesthesia residents the freedom to interact and converse without the rigors of the hospital.

The business of the PSA was conducted after a lunch buffet was served. The usual business was conducted, such as the approval of the minutes of the meeting of 2008 and approval of the budget and treasurer's report.

A slate of officers was presented to the membership for a vote. The slate was approved without opposition, naming Meg Tarpey, M.D., as the new Society Vice President and confirming Shaun Beaman, M.D., as a new ASA Alternate Delegate. Then the membership voted two new members of the board from the general membership. Bhaskar Deb, M.D., from Reading, Pennsylvania, became the Society's representative to the Pennsylvania Medical Society, and Michael Brady, M.D., from

Beaver, Pennsylvania, was elected as an ASA Alternate Delegate.

Joseph Galassi, M.D., had an excellent presentation to the members with an update of the year's activity of the board of directors and stressed the need for all in attendance to become more politically active on behalf of their patients.

Dr. Galassi thanked all who served as board members throughout the year. He had a special thanks to Sean Kennedy, M.D., for his inspiration during his formative years as a resident at the University of Pennsylvania.

Steven Neeley, M.D., the newly elected President, addressed the membership with the idea that a grassroots effort is necessary for our profession to continue in Pennsylvania. He gave clear examples of the push for less qualified caregivers to carry out the profession of the anesthesiologist. Dr. Neeley was awarded the traditional wooden mallet by Dr. Galassi.

Dr. Neeley in kind awarded Dr. Galassi with a copy of the plaque of thanks for all the dedicated hard work which he performed

throughout the year.

Erin Sullivan, M.D., then presented a Lifetime Achievement Award to Carol Rose, M.D., for all the timeless hours that Carol gave to our Society.

The PSA has been in search of new individuals to join the board of directors for the past few years. This year we have added two new faces, but we will need more in the near future. There will be more retirements from this position in the near future. If you or one of your associates is interested, please contact the PSA (717) 558-7750, ext. 1596.

Members of the PSA are permitted to attend any general meeting of the board of directors throughout the year. I am sure you will be impressed with the depth and scope of our agenda and conversations. Come and see the PSA in action.



District Director's Report—

ASA Annual House of Delegates Meeting

by Donald E. Martin, M.D.

Though the current health care reform debate dominated much of the discussion at the ASA Annual Meeting in New Orleans from Oct. 17-21, several other issues shared the spotlight at the House of Delegates meetings.

Perhaps the most controversial issue was the possibility of charging the ASA members a registration fee for the ASA annual meeting. Registration

fees have already been increased significantly for non-members, and the House of Delegates acted to remove restrictions on charging registration fees to members.

This action would clear the way for the registration fees, which would likely be approximately \$200 for active members, to be charged for the first time at the 2010 Annual Meeting in San Diego.

As the ASA accounting processes have been improved over the past two years, it has become apparent that the Annual Meeting costs have been higher than previously appreciated. Further, most other medical continued on page 13



Celebrating a Lifetime of Achievements

by Patrick Vlahos, D.O.



Outgoing PSA President, Joseph Galassi, M.D., left, congratulates Carol Rose, M.D., after she received the Lifetime Achievement Award at this year's PSA Annual Meeting in New Orleans.

This year's ASA Annual Meeting marked a special occasion—the celebration of the legendary career of one of my personal friends and a strong supporter of the Pennsylvania Society of Anesthesiologists.

I met Carol Rose, M.D., when I was wet behind my ears and she served as an anesthesia resident at Mercy Hospital in Pittsburgh. At the time, she held the banner and shield that was used to both promote and protect the specialty of anesthesia.

Carol had a very soft approach with potential medical students and those residents who seemed unable to “see the light” of the medical practice of anesthesia. She befriended many potential residents early in her career. Carol also had a very comforting approach to her patients.

“Mama Rose” was known by many at the hospital. If you had a problem, chances are Mama Rose had a solution. Her manner and approach of caring for her patients was a huge example to us underlings.

She seemed to never be flustered by difficult situations and always had some words of wisdom. Most of her wisdom was passed on to her by her family from one generation to another generation. If a resident lacked for the loving conversation of a motherly individual, they would seek out Mama Rose.

Carol had her own family, but no one would know that when she was at the hospital. She was always a professional.

Carol had many interests. Certainly one of her passions is the role of women in medicine. She was a leader when it was not popular to be an outspoken female in the medical profession. She was a great example for all women and not simply the women in medicine.

Carol could have simply lived her life as an anesthesiologist and raised her two children, but she had a calling to do more. She was inspired by our residency director, E.S. Siker, M.D., who was a legend in his own right.

Carol became the president of the PSA, and served not one but two separate terms. She has served the Pennsylvania medical community as the president of the Pennsylvania Medical Society and continues to serve as a representative to the AMA.

Carol will retire from full-time practice in June of 2010, but she will remain active in our minds and hearts.

The PSA recognized Carol's service and accomplishments by awarding her with a Lifetime Achievement Award at this year's PSA Annual Meeting at the ASA Annual Meeting in New Orleans.

Carol, thank you for your years of guidance and leadership.

Physicians ‘Contribute’ More Than Their Share to Balance

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The Commonwealth granted abatements worth almost \$1 billion and funded it with somewhere between \$330 and \$500 million. Once more, the pot of money proved irresistible and substantial efforts to show the legislature that doing so was unfair and illegal failed.

Again, the Pennsylvania Medical Society and HAP have brought suit, seeking both to obtain the full funding that was promised and to restore the transfer of funds. That suit was filed in December 2008, well before

the current budget impasse, but it will likely address the legality of the Retention fund transfer.

Commonwealth Court has already ruled in physicians' favor in a preliminary stage of this case, but the Commonwealth is defending it aggressively.

In that case, the Pennsylvania Medical Society and HAP recently filed a brief that summarized the unfortunate turn of events:

“The abatement program began with important goals and a substantial commitment, both by the Commonwealth in granting

abatements and health care providers in agreeing to continue practicing in Pennsylvania. It ended with the Commonwealth renegeing on its promises, failing to fund the abatements granted and diverting more than \$800 million in Mcare and HCPR Funds to unrelated purposes.”

That statement is as sad as it is true.

PSA Member Reach Out to State Legislators at Bi-annual Event

by Patrick Vlahos, M.D., and John Milliron, Esq.

The PSA's Legislative Reception serves as an important opportunity for members to reach out to state legislators in a low-key setting. In this forum, which is held every other year, PSA members can better educate legislators about their profession and engage in a genuine conversation about how legislative activities affect their daily mission of practicing safe patient care.

The most recent Legislative Reception—held Oct. 6, 2009, at the Harrisburg Hilton—drew approximately 90 anesthesiologists from across

Pennsylvania and 62 legislators. Almost all of the members of the House Professional Licensure Committee made a point of stopping by and expressing their opposition to any change to the requirement of physician supervision of anesthesia.

Before meeting legislators, PSA's Immediate Past President, Joe Galassi, M.D., met with members to discuss the issues facing the specialty in Washington. He was followed by John Milliron, Esq., PSA's legislative lobbyist, who updated members on Pennsylvania House Bill 1866, which

is the most recent attempt by the Pennsylvania Association of Nurse Anesthetists to practice independently.

Finally, incoming President Steve Neeley, M.D., spoke about the importance of participating in the payroll deduction plan for the PSA Political Action Committee, or Z-PAC.



From left to right: Carol Rose, M.D., Joseph Answine, M.D., and Representative Sue Helm (R-Dauphin County).

President's Message

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passage of a bill that would change the anesthesia scope of practice is only a new legislature away (every two years the State House is elected).

Each of us has the duty to build a relationship with our local state representatives so that we can be that voice of reason and that our voice will be heard. It does not help for us to be right, if the lawmakers do not know about us and that patient safety is our priority.

As part of our effort to educate the public and our lawmakers, we are beginning a public relations campaign to increase awareness of the key role anesthesiologists play in patient safety. We will give more details on this as our campaign unfolds—hopefully including Internet and media spots.

But no campaign will be successful without our membership stepping to the

forefront of patient care. Make sure we take the time in our pre-operative visits to identify who we are and our responsibility and role in each patients' anesthetic.

Be friendly, kind and take time to answer questions and address fears. Visit with patients post operatively in PACU and outpatient areas. Too often we are the "invisible provider." Be visible! Be very visible!!

And lastly, let me emphasize the importance of your individual political activity. You are all physicians and are important to lawmakers. They want to talk to you and associate with you, but you must take the time to do this.

Be a friend as you visit instead of preaching/pontificating to them. You do not have to agree with all their views, so do not debate them. Thank them for their support when you can. Lastly, we must support them financially. Our political opponents all seem to

exceed our financial commitment, only making it appear that we are apathetic as a group.

Let us make a difference. Support candidates who support PSA issues, no matter what their party affiliation is. Attend their political functions. Do not forget to also give to Z-PAC. So... 1) be a friend, 2) educate, and 3) donate.

Again, we have learned it only takes a brief period of letting down our guard to start the political ball rolling against us. Stay vigilant in the operating room and the political arena. Too much is at stake to stay on the sidelines. Keep up the good work, but please expand your work and efforts in these regards to all you colleagues.

It will be very difficult if we are not united as a Society—so let's all do our part and see great results in 2010.



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CMS Issues Final Rule for Teaching Anesthesiologists

As part of the recently released final rule for the 2010 Physician Fee Schedule, the Centers for Medicare and Medicaid Services (CMS) will fully implement Medicare anesthesiology teaching rule reforms beginning January 2010 as intended by Congress and advocated by ASA.

The final rule represents a culmination of many years of work by ASA members, leadership and legislative and regulatory staffers in Washington, D.C., to rectify the 50 percent payment penalty for anesthesiology teaching programs.

The newly released rule will correct this payment inequity, and allow teaching physicians full payment for up to two concurrent procedures provided with residents. This payment will provide a level playing field for anesthesiology residency teaching programs, and for anesthesiologists as teaching physicians.

"This is a huge triumph for the medical specialty of anesthesiology,

and ASA members are to be commended for their dedication to this legislative and regulatory priority," said ASA President Alexander A. Hannenberg, M.D. "After a long- and hard-fought battle, academic programs will finally receive full Medicare payment for the expert anesthesiology medical care they provide to patients. This victory proves what ASA can achieve through unrelenting advocacy efforts."

The Agency did not formally address the issue of anesthesia "handoffs" in its final rule. Thus, different anesthesiologists in the same anesthesia group practice can be considered the teaching physician when fulfilling the statutory requirement that the teaching anesthesiologist be present at the key or critical portions of the anesthesia service. ASA is pleased that the Agency followed legislative intent and did not focus on unrelated topics.

PSA's Revamped Web Site Addresses Several Audiences

by Edward Dench, M.D.

For the past year, many of your PSA board members have been working hard to revamp our website, www.psanes.org. We plan to introduce a visually appealing, functional website for all our use.

The site will be aimed at several audiences, including PSA members, non anesthesiologist physicians and legislators. We believe that the site map, drop-down navigation and robust search engine will make it easy to find information that will be available to educate these groups about what anesthesiology has to offer.

It will include online dues payment, links to important information and guidelines as well as continuing education opportunities. Secure site information will be available for members only, allowing the board to better communicate with the membership about important legislative issues.

As we go online after the new year, we would appreciate comments, suggestions and additional content as the website will be a member benefit that should be useful for all of us.



Welcome New Members

Active

Frederick T. Allen, MD
Fenny Anthikad, MD
Dolores M. Beane, MD
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Thomas F. Boerner, MD
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Maryellen F. Eckenhoff, PhD
John E. Scharf, MD
Renlong Zhou, PhD

Resident

Seth H. Gunderson, DO

Join an ASA Committee

by Donald E. Martin, M.D.

Beginning in January, ASA President-Elect, Mark A. Warner, M.D., from Mayo Clinic, will appoint active ASA members from across the country to fill open positions on the Committees of the American Society of Anesthesiologists for 2010-2011.

A complete listing of ASA Committees, with their current members and chairs, is available on the ASA website at www.asahq.org. Click on About ASA, then ASA Committee Listing.

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

No matter how many supporting nominations you may receive from others, this self nomination form must be completed, essentially to let Dr. Warner know that you are interested and would be willing to serve if appointed.

Erin Sullivan, M.D., and Don Martin, M.D., will be responsible for sponsoring Committee Nominations on behalf of PSA. If you would like the support of PSA for your nomination, or would have any questions about either the committees themselves or the nomination process, please contact either one of them at the addresses below.

If you would like PSA support for your nomination, also please include an abbreviated CV or some background information about yourself that is particularly relevant to the committee(s) in

which you are interested. Finally, confirm that you have completed the online self nomination form and listed one of them on this form as an "ASA member from whom they may be receiving a recommendation on your behalf."

They 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 Jan. 15, 2010. Therefore, for Society support, **please contact us by Dec. 30, 2009**. Appointments will be announced in May of 2010.

Erin A. Sullivan, MD, University of Pittsburgh Medical Center, 200 Lothrop

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I Thought There was No 'I' in Team

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rate from epinephrine is not an allergy, or that *Advil* three times a day for chronic neck pain and *Aleve* daily for bad knees may not be a healthy combination, or that *Prinivil* in the morning and *lisinopril* in the afternoon is not dual therapy for hypertension, or that a fasting glucose of 186 is not pre-diabetic. Show them the squiggly lines that make up their ECG and explain a little about what they mean. All of these can be done in about five minutes, but can leave long-lasting positive effects.

- Pop into the waiting room post-operatively and tell the family that the anesthetic went well, especially for the more involved cases, and in the recovery room briefly after the patients have recovered somewhat to shake their hands and wish them well. Answer any lingering ques-

tions if they arise, and give them your card with contact information if others come to mind. I know that making these visits is tough because we are flying everywhere throughout a given work day; but if time allows, it is very worthwhile.

- Lastly, have your hands in the pre-operative care of especially the sicker patients. Let the surgeons know that you want to be "in the loop" for any patient that may pose significant problems, whether based on general health or the extent of the procedure prior to that individual being wheeled into the OR.

Furthermore, demonstrate your obvious concern and desire to be involved with patients after leaving the recovery room, especially those who posed significant challenges intra-operatively. We need to act like the "total physicians"

that we are, and demand the appropriate involvement in our patients' care.

I know that I am probably not telling you something that you don't already know, but be aware that all physicians are being targeted to be replaced by non-physician providers. Your value in patient care is best demonstrated by your hands-on care of the patient.

Remember, it may be done quite out in the open or very insidiously by telling the patient that "I will be directly providing the anesthetic." Regardless of the method, the desired outcome is the same. It seems a little silly and very sad; but, we have to continuously demonstrate our "worth" to our colleagues and, much more importantly, to our patients.

There is no "I" in team (but there are two in physician). One is because "I" am a Doctor and the other is because "I" am an Anesthesiologist.

ASA Annual House of Delegates Meeting

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specialty societies the size of ASA currently charge annual meeting registration fees.

In addition, registration fees would provide an important source of revenue to supplement the revenue from member dues. Finally, the registration fee has been argued to be the fairest to all ASA members, by charging only those who attend the meeting, and not all dues-paying members, for meeting expenses.

The second issue that generated significant controversy was the strained relationship between the specialty of anesthesiology and the American Medical Association (AMA), brought about by the AMA's quick support of House Bill 3200, including a Medicare-linked fee schedule that was detrimental to our specialty.

Some members felt that ASA should align with other organizations that may better represent all physicians. However, most ASA delegates felt that, although ASA should continue to work with other like-minded organizations to promote our members' interests, now was the time for us to strengthen direct communication with the AMA executive leadership, and enlist its support for the benefit of our members.

The third area of controversy directly involved the practice of anesthesiology, and more specifically the monitoring of exhaled carbon dioxide and airway management during endoscopic procedures. The use of exhaled or end tidal CO₂ monitoring

for non-intubated patients has been controversial for some time.

Because of some recent, though limited, evidence from the ASA closed claim study, the Committee on Ambulatory Surgical Care recommended the use of exhaled CO₂ monitoring for patients having upper endoscopic procedures, and more specifically recommended endotracheal intubation for patients undergoing ERCP in the prone position.

The committee felt that it was extremely important at this time, when gastroenterologists are adopting recommendations for carbon dioxide monitoring and the Ethicon "SEDASYS®" system, which automatically delivers propofol and also employs carbon dioxide monitoring, that ASA take a strong position advocating this type of monitoring for sedated patients.

However, in many locations ASA members do not routinely use exhaled carbon dioxide monitoring for non-intubated patients, and particularly do not intubate all patients having ERCP. Therefore, compromise language was adopted that recommended monitoring of exhaled carbon dioxide should be "considered during endoscopic procedures in which sedation is provided with propofol, and especially during procedures on the upper gastrointestinal track."

Similarly, instead of recommending endotracheal intubation, the statement that was adopted recommended

"careful attention to airway management" during ERCP procedures.

The ASA officers who were elected for 2009-2010 are:

- **President** – Alexander Hannenberg, M.D. from Boston.
- **President Elect** – Mark Warner, M.D. from Rochester, Minn.
- **1st Vice President** – Jerry Cohen, M.D. from Gainesville, Fla.
- **Vice President for Scientific Affairs** – Arnold Berry from Atlanta.
- **Vice President for Professional Affairs** – Robert Johnstone from Morgantown, WVa.
- **Secretary** – Arthur M. Boudreaux, M.D. from Hoover, Ala.
- **Treasurer** – John Zerwas, M.D. from Houston, Texas.
- **Assistant Secretary** – Linda Mason, M.D. from Loma Linda, Calif.
- **Assistant Treasurer** – James Grant from Bloomfield Hills, Mich.

Approximately 15,000 people attended this year's ASA Meeting in New Orleans, and took advantage of the largest scientific and academic program ever offered. The meeting opened with a new Plenary Session entitled "The Celebration of Advocacy" that highlighted the controversy surrounding health care reform and the effective advocacy of our Society at both the state and national level.

Erin Sullivan, M.D., from the University of Pittsburgh and alternate director of PSA, was instrumental in planning this session.

Join an ASA Committee

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Street, PUH C-224, Office: 412-647-3262, Fax: 412-647-6290, esullivan@pitt.edu, Alternate District Director.

Donald E. Martin, MD, Department of Anesthesiology, Penn State University College of Medicine, P.O. Box 850, Hershey, Pennsylvania 17033, Office: 717-531-6140, Fax: 717-531-5449, dmartin1@psu.edu, District Director.

The Three Basic Elements Needed for Ongoing Political Success

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They insert the word “collaboration” or “cooperation” instead, or as this year’s legislation, the phrase is “overall direction.” But in every case two things are very evident:

- Physician supervision would no longer be required.
- A new phrase that will be defined later by the Board of Nursing is inserted in its place.

Let me say that again: The Pennsylvania Board of Nursing will decide how anesthesia is administered to patients in hospitals, ambulatory surgery centers and physician and dental offices. Nurses will define the

terms—not physicians and not the Board of Medicine. Hopefully, you will find that prospect as distasteful as it is unsafe and you will do something about it.

Every member of the PSA needs to do two things: Call their local state representative and leave a message that you oppose House Bill 1866, because it would be unsafe for your patients. Then send them an e-mail giving your reasons. You can find your legislator and his/her email and phone by going to:

www.legis.state.pa.us.

Then call the PSA legislative number (1-800-822-6789) and tell our lobbyists. They will then follow up with

the House member and continue the dialogue and answer any questions they may have. You can also reach them at John@Millironassociates.com or Andy@Millironassociates.com.

Lastly, we need your financial help for Z-PAC, the Political Action Committee for Pennsylvania’s anesthesiologists. Many of our very good friends in the House and Senate will be targeted by the trial bar and PANA Pac. We must be financially capable of providing their campaigns with our support. All contributions must be personal checks or by personal credit cards. Call the number above for details.

Health Care Reform?

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The failure at this point to fix the sustainable growth rate formula continues to increase the probability of decreases to physician reimbursement. The pronouncement that this bill would not add one penny to the burgeoning national debt is held in disbelief in the USA and around the world as reflected in the falling value of the dollar.

The current discussion to replace the dollar as the international currency is gaining momentum. The addition of national health care at this time in the country’s economy is not the item of most citizens’ concern. The massive so-called stimulus bill that was rushed through Congress to limit unemployment has failed to halt the rise of joblessness to near 10 percent.

While the stock market has rallied, the economy may erase these gains. If you look at the workers who are discouraged and no longer seek employment, the rate is closer to 17 percent. If you include the workers the government does not even count, such as the unemployed farm workers, the idle self employed and workers in private homes, the rate is closer to 20.6 percent.

This is according to John Williams who compiled figures for Shadow Government Statistics. This serves to underscore the fact that health care reform is not on the front burner for the American citizens. It is the economy stupid. The rush now to pass this massive health care bill, which will likely create a larger deficit, is unwise.

In the meantime there are cost effective bipartisan items that could be done rapidly and would be effective. They include the following:

- Allow the purchase of health care insurance across state lines by repealing the federal prohibition to do so. There is no cost for this option and it increases competition, which is likely to bring prices down.
- Preclude the competing insurance companies from excluding coverage because of health preconditions. Again, this is easily established.
- Establish tax credits for the small businesses that purchase health care coverage for employees. This is a tax credit enjoyed currently by large corporations. This would be a stimulus to small businesses – the

driver of jobs that the economy needs.

- Establish tax credit health savings accounts for individuals that if unused yearly could be rolled over to IRAs. Again, this is easily established and is not a great cost item. It would stimulate better management of health expenditures by the individual.
- Establish a national limit of medical liability for an estimated savings of \$70-80 billion. These items are widely accepted and could be implemented with far less than 2,000 pages. While they echo the Republican proposals, they have bipartisan support across the country.

At least it would be a start for some health care reform that does not break the bank and may actually help the economy. The recent election results support the congressional drive for universal health care at any cost, maybe a cost America will not accept. The public option as of this writing may not be an option for America.

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