



PRESIDENT'S MESSAGE

Changing Times Calls for New Approach

by Joseph F. Talarico, D.O., President

It seems like a cliché to state that we are living in difficult times. During my more than 50 years, 30 of which have been as a physician, I can't remember a time that, for one reason or another, that very statement hasn't justifiably been made, either regarding our profession or society in general. I believe that from the perspective of the specialty of anesthesiology, the past year has indeed been particularly difficult; one may reasonably conclude that the specialty is under siege.

Components of the siege include the following:

1. Critically flawed studies commissioned by groups with an obvious interest in the predetermined conclusion that anesthesia can be administered as safely by non-physicians as physicians.
2. Almost weekly op-eds using the same bogus studies to advance the agenda of the new "nurse doctors."
3. Advancing an agenda touting the "new nurse doctors" and their weekend-long

residencies (the inference is we physicians wasted 12 or more years, when we could have been a "doctor" in six years.) The conclusion is that there is a concerted effort to obtain a medical degree through legislation.

I work every day with nurse anesthetists and very much value their contribution to the care of my patients. I have also administered anesthesia myself for almost half my career. Both anesthesia care models have proven to be effective and safe ways to manage the care of patients during the critical perioperative period. Unfortunately, AANA, PANA and other nursing organizations have with some degree of success conducted a multifaceted strategy to undermine physician supervision of anesthesia services.

Numerous times over the past 10 years, essentially the same bill with some meaningless wording changes has been introduced into the Pennsylvania State Legislature with the obvious objective of ending physician supervision of

anesthesia services. Some state governors are opting out of the Medicare regulation requiring physician supervision for the purpose of improving "access to care."

Nurse anesthetists are taught to inform each patient that he/she is *the* "hands-on provider" with no mention of physician supervision. They wear buttons that claim "we never miss a beat" (insinuating, of course, that anesthesiologists do). Personally, I believe that a clear majority of nurse anesthetists do prefer to work as part of the anesthesia care team, and respect the input of the anesthesiologist as we respect theirs. Unfortunately, these are not the individuals who give testimony in front of legislative committees, commission patient safety studies from reviews of billing data, and write op-eds.

As a matter of fact, two years ago, the president of PANA testified before the Pennsylvania House Professional Licensure Committee that the anesthesiologist is *only* necessary for the purpose of training residents. A relatively small minority of zealots, financed by

Winter 2010



Contents

Republican Governor, State Senate and State House—What Do We Do Next?	PAGE 4
Elections 2010, As I See It	PAGE 4
The Ins and Outs of the Medicare ‘Opt Out’ Rule	PAGE 5
Why Are Residency Graduates Really Fleeing Pennsylvania?	PAGE 7
Know Your Officers	PAGE 8
New Performance Measures for Anesthesiology Actions of the 2010 ASA House of Delegates to Improve the Daily Practice of Anesthesiology	PAGE 9
What to Tell a Kid Who Wants to Go to Medical School?	PAGE 11
New Practice Parameters	PAGE 12
Welcome New Members	PAGE 15

2010–2011 Officers

President Joseph Talarico, D.O.	Delegates to the ASA House of Delegates Joseph F. Answine, M.D. John J. BianRosa, M.D. Edward H. Dench, M.D. Robert F. Early, Jr., M.D. Joseph W. Galassi, Jr., M.D. Patrick K. McGannon, M.D. Craig L. Muetterties, M.D. Steven W. Neeley, M.D. Richard O’Flynn, M.D. Joseph L. Seltzer, M.D. Erin A. Sullivan, M.D. Joseph Talarico, D.O. Meg Tarpey, M.D. Patrick J. Vlahos, D.O. Steven L. Whitehurst, M.D.	Alternate Delegates to the ASA House of Delegates Michael Ashburn, M.D. Joshua Atkins, M.D. Shawn Beaman, M.D. Michael C. Brody, M.D. James Cain, M.D. Robert Campbell, M.D. David Gratch, D.O. Scott Helsley, M.D., Ph.D. Andrew Herlich, M.D. Joseph McComb, D.O. Richard Month, M.D. Paul J. Schaner, M.D. Kevin Slenker, M.D. Thomas Witkowski, M.D.
President-Elect Meg Tarpey, M.D.		
Vice President Joshua Atkins, M.D., Ph.D.		
Past President Steven W. Neeley, M.D.		
Secretary-Treasurer Patrick J. Vlahos, D.O.		
Asst. Secretary/Treasurer Joseph F. Answine, M.D.		
District Director Donald E. Martin, M.D.		
Alt District Director Erin A. Sullivan, M.D.		
	Delegate, Pennsylvania Medical Society House & Interspeciality Committee Primary Joseph W. Galassi, Jr., M.D.	
	Alternate Bhaskar Deb, M.D.	
	Carrier Advisory Representative Donald E. Martin, M.D.	



PENNSYLVANIA
society of
ANESTHESIOLOGISTS

Sentinel

Pennsylvania Society of Anesthesiologists Newsletter

Editor

Paul J. Schaner, M.D.

President

Joseph Talarico, D.O.

Association Director

Susie Wilson

The PSA Newsletter is an official publication of the Pennsylvania Society of Anesthesiologists Inc. Opinions expressed in this newsletter do not necessarily reflect the Society's point of view. All correspondence should be directed to:

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

Right Where The Action Is

Core Readings. Real Time.



ECOM[®] is not affected by changes in peripheral vasoconstriction.
Can your cardiac output monitor say that?

ECOM[®]. Beyond Cardiac Output.

ECOM[®] provides beat-to-beat display of Stroke Volume Variation for real-time fluid management. Reduce patient complications, and reduce the length of hospital stay*

For a cost-free evaluation contact us at:

525 French Road, Utica, NY 13502
800.448.6506 • +1 315.624.3140 • Fax +1 315.624.3255
ecom.info@conmed.com • www.conmed.com

©2010 ConMed Corporation, Control # MCM201094

MAD 9073

CONMED
PATIENT CARE

* Pearse, et al. Early goal-directed therapy after major surgery reduces complications and duration of hospital stay. Critical Care (2005) 9:R687-R693

Republican Governor, State Senate and State House—What Do We Do Next?

by John P. Milliron, Esq., PSA Legislative Counsel

The Republicans have swept control of both the Governor's mansion and the legislature for the next two-year session of 2011-2012. What does that mean to you as anesthesiologists and physicians? Here are some thoughts.

Governor-elect Tom Corbett is considered to be very pro-physician. He believes in tort reform and returning the \$700 million to

the Mcare Fund that is now tied up in the courts. But even more significant to anesthesiologists is Mr. Corbett's firm belief in physician supervision. He has told us several times that he can't imagine having surgery without an anesthesiologist being present and supervising the room. Good for our patients' safety too!

The House had been 104 Democrats and 99 Republicans. Most people felt the House would return to the Republicans, but the final number was a surprise—112 Republicans to 91 Democrats. This means that the control of the next legislative agenda will be in the very competent hands of the

new House Majority Leader, Rep. Mike Turzai (Allegheny County).

Many of you from out west know Mike. For the rest of you, here is a quick recap: Mike is married to a physician, is pro tort reform and pro nurse supervision. Rep. Turzai has only been a member of the House for 10 years, but his intellect, honesty and work ethic has earned him the respect of his colleagues – enough to elect him to the second highest position in the House of Representatives. Mike is a good person who we will enjoy working with in the coming months and years.

continued on page 5



Elections 2010, As I See It

by Paul J. Schaner, M.D., Sentinel Editor

The elections are over (almost) as the dust settles. The tsunami for the Republicans was demonstrated at the state and federal

levels. The Tea Party has shown it is a force in elections and is here to stay.

Unlike the Democratic and Republican parties, it is not a party but a grassroots movement. It is, however, a potent political force. The turnover of 60-plus seats in the Congress is historic. The change of control to Republican in the House will preclude any one-sided agenda and may result in the beginnings of repeal of health care legislation in whole, more likely in part.

The retention of the Bush Tax Cuts appears more likely, the out-of-control spending and growing government reduced and/or contained, spending cuts hopefully will be done, Cap and Trade gone, card check gone. The obvious hang-up will be the Senate, which is on the face of the vote marginally Democratic.

Newly elected Senator Joseph Manchin, the former Democratic Governor from West Virginia, has a record of siding with Republicans on multiple issues. Senator Joseph Lieberman may be an ally on many issues as well as some of the 33 Senators who face 2012 elections.

The long-absent bipartisanship may surface because the Republicans can't

be ignored. The President will be in focus because the veto of bills is in his hands for the passage or failure of any bipartisan effort. The real problem is the economy stupid. The urgent need is for jobs, jobs, jobs. It is striking the major worldwide economies have rebounded far better than the USA. The dollar is under attack. The Fed is pumping \$600 billion into the economy.

The danger of inflation has increased. The national debt has the nation on the brink of financial disaster. It is essential to return the creation of jobs to the small businesses by the creation of a stable atmosphere that permits expansion and growth. Government must get out of the

continued on page 15

The Ins and Outs of the Medicare ‘Opt Out’ Rule

by Robert Hoffman, Esq., Eckert Seamans Cherin and Melott

Elsewhere in this newsletter, PSA President Joe Talarico writes, in part, about actions taken by governors of a few other states to “opt out” of the Medicare anesthesiologist rules. This article explains that issue.

Medicare establishes “conditions of participation” that set out the standards that must be met for Medicare to reimburse a provider. The anesthesia rules are contained in conditions of participation that apply to hospitals and ASFs, and there are analogous conditions that apply to most major services and systems within a hospital.

For anesthesia, Medicare establishes the baseline rule that physicians are to be in charge. Specifically, the Medicare rule is that anesthesia may be administered only by:

- a qualified anesthesiologist;
- a non-anesthesiologist physician;
- a dentist, oral surgeon or podiatrist if qualified to do so under state law;
- a CRNA who is under the supervision of either the surgeon or an anesthesiologist who is immediately available if needed; or
- an AA who is likewise under the supervision of an anesthesiologist who is immediately available.

The “opt out” concerns the CRNA supervision rule. Specifically, Medicare allows states to eliminate the supervision requirement, thus letting CRNAs practice independently of anesthesiologists and even of surgeons, if a governor submits

a letter to CMS requesting an exemption.

There are, however, a series of criteria that must be met. First, the governor must “consult” with the state’s boards of medicine and nursing on issues related to “access to and quality of anesthesia services in the state.” Second, the governor must conclude that it is in the “best interests of the state’s citizens to opt out” of the supervision requirement. Finally, the opt out must be consistent with state law, that is state law must allow CRNAs to practice independently.

Sixteen states, almost all west of the Mississippi, have opted out of the CRNA supervision rule. They are California, Colorado, Iowa, Nebraska, Idaho, Minnesota, New Hampshire, New Mexico, Kansas, North Dakota, Washington, Alaska, Oregon, South Dakota, Wisconsin and Montana.

California and Colorado are the most recent, in 2009 and 2010, respectively. The California and Colorado anesthesia societies are challenging the decisions in court and in October a California trial court recently ruled against the anesthesiologists there.

The gist of what seems to have been the winning argument in California (there is no court opinion as this article is written) is that California law makes the “administration of medications” on a physician’s order part of the “practice of nursing.” Because anesthesia is a “medication,” RNs with training—i.e. CRNAs—can administer it. That is exactly the logic Gov. Arnold Schwarzenegger

continued on page 13

Members Can Suggest Clinical Topics

The PSA website (www.psanes.org) contains informative articles on clinical topics such as perioperative visual loss and regional anesthesia in patients on antithrombotic therapy. If you have a suggestion for other topics or would like to contribute an article, e-mail us at psa@pamedsoc.org.

REPUBLICAN GOVERNOR, STATE SENATE AND STATE HOUSE – WHAT DO WE DO NEXT?

continued from page 4

The Senate was 30-20 Republican and the election had the least effect here. It remained 30-20 Republican. The two Republican leaders are the same as last session—President Pro Temp Joseph Scarnati from Jefferson County and Majority Leader Dominick Pileggi from Delaware County.

The 2011-2012 legislative agenda for the PSA is still being finalized by the Executive Committee and the Board of Directors, but we expect it to be an aggressive one. Patient safety has always been our first and primary concern. Now it is a matter of deciding how to best ensure that safety and quality of care continue for years to come.

We will be hosting our Legislative Reception again this fall in Harrisburg. The details are still being worked out, but please make every effort to have as many of your colleagues attend as possible. We have more than 100 new House members who have been in office less than four years. That is over half the entire House! We need your time and energy this year. More details will be available in early January.

stability matters.

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

Medical Protective, a proud member of Warren Buffett's Berkshire Hathaway, has always believed that to provide our healthcare providers the best defense in the nation, our financial stability needs to be *rock-solid*, stronger than any other company.

Stability even in the worst of times.

Medical Protective is the only medical professional liability insurance company to protect their healthcare providers through all the business and economic cycles of the last 110 years, including the tough economic times of *the Great Depression*. We are also proud to have provided unmatched defense and stability during all the medical crises.

We have received higher ratings from A.M. Best and S&P than any other carrier in the healthcare liability industry.

Trust Stability. Trust Medical Protective.



Contact us today for a medical insurance check-up and a FREE, no-obligation quote.

- Call: 800-4MEDPRO
- Email: experts@medpro.com
- Visit: www.medpro.com
- Contact your local Medical Protective agent

All products are underwritten by either The Medical Protective Company® or National Fire and Marine Insurance Company®, both Berkshire Hathaway businesses. Product availability varies based upon business and regulatory approval and may be offered on an admitted or non-admitted basis. ©2010 The Medical Protective Company® All Rights Reserved.

Why Are Residency Graduates Really Fleeing Pennsylvania?

by Richard C. Month, M.D., Immediate Past President of PSA Resident Component

At the PSA Board meeting in April, the PSA Resident Component raised the question of resident retention: were residents really leaving Pennsylvania and, if so, why? Almost everyone in attendance knew the answer was “yes,” and that the reason why must include one or more of the following phrases: “CRNAs,” “Malpractice,” or “Reimbursements.” Despite what we all knew to be true, no one could quantify the problem.

To remedy that, the PSA Resident Component e-mailed a survey to all graduating CA-3 residents in Pennsylvania. We first asked if they planned within the next five years to be practicing in Pennsylvania. We then asked them to rate several issues as to how they influenced their decision for or against practicing in the Commonwealth.

Of 102 graduating senior residents, we received 52 responses, a response rate of 51 percent. Twenty-four respondents (46.1 percent) said they will likely not, very likely not, or definitely not practice in Pennsylvania in the next five years. This included 13 (25 percent) who will definitely not be practicing in Pennsylvania. Nineteen respondents (36.5 percent) will more than likely be staying, with 10 (19.2 percent) definitely staying. Seven respondents (13.5 percent) are unsure of their plans, and two respondents did not answer the question.

The first two groups were then asked to rate, from 0 (none) to 5 (strongest), how strong an influence each of the following was on their decision:

- Malpractice/Legal Climate
- Price/Availability of Malpractice Insurance
- Job Availability
- Reimbursement/Salary
- CRNA Lobby/Risk of CRNA Independent Practice
- Proximity to Family
- Other Familial Concerns
- Taste or Distaste for Pennsylvania

Of those probably leaving, the strongest draw was family: 54 percent rate proximity to family as their strongest influence for leaving, with a whopping 79 percent rating it a strong, very strong, or strongest influence. These are even more overwhelming for those definitely leaving: 69 percent (9 out of 13) rate proximity to family as their strongest influence, and 85 percent (11 out of 13) rate it as at least a strong influence.

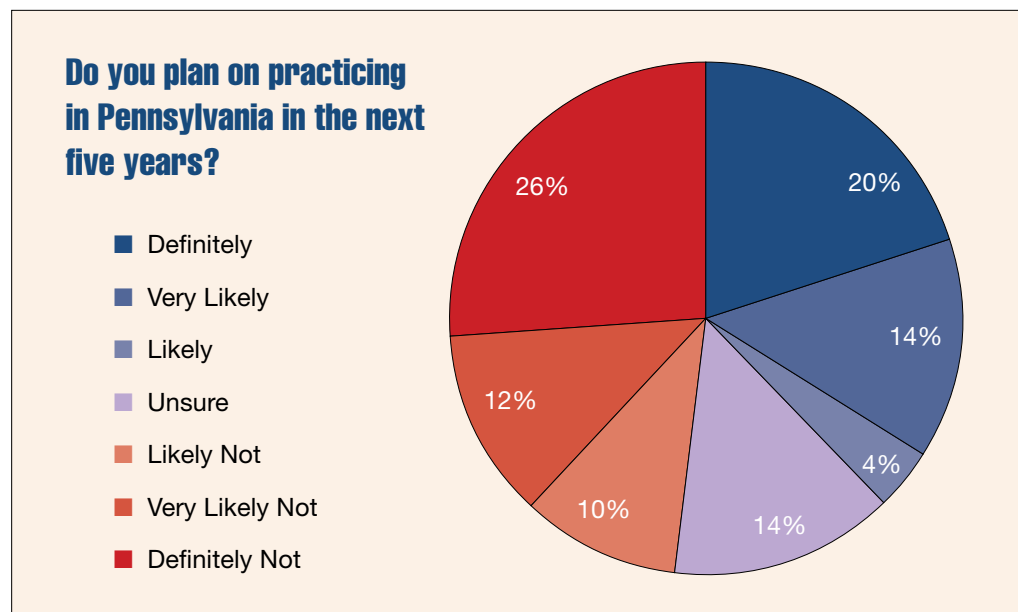
The only other consensus concern is the CRNA lobby, with 54 percent (7 out of 13) of those definitely leaving and 58 percent

(14 out of 24) of those probably leaving rating it at least a strong influence. No other issue above was rated at least a strong influence by more than half of this group. None of the issues were thought to be a positive influence by more than half the group.

Of those probably staying, again, family played the strongest role in the decision. Sixty percent of those definitely staying and 52 percent of those probably staying rate family as their strongest influence, while 90 percent of those definitely staying and 74 percent of those probably staying rate family at least a strong influence. Also rating at least strong by more than half



continued on page 15



Know Your Officers

As a regular feature in this and upcoming editions of *The Sentinel*, we will run Q&As with current PSA leaders. In this edition, you'll learn more about incoming PSA President Joseph F. Talarico, D.O., and Resident Component President Ryan Ball, M.D.



Outgoing PSA President Steven W. Neeley, M.D., right, passes the gavel to incoming PSA President Joseph F. Talarico, D.O., left, during a ceremony in October at the ASA's Annual Meeting in San Diego.

Joseph F. Talarico, D.O.



Current Employer:
University of Pittsburgh Physicians
Medical School:
Philadelphia College of

Osteopathic Medicine

Where did you do your Residency, Fellowship? Hospital of Philadelphia College of Osteopathic Medicine

What hobbies/interests do you have outside of work and the PSA? Wine making, carpentry, pizza making in the wood fired pizza oven I built in my back yard.

What percentage of your work is clinical, teaching, research? 70 percent clinical, 25 percent teaching, 5 percent research

Who is your hero in the history of anesthesia and why? I have no heroes. Having heroes implies they are in some way superior to the competent clinical anesthesiologist in a community hospital.

What year did you join the PSA? I joined as a first year anesthesiology resident in 1986.

What prompted you to become involved with a PSA leadership role? After spending 12 years in various community hospitals, where there weren't enough anesthesiologists to enable me to be active in the PSA, when I joined the UPMC group, I immediately sought involvement with the organization. Since I was given the opportunity to become involved, I felt it was important to exert the effort for the PSA.

What leadership roles have you held in the past? Managed a small anesthesiology practice in Erie, Pa., where I was the Chief of Anesthesia and Chief of Surgery at various times. Chair of the Evaluation and Competence Committee of the Anesthesiology Residency Program at UPMC. I also served as program Director of Osteopathic Rotating Internship at UPMC Mercy.

What accomplishments/issues are you most proud of during your time in PSA? While I can't take credit, as it was a group effort, I take pride in the PSA's efforts to preserve the physician direction of anesthesia care in Pennsylvania and its positive effect on patient safety.

Other than the obvious benefits, why would you recommend that others apply for a PSA Board position? Being part of a group of tireless advocates for anesthesiology is rewarding. In my eight years of involvement, we have had formidable success in the legislative arena, primarily because our objectives are consistent with patient safety. Playing a role in enhancing patient safety in anesthesiology can be extremely rewarding.

How much time does being a PSA Board member involve?

Approximately eight to 10 days per year plus an average of 15-30 minutes per week of dealing with issues that arise (primarily by e-mail and telephone) for a board member. One or two extra days per year at meetings in Harrisburg for executive committee members. I expect another two to three hours per week on average as president.

Is there anything else you'd like to share with PSA members about yourself (interesting facts, family, etc.)? I am married with seven kids and eight grandchildren.



Ryan D. Ball, M.D.

Current Employer:
UPMC
Medical School:
University of Kentucky

Where did you do your Residency, Fellowship? UPMC

What percentage of your work is clinical, teaching and research? 75 percent clinical, 25 percent research

What year did you join the PSA? 2009

What prompted you to become involved with a PSA leadership role? I saw a need for resident involvement at the state level. Thought it would be a good experience.

What leadership roles have you held in the past? Chief Resident (current), ASA Selection Committee (Med School), Junior Chief of Recruitment (UPMC Anesthesiology), Alternate Delegate for State of Pennsylvania.

New Performance Measures for Anesthesiology: Actions of the 2010 ASA House of Delegates to Improve the Daily Practice of Anesthesiology

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

Quality and performance measurement are at the center of the growth of the CMS Pay for Performance Program, as well as similar programs at the state level and among private insurers. In 2010, quality measurement means outcome measurement. If anesthesiologists do not establish outcome measures for ourselves, then one of two things could happen. First, measures could be imposed on us by others. Second, an absence of any quality measure for our specialty would eventually render us ineligible for payment incentives.

Therefore, ASA is moving quickly to establish outcome measures for the specialty. The Committee on Performance and Outcome Measurement and the Anesthesia Quality Institute are leading this ASA effort.

At this year's annual meeting in San Diego, two specific outcome measures were approved. They will be sent to the National Quality Forum and to CMS as quality measures for the Pay for Performance Program.

Anesthesia Performance Measures Approved by the ASA House of Delegates:

- **Multimodal therapy to prevent postoperative nausea and vomiting** – This performance measure will be based on the fraction of adults who have risk factors for postoperative nausea and vomiting and are receiving general anesthesia, who also receive at least two

prophylactic pharmacologic antiemetic agents of different classes. Therefore, since it measures types of therapy rather than simply the incidence of postoperative nausea and vomiting, this is at least partly a process measure and so compliance will be more predictable.

- **Maintenance of intraoperative normothermia** – This outcome measure has been revised to be solely based on outcome. It measures the percentage of elective surgical patients over age 18 who receive neither intraoperative controlled hypothermia nor cardiopulmonary bypass and who then have a temperature of at least 35.5 degrees centigrade postoperatively. This measure does take into account several risk factors but cannot be met simply by using hot air warming as in the past.

New Anesthesia Performance Measures Currently Being Developed:

- Use of ultrasound to localize the internal jugular vein when it is cannulated for central venous access.
- The administration of aspirin perioperatively to patients who have a drug eluting cardiac stents.
- **Muscular relaxant reversal** – either the reversal or the documented resolution of the neuromuscular blockade following a general anesthetic in which neuromuscular blockade was used.



- The establishment of specific hospital protocols for patient transfers between health care providers.

Performance Measures Already Approved by the ASA and the National Quality Forum:

- Timely administration of Antibiotic prophylaxis
- Prevention of Ventilator Associated Pneumonia
- Prevention of Catheter Related Blood Stream Infection

Each of the two new performance measures is supported by a significant volume of scientific evidence. Most of them are, or will be, published on the ASA website at www.asahq.org. It is important for anesthesiology groups to move quickly to establish practices in their own institution that are compatible with these measures. This will enable them to take advantage of performance incentives, and avoid decreases in payment for poor performance. These measures are put into place by CMS during the next several years.

Find more practice guidelines at the PSA's website (www.psanes.org) under the clinical resources section.



MEDCON

Providing expert anesthesia and pain management billing service since 1990

Solely dedicated to anesthesia

Capable to benchmark your practice's performance against Medcon's 2,000 anesthesia provider clients in PA, NJ, NY and MA

Solid management staff averages 15-years employment with Medcon

For more information please contact:

Joe Mercer, VP Business Development

Medcon

301 Route 17 North

Rutherford, NJ 07070

(877) 562-9820

joemercer@medcon-financial.com

What to Tell a Kid Who Wants to Go to Medical School?

by Joseph F. Answine, M.D., PSA Assistant Secretary Treasurer, PAMED Specialty Trustee

I have a son and daughter interested in becoming physicians. In the old days, having a child follow in the family business would be a dream come true for a father or mother. However, when I tell my colleagues about my children's interest, they universally ask if I can talk them out of it. Although some of that may be in jest, there is a hint of sincerity in the statement.

I watch my son struggle through organic chemistry and advanced calculus into the early morning hours while his junior year buddies are "chilling," because they have finished their freshman art history homework by mid-afternoon. In the back of his mind, he is questioning whether it is worth it. Is it?

Consider the following:

1. The combined cost of a pre-med and medical school education averages \$400,000, including room and board.
2. It takes a decade and a half of your life to complete your education.
3. You will miss about 10 years worth of appropriate salary and benefits.
4. Medical reimbursement and, therefore, incomes continue to decline.
5. The risk of litigation continues to be high.
6. Various groups continue to question the need for physician involvement in patient care.
7. The work hours continue to be long and frequently interrupted sleep becomes a normal part of life.

It's hard to argue for a medical career. There is also the agony you feel wondering if it is, at least

in part, your fault when a patient is lost in the operating room. Or the heartbreak you feel when performing a "gift of life" harvest on a 3-year-old child who has died from head trauma.

What have I noticed over the years? When battling non-physicians over maintaining doctor/patient relationships, I don't see an inkling of respect for my efforts as a physician in the eyes of the legislators or those fighting against me. I feel as if I am slowly losing any say in what equipment I use or the medications that I can administer to my patients. I seem to see fewer and fewer physicians being the true leaders of hospital systems, outpatient facilities or even their own offices. I also see individuals getting increasingly angrier over health care issues, especially their growing health care expenses, and much of that anger is directed toward the health care provider.

Ok, I'm depressed. What was I thinking when I decided to go into medicine?

But what about the young lady who wheels a stroller up to me at the supermarket and shows me a little cherub with drool and left over puréed peas rolling down his face, and proceeds to thank me for the great care I delivered for her emergency cesarean section. What about the thousands of patients who I help through difficult situations in their lives? What about the thank you cards and cookies (I love cookies!) that my office manager hands me delivered by grateful patients?

What about that new look of respect (and a little amazement) that appears on the faces of the

other parents sitting at my kids' sporting events when they find out that I am actually an anesthesiologist. Never mind that my tennis shoes are untied, my jeans are old and tattered, my collar is accidentally half up and I forgot to shave? What about that feeling of "walking on air" when I find out that the "half dead" patient I struggled with for hours in the OR walked out of the hospital a few weeks later? And what about those amazing medical people who I have met and learned from over the years?

So what do you tell a kid who wants to go to medical school? If that is your dream, go for it. You will get through organic chemistry, physics and Calculus II as well as anatomy, histology and your surgical acting internship. You will pay off your loans, and out there will be mom with a snotty-nosed kid thanking you for your care. The many sacrifices are well worth it. I don't think there are many doctors lying on their deathbeds saying "I wish I would have done something with my life."

(As an aside: The statement about my less-than-stellar wardrobe when I make an appearance at my kids' sporting events was an inside joke for Dr. Julien F. Biebuyck. He is a true gentleman and a person at the top of my list of those individuals who I give credit to for all the positive things that I have achieved throughout my career.)



New Practice Parameters

Actions of the 2010 ASA House of Delegates to Improve the Daily Practice of Anesthesiology

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

ASA is continuously updating existing evidence-based best practices, and establishing new ones, for the specialty of anesthesiology. These best practices, designated either as practice parameters, practice advisories, or practice guidelines, represent the most up-to-date guidelines for clinical practice in our specialty, based on both scientific evidence and the consensus of expert consultants and practicing anesthesiologists.

Parameters, Advisories, and Guidelines Approved in 2010:

- **Practice Guideline for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: Application to healthy patients undergoing elective procedures.**

This guideline was last published in 1999, and has been revised in 2010. The revised guideline recommends no routine use of either gastrointestinal stimulants such as metoclopramide, gastric acid secretion blockers such as ranitidine or omeprazole, antacids, antiemetics, or anticholinergics. The recommendations for preoperative fasting are similar to those published in 1999 and summarized in the table:

Fasting Recommendations¹

Ingested Material	Minimum Fasting Period ²
Clear liquids ³	2 h
Breast milk	4 h
Infant formula	6 h
Non-human milk ⁴	6 h
Light meal ⁵	6 h

1. These recommendations apply to healthy patients who are undergoing elective procedures. They are not intended for women in labor. Following the guidelines does not guarantee complete gastric emptying.
2. The fasting periods noted above apply to all ages.
3. Examples of clear liquids include water, fruit juices without pulp, carbonated beverages, clear tea, and black coffee.
4. Since non-human milk is similar to solids in gastric emptying time, the amount ingested must be considered when determining an appropriate fasting period.
5. A light meal typically consists of toast and clear liquids. Meals that include fried or fatty foods or meat may prolong gastric emptying time. Additional fasting time (e.g., eight or more hours) may be needed in these cases. Both the amount and type of foods ingested must be considered when determining an appropriate fasting period.

- **Practice Advisory for the Perioperative Management with Cardiac Implantable Electronic Devices: Pacemakers and Implantable Cardioverter Defibrillators.**
This practice advisory provides evidence-based recommendations on the preoperative evaluation, preoperative preparation and reprogramming, intraoperative management, and necessary postoperative management for patients with pacemakers and internal cardioverter-defibrillators, as well as patients with devices designed to provide the newer cardiac resynchronization therapy. This guideline is revised slightly from the last version published in 2005. It has useful recommendations for management of these implanted electronic devices during multiple types of specialized surgical procedures. It is based primarily on the small amount of evidence currently available, and so its recommendations are somewhat limited.
- **Practice Advisory for the Prevention of Perioperative Peripheral Neuropathies.**
This advisory was last published in 2000, and the revised practice advisory provides specific positioning recommendations for the upper and lower extremities, as well as specific recommendations for protective padding.
- **Update of the Standards for Basic Anesthetic Monitoring.**
The standard for basic anesthetic monitoring of ventilation using exhaled carbon dioxide was expanded to include the recommendation “during moderate or deep sedation, the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure or equipment.”

One practice guideline that was not approved but still has very important implications for our daily practice in the future is the “Practice Guideline for Central Venous Access.” This practice guideline was not approved in its current form. However, the primary recommendations for asepsis during central line placement, and particularly the use of ultrasound guidance for the placement for internal jugular catheters, are supported by sound scientific evidence and will likely become a part of practice advisories and practice guidelines for both ASA and other organizations in the near future. Therefore, individual departments of anesthesiology should begin planning now to have the equipment and practices in place for the use of ultrasonic guidance for the placement of most central venous access catheters in the future, at least those placed by the internal jugular route.

continued on page 16

PRESIDENT'S MESSAGE

continued from page 1

the association dues and PAC contributions, are a real threat to our specialty.

For the past eight years, I have had the pleasure of serving on the PSA Board of Directors, and have been extremely impressed at the response of the PSA officers and our legislative and legal counsel to these and other threats to our profession. We have effectively stopped every expanded scope of practice bill in its tracks. In Pennsylvania, the PSA has had arguably more success than any other specialty society in preserving patient safety by preserving physician supervision of paramedical personnel.

It is very tempting to take comfort in our past successes and continue to play defense and preserve the status quo. However, it seems to me that the present environment calls for a reappraisal of our strategy and consideration of a more offense-based approach.

As a Pittsburgh Penguins fan, I call this the Michel Therrien strategy. Therrien, the Penguins' head coach at the time, brought the Penguins to the Stanley Cup Finals in 2008 using a defensive strategy that largely handcuffed his offensive superstars. On the basis of talent and determination, his team reached the finals and fell two games short.

He wasn't so fortunate in 2009. His team didn't change appreciably, but the competition improved. After a mediocre first half of the season, he was replaced by Dan Bylsma, who immediately unleashed his offensive talent. The Penguins didn't lose many games the remainder of the season on their way to the Stanley Cup championship. The Therrien strategy has served the PSA very well in the past, and was very likely the most judicious strategy in that environment. The game, however, has changed slowly but surely over the past few years.

On pure merit, we should not be in this situation. There is no comparison between the training of an anesthesiologist and a nurse anesthetist; there is simply no substitute for a medical degree and four years of residency. Unfortunately, this fight will be fought in the political realm, where merit alone will not suffice.

We must build on our natural advantage (the facts) with effective messaging and advocacy. We must also continue to expand our practice into all aspects of perioperative care, and do so while maintaining a high profile. Finally, we must make it clear to our patients that we will be supervising or providing their anesthesia care, and that our immediate availability is an indispensable component of their perioperative well being.

The Pennsylvania Society of Anesthesiologists is in the process of developing aggressive strategies to preserve anesthesiology as the practice of medicine in Pennsylvania. We are in the process of contacting all our members for their input and support. These strategies will be successful if, and only if, the membership is in agreement with and in support of them.

A major component of this strategy is statutory (as opposed to regulatory) recognition of supervision of anesthesia services. Passage of this legislation would make expansion of the scope of practice considerably more difficult. The PSA Board of Directors encourages your input in the development of this initiative, and urges your advocacy.

We ask that you get to know your state representatives and senators and contribute to Z-PAC, the political action committee of the PSA. As we progress, we will continue to remain in contact with you, asking for your input as well as asking you to contact your legislators as the need arises. The strategy will be the most aggressive posture that the PSA has undertaken in recent years. I am confident that you will be pleased with this approach.

THE INS AND OUTS OF THE MEDICARE 'OPT OUT' RULE

continued from page 5

adopted in his opt-out decision and his lawyers made in defending it.

They argue that there is no difference—at least as a matter of law—between a physician order for pain medication to a post-surgical patient and the provision of anesthesia care. Similarly, they argue that there is no difference in the monitoring on the medication's effects provided for that post-surgical patient and a patient who is in surgery, no greater skill required for the latter than the former and no greater risk of adverse consequences. Finally, that argument essentially equates the actual administration of an anesthetic, which is in most cases a routine task, with what anesthesia care actually entails.

Could it happen in Pennsylvania? There is, of course, no way to know for sure. But Governor-Elect Tom Corbett has expressed no interest in an "opt out." Pennsylvania statutes, although they certainly authorize registered nurses to administer medication on a physician's order, do not recognize CRNAs as a distinct group, let alone provide them with an independent scope of practice mirroring that of anesthesiologists.

CRNAs remain governed by the Professional Nursing Practice Act and it clearly does not grant RNs independent practice. Although CRNPs are carved out and treated somewhat differently in that act, given a scope of practice that is less dependent on physician supervision, CRNAs are not.

Determining, as Medicare requires, that Pennsylvania law allows CRNAs to practice independently will be a hard conclusion for Governor Corbett to reach.

Mr. Hoffman serves as outside legal counsel to the PSA.

Offering financial strength, superior customer service and solid litigation protection to our physician policyholders and their staff for over 30 years.

There are many choices,
but there's only one PMSLIC.

Experience the Difference.

For additional information on PMSLIC's medical liability insurance, please contact Kathryn Elliott, JD, Director, Sales and Marketing.

Phone: 800 445-1212, ext. 5551 or 717 802-2365

E-mail: kelliott@pmslic.com



PMSLIC

MEDICAL LIABILITY INSURANCE

ALWAYS WITH YOU

WWW.PMSLIC.COM

WHY ARE RESIDENCY GRADUATES REALLY FLEEING PENNSYLVANIA?

continued from page 7

this group are residents who liked Pennsylvania (80 percent definitely staying, 74 percent probably staying), salaries and reimbursements (70 percent and 58 percent), and, surprisingly, CRNA lobby (70 percent and 47 percent). None of the factors was felt to be a negative influence by more than half of this group.

Amazingly, what we presumed about our residents turned out to be untrue. While one-in-four graduating CA-3s in Pennsylvania are absolutely sure they won't practice here, and nearly half are surer than not, they are leaving for the noblest of reasons: family. In the same vein, those deciding to stay are staying primarily because either they like Pennsylvania or they want to stay close to family. While there is still much to improve about the state of anesthesiology in Pennsylvania, I find our results very comforting.

Editor's note: This supports the reason to school as many qualified Pennsylvania natives as possible in our medical schools and residencies in order to enhance the number of medical professionals retained in Pennsylvania.

ELECTIONS 2010

continued from page 4

way. It is clearly the mandate of the newly elected to work to improve the economy. Those who do not join in will bear the ire of the 2012 voters.

The outstanding lesson from the recent election is the power of the voter. Your vote matters and so does your input to your government representatives. One vote can change an election. While your elected officials can't tell how you vote, they can tell if you voted.

If you have been actively involved in the election of your Representative and Senator, keep the contact active. If you haven't established your contacts, work to do so. The potential power of the government has been demonstrated for you, your patients and your family. Every aspect of your life can be fair game for the government. Make certain your government represents YOU. The time for your involvement was yesterday. If it didn't happen, make sure it is today.

Welcome New Members



Active

Bill D. Alexander, M.D.
Emily J. Baird, M.D.
Andrew Harter, M.D.
Charles B. Luke, M.D.
Wende Goncz, D.O.
Jason T. Bundy, M.D.
Kimberly K. Cantees, M.D.
Rebecca B. Lim, M.D.
Aubrey V. Verdun, M.D.
Shiv K. Goel, M.D.
Krzysztof Laudanski, M.D.
Ali R. Bakhshalizadeh, M.D.
Richard C. Month, M.D.
Michael G. Rossi, D.O.
Moheb M. Mosa, M.D.
Javaid A. Malik, M.D.
Susan Banez, M.D.

Affiliate

Edward J. Quirk, M.D.

Resident

Phillip S. Adams, D.O.
Michael L. Boisen, M.D.
Bernard C. Ciongoli, D.O.
Michael J. Duggan, M.D.
Meghan B. Lane-Fall, M.D.
Charles J. Lin, M.D.
Sobia F. Mansoor, M.D.
April A. McIver, M.D.

Alexandria N. Nickless, D.O.
Justin Pachuski, M.D.
Tejas D. Parikh, M.D.
Prakash A. Patel, M.D.
Dennis P. Phillips, D.O.
Samuel H. Plummer, D.O.
Nathan A. Poulson, M.D.
Saravanan Ramamoorthy, M.D.
Norman D. Randolph, M.D.
Seline N. Read, M.D.
Christopher C. Rigsby, D.O.
Cara A. Riley, M.D.
Kristin L. Schreiber, M.D.
Debra M. Seidenberg, M.D.
Megan J. Sharpe, M.D.
Edward J. Shen, M.D.
Jonathan E. Shirey, M.D.
Anthony T. Silipo, D.O.
Sarah A. Solomon, D.O.
William B. Somerset, D.O.
Christopher A. Steel, Jr., M.D.
John F. Termini, M.D.
Filip B. Trojanowski, M.D.
Michael J. Tuttle, D.O.
Malina M. Varner, M.D.
Audra Webber, M.D.
Ryan R. Wilson, M.D.
Lisa K. Wong, M.D.

Student

James J. Lamberg



PENNSYLVANIA
society of
ANESTHESIOLOGISTS

777 East Park Drive
P.O. Box 8820
Harrisburg, PA 17105-8820

PRSRT STD
U.S. POSTAGE
PAID
HARRISBURG PA
PERMIT NO. 922

Mark Your Calendars: Future Meeting Dates

**Board of Directors meeting
in Philadelphia** – March 27, 2011;
all members are invited to attend

**ASA Legislative Conference
in Washington, D.C.** – May 2-4, 2011,
at J.W. Marriott.

**Bi-Annual Legislative Reception
in Harrisburg** – October 2011;
stay tuned for date and location

KNOW YOUR OFFICERS

continued from page 8

What accomplishments/issues are you most proud of during your time in PSA? High participation rate by UPMC residents in PAC, newsletter articles.

Other than the obvious benefits, why would you recommend that others apply for a PSA Board position? Exposures to motivated individuals, good topics of discussion, access to mentors.

How much time does being a PSA Board member involve? As much as you can work, but typically it is very reasonable!

What hobbies/interests do you have outside of work and the PSA? The beach, skiing (snow), fishing, traveling and horseracing.

Is there anything else you'd like to share with PSA members about yourself? I have Run with the Bulls in Pamplona, Spain.

NEW PRACTICE PARAMETERS

continued from page 12

We can expect each of these guidelines to appear on the ASA website (www.asahq.org) under the tab "Clinical Information" within the next few weeks. Most of these guidelines will also be published in *Anesthesiology* over the next several months. Each guideline includes detailed rationale for its recommendations, as well as a summary of all its recommendations near the end of the document.