



PRESIDENT'S MESSAGE

The Sky is Still Falling

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

During my residency, I was repeatedly informed by my trainers that I was entering a field wrought with uncertainty. The only certainty was that medicine in general and anesthesiology specifically were doomed. Thirty years later, 22 of which I spent in anesthesiology, I am still standing, and, by most measures, thriving.

Being essentially optimistic by nature, I haven't spent many sleepless nights over the course of my career pondering the ultimate demise of my chosen profession. Some may accuse me of being naïve, but again, after 30 years, I am still here. I believe there is a difference between optimism and naivety: one can be optimistic but proactive, whereas the naïve individual is more likely to believe that everyone recognizes his/her indispensability and as a result neglects to take the steps necessary to ensure his/her future.

Over the past 30 years, our profession has confronted many challenges and has survived, if not prospered. Our survival is due in no small part to our predecessors'

largely successful efforts on our behalf. A notable exception to our many successes, the institution of the RBRVS (Resource-Based Relative Value Scale) in 1992, has had an ongoing negative impact on anesthesiology. The RVRBS was developed at Harvard University and published in 1988, was signed into law by President George H. W. Bush in 1989, and took effect in January 1992.

For most medical specialties, the RBRVS was not that bad, reimbursing at 80 percent of the usual and customary fees. Anesthesiologists were reimbursed at 30 percent as a result of a miscalculation that was subsequently recognized as flawed by CMS (Centers for Medicare and Medicaid Services). To the present day, however, this inequity has not been remedied, in spite of tireless advocacy on the part of anesthesiologists and our representatives at ASA and PSA. While we will continue to seek a remedy for this error, once the die is cast, it is extremely difficult to repair the damage. In

the current environment, the odds of a resolution are not good to say the least. While I do not know exactly how or why we were left out of the discussion, it is unlikely that this flawed reimbursement system would have been instituted as it existed if organized anesthesiology had a seat at the table. The bottom line is that *we can never let something like this happen again.* (Editor's note: *The ASA has been, and continues to be, at the table.*)

While the case can certainly be made that the sky is still falling today, the worst case scenario is accept the inevitability of our demise and crawl into a hole with the objective of surviving as long as we can. On the other hand, it would be no better if we do nothing because we are so certain of our inherent value that we assume that, in the end, our elected representatives will do the right thing and preserve the status quo.

In Pennsylvania, we continue to be threatened by those who want our jobs. In mid-August, former PSA President Dr. Joe Answine, PSA Legislative Council John Milliron, and I attended a meeting called by Pennsylvania Senator Robert Tomlinson, majority continued on page 5

Fall 2011



Contents

Stay Handy: PSA Members Can Make a Difference	PAGE 3
Solid Grassroots Network is the Key to Victory	PAGE 4
In Memoriam: Steven D. Bell, M.D.	PAGE 5
Peri-operative Diabetes Management for Dummies: Just Check the Sugar!	PAGE 6
Perioperative Management of Patients with Cardiac Rhythm Management Devices – Recent Guidelines	PAGE 8
Read More Clinical Pieces at www.psanes.org	PAGE 9
Court Cases of Interest	PAGE 10



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

2010–2011 Officers

President

Joseph F. Talarico, D.O.

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.

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.
Erin A. Sullivan, M.D.
Joseph F. 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.
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.

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.

Stay Handy: PSA Members Can Make a Difference

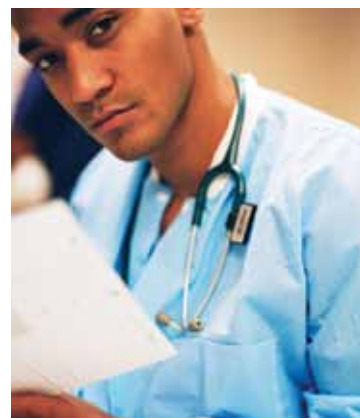
by Paul J. Schaner, M.D., Sentinel Editor

Place your left hand palm down and extend your fingers. You will note each digit varies in length and girth. Finger function varies. The smallest finger is a frequent ring site and often a social sign when it is held extended and the others are at rest. The adjacent ring finger holds the time-honored place for the wedding band. The middle finger, fully extended alone, is another nonverbal comment in frequent use. The index finger is a work horse performing multiple functions in this digital world often pointing to the blamed party. The thumb is used in opposition to the other fingers and is largely responsible for man's assent in the world.

The hand and its members are a reflection of society. Each of us has a function better done by one than the other. All are important and functioning together is critical to success. Take the palm down hand and make a fist. You will now note that all the fingers come together and size is equalized. This union is much stronger than any one member. The joined fingers can accomplish function not possible by one member.

At this critical time in political history we must be united. A strong solid front can overcome obstacles not possible by an individual. Please as an offhand comment, join your fellow

anesthesiologists and beat on the doors of politicians. The Fall Legislative Reception at the Harrisburg Hilton on **Monday, October 3** will be a hands-on effort for patient safety. Don't flip the finger at this effort! Get a grip take the trip, be at hand to talk with *your* legislative representatives. Call and ask your Representative and Senator to be there because you will be there to greet them. We will applaud your effort with both hands.



Simulation-Based Education for Maintenance of Certification in Anesthesiology (MOCA)

Advantages to attending a MOCA Course at the Penn State Hershey Medical Center:

- Skills Training
- Crisis Intervention
- Teamwork
- State-of-the-Art Facility



Upcoming Sessions:

November 5, 2011

March 10, 2012



8 AMA PRA Category I Credit(s)[™]

"Patient safety starts here..."

If you're going to spend 8 hours of your day at your MOCA course, why not spend it where you can get the absolute most out of it?

Fees:

MOCA Certification: \$1,500 per person, including instruction, handouts, lunch, refreshments.

Optional ACLS Course: \$175.00

For more information: www.pennstatehershey.org/web/ce/home/programs/physicians

or contact Gail Frohnert, gfrohnert@hmc.psu.edu, 717-531-5173

Solid Grassroots Network is the Key to Victory

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



You may have heard about the junior attorney in one of the world's most powerful law firms. He wanted desperately to become a partner. So the devil came to him and said that he would not only make this young lawyer a partner, but he would make him the most influential and wealthiest partner in the firm. The devil told the young attorney that in return, he wanted the lawyer's soul and the souls of his wife, his children, his mom and his dad. The young lawyer thought for a second and then replied: "What's the catch?"

In politics, everybody wants to win, and when we tell them how basic it is, they say "What's the catch?" The best way to win

any fight in the legislature is very simple—and it's never the one you think—it's **you**. That's right—it's **you**.

Legislators want to know you. They want to hear about issues from you. They want to be able to sense the seriousness of the issue, the facts of the issue, the impacts of the issue—and they want to hear about it from you, their constituent.

Constituents have the greatest influence on how legislators vote on any given issue. And if it is a health care issue that impacts their families and their constituents, they want to hear everything about it from a physician. We are not talking about financial issues—reimbursement or medical malpractice for example—but when legislators are voting on the delivery of health care services, they want to talk to you, the constituent, the physician.

And if they don't hear from you, to whom will they probably listen? Possibly another constituent who took the time to talk to them—a nurse, an optometrist, a chiropractor—will get their ear and give them information that we all know is incorrect. But legislators don't know it is bad information if you don't take the time and tell them yourselves!

The PSA's Legislative Reception is coming Monday, October 3, in Harrisburg. The details are in the newsletter. Be one of those physicians who comes and talks, one on one, with his or her legislator. Be that magic element that wins legislative battles—be you. Take time from your busy schedules to be that physician constituent who can influence a legislator's vote because you were there.

SAVE THE DATE

PSA Legislative Reception

Monday, October 3, 2011 • Harrisburg Hilton

Who should attend? PSA members

Why? This event provides an opportunity for PSA members to meet their state legislators in a casual setting and discuss issues of importance to anesthesiologists. Join us at 5 p.m. for a buffet dinner and briefing. Then enjoy cocktails while mingling with your state legislators from 6-8 p.m.

In Memoriam: Steven D. Bell, M.D.

We are sorry to report that Steven D. Bell, M.D., passed away suddenly on July 2. Dr. Bell was a member of the board of directors and past president of the Pennsylvania Society of Anesthesiologists.

Dr. Bell obtained his M.D. degree at the University of Oklahoma School of Medicine in 1975, and completed his internship, residency in anesthesiology, and fellowship in critical care medicine at the San Diego Regional Medical Center.

He spent the large majority of his career as an anesthesiologist at Thomas Jefferson University Hospital in Philadelphia as an assistant professor and director of both critical care services and perioperative medicine. In 2007, Dr. Bell needed to retire from the clinical practice of anesthesiology because of back injuries, and subsequently he worked for Surgical Monitoring Associates in Springfield, providing and overseeing neuro-monitoring services. Dr. Bell was a member

of the board of directors of the Pennsylvania Society of Anesthesiologists from 1993 to 2008, and served as our vice president, president elect and president between 2001 and 2003.

Dr. Bell lived in West Chester and is survived by his wife Teresa and six children. Dr. Bell made tremendous contributions to the medical specialty of anesthesiology, and to our state society as well as to the American Society of Anesthesiologists.

THE SKY IS STILL FALLING

continued from page 1

chair of the Senate Professional Licensure Committee, to attempt to come to an agreement with the CRNAs on scope of practice. While it seemed that we left the meeting in a favorable position, I don't see this issue going away in the immediate future.

On the federal level, I am sure you are aware that the recent deal to increase the debt ceiling involves potential reimbursement cuts to Medicare providers. Under the immediate budget deal, the "Super Committee" will recommend cuts. If it fails to do so or if Congress doesn't adopt its recommendations, Medicare will automatically be cut by 2 percent and those cuts will undoubtedly come out of providers' pockets. These cuts are limited to 2 percent, but it is anyone's guess what kind of agreement will be made by the "Super Committee;" it could recommend deeper cuts in Medicare or none at all, or how the default cuts will be determined if they fail to reach an agreement. No matter where

any of us fall on the political spectrum, I believe one thing is certain: Medicare cuts will not be good for anesthesiologists. If and when these cuts are discussed, we cannot repeat 1989. We must have a seat at the table when the specifics are formulated.

Considering the current threats and those to come in the future, the only judicious course of action is to continue to advocate for our issues at both the state and federal levels. We cannot and should not count on our patients to advocate for us: considering the current general state of affairs, our patients are justifiably more concerned with the immediate concerns of their own family than with scope of practice or anesthesiologists' reimbursement. We must ensure that we maintain a seat at the table when the issues that affect our future are decided.

I am confident that both the PSA and ASA will tirelessly advocate for these issues, but we cannot be successful without your involvement. For your own sake and that of our profession, you must take an active role to ensure that anesthesiology thrives in the

future. Develop a relationship with your elected representatives, call and write them to advocate for our issues, and contribute to Z-PAC at the state level and ASAPAC at the federal level (these are separate political action committees and are both vital to our interests; we must contribute to both). A good start on the path to advocacy is to assure that every anesthesiology group in Pennsylvania is represented at the PSA Legislative Reception at the Harrisburg Hilton on October 3, 2011.

Finally, this will be my final President's Message. At the PSA annual meeting in Chicago next month, Meg Tarpey, M.D., will be installed as the next President of PSA. I am pleased to leave the office in Meg's more-than-capable hands. Thank you for giving me the opportunity to represent you for the past year. I have had the pleasure of meeting many of you along with other board members at our regional outreach meetings across Pennsylvania, and will hopefully meet many more of you in the coming months as we continue to conduct these meetings throughout the state.

Peri-operative Diabetes Management for Dummies: Just Check the Sugar!

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

What do we know about peri-operative glucose control? We know that infection rate, length of hospital stay, overall cost for the hospitalization, and morbidity and mortality are directly proportional to peri-operative blood glucose levels. We also know that there are numerous studies demonstrating improved overall outcomes with improved glucose control.



The exact mechanism for the improved outcomes is not known but it is commonly attributed to the reduced infection rate. We also know that hyperglycemia is detrimental in the face of cerebral ischemia. Diabetes mellitus (DM), type 1 and 2, is a disease involving an ever growing number of our patients. As per the most recent National Diabetes Fact Sheet released on Jan. 26, 2011, by the American Diabetes Association, 8.3 percent of the United States population has a variation of this disease.

I received my education on diabetes management the hard way. My daughter, at the age of four, was diagnosed with Type 1 DM. That was in 1997. I learned quickly that it isn't easy to manage DM on a day-to-day basis. It is just as difficult to manage it in a surgical patient with altered individual routines, surgical stresses, the effects of multiple medications on glucose levels and ever changing blood volumes.

In 1994, three years before my daughter's diagnosis, I was asked about the appropriate management of DM intra-operatively during my oral board examination. Not being sure of the correct answer and in order to buy an extra minute to collect my thoughts, I uttered a statement that probably bought me the passing grade I needed: "There are many ways to treat diabetes during surgery; however, if you check the blood sugar frequently, all reasonable plans would work."

In my ignorance, I demonstrated a flash of intelligence. As complicated as DM is—actually, it all boils down to keeping the blood glucose as close as possible to the normal range—you can safely lower it with insulin and raise it with glucose, but only if you know what it is. If your operating room doesn't have access to a glucometer, you probably shouldn't be taking care of a diabetic. Sending a sample off to the lab is not acceptable because by the time the results get back to you, the patient's actual blood glucose level could be dramatically different. You would be treating your patient based on historical data. If I teach you nothing else, knowing a recent glucose level will keep your patient out of trouble.

It is assumed that we as physicians, including anesthesiologists and surgeons, are all over this, but even the smartest still don't fully get it. My daughter was told before a minor procedure to turn off her insulin pump at midnight prior to surgery because they wanted her to be a little "sweeter" on arrival to the operating room. If she followed the

facility's directions, she would be definitely sweeter to the tune of about 400 to 500 gm/dl.

An insulin pump is designed to function in a similar fashion (although at a prehistoric level) to a pancreas. It delivers a low level of insulin continuously and releases more (by the patient programming a bolus) when the glucometer reading demonstrates an elevated blood glucose level. Insulin pumps are becoming very common in all age groups, especially children and young adults whom we will increasingly encounter in the surgical suite. Two major misunderstandings were obvious with my daughter's pre-operative instructions:

- 1) They didn't understand the types of insulin used in insulin pumps (humalog/novolog/apidra), which are incredibly short acting (they usually peak in an hour or less and are completely gone in three to five hours maximum).
- 2) They didn't realize that diabetics could have a rise in their blood glucose without food intake.

Our bodies are constantly breaking down complex molecules to sugars. The easiest way manage an insulin pump is to leave it running throughout the surgery. It will only be delivering a low level infusion unless programmed to give a bolus for an elevated sugar level. If it has to be removed for the surgery, leave it on as long as possible and run an IV insulin infusion (regular insulin is most commonly used) until the pump can be restarted post-operatively. For long or more complex procedures, stop

continued on page 7

PERI-OPERATIVE DIABETES MANAGEMENT FOR DUMMIES: JUST CHECK THE SUGAR!

continued from page 6

the pump and start an IV insulin infusion in the pre-op area.

Here are some other diabetes basics:

- 1) **Do the case as the first in the morning if possible so the patient's routine is only minimally altered.** If the procedure is later in the day, have the patient monitor the blood glucose levels in the morning as frequently as needed, and treat highs with short acting insulin and lows with clear sugar containing liquids up to four hours before the case. Administer IV dextrose on arrival to the facility. If they don't take insulin chronically, have them call into the facility with highs and treat lows as above, and come in early for possible IV insulin therapy if needed.
- 2) **If they are undergoing an outpatient procedure, discuss restarting their usual regimen based on food intake and post-operative glucose levels before they leave.** This has to be individualized and the occurrence of severe "highs" and "lows" must be discussed with the patient, especially those who are not used to close monitoring of his or her diabetes. The risk of morbidity and mortality is higher when poor glucose control is combined with recovery from anesthetics and the addition of narcotic pain medications.
- 3) **Check a blood glucose level just prior to the beginning of the case so you have a starting point and then treat accordingly.** Most facilities now have a "diabetes regimen" for glucose

Insulin Effectiveness by Type

Type	Onset	Peaks	Duration
Rapid Acting			
Humalog (Lispro)	<15 min.	30-90 min.	<5 hrs.
Novolog (Aspart)	10-20 min.	1-3 hrs.	3-5 hrs.
Apidra (Glulisine)	10-15 min.	.5-1.5 hrs.	<5 hrs.
Regular (R)			
Humulin R	30-60 min.	2-3 hrs.	4-6 hrs.
Novolin R	30 min.	2.5-5 hrs.	8 hrs.
NPH			
Humulin N	2-4 hrs.	4-10 hrs.	14-18 hrs.
Novolin N*	90 min.	4-12 hrs.	up to 24 hrs.
Pre-Mixed			
Humalog 75/25	15 min.	1-6.5 hrs.	18-26 hrs.
Humulin 70/30	15-30 min.	2-12 hrs.	18-24 hrs.
Novolin 70/30	30 min.	2-12 hrs.	up to 24 hrs.
Humulin 50/50	15-30 min.	2-12 hrs.	18-24 hrs.
NovoLogMix 70/30	10-20 min.	1-4 hrs.	up to 24 hrs.
Peakless/Basal			
Lantus (Glargine)	1-4 hrs.	minimal	24 hrs.
Levemir (Detemir)	1-4 hrs.	minimal	up to 24 hrs.

Figure 1: The many types of insulin with onset, peak and duration of action

- 4) **Know exactly when the patient last took diabetic medications, including pills and insulin.** Know the specific pill(s) and type of insulin(s), because there are many with incredibly varied mechanisms and durations of action. I urge you to have a good understanding of each. There are types of insulin that peak in an hour (humalog) to never peaking and lasting for 24 hours or more (lantus). (Figure 1) Furthermore, there are many classes of oral agents, including sulfonylureas, biguanides, thiazolidinediones, alpha-glucosidase inhibitors, meglitinides and Dipeptidyl peptidase IV inhibitors.
- 5) **The most common pre-operative instruction given to patients is to stop all glucose lowering pills the morning of surgery and take half of the evening insulin the night before.** We seem to do this whether the surgery is major or minor, long or short, or in the morning or afternoon. I guess we want to feel as though we have some sort of plan. As long as you have an understanding of what they have taken and when they last took it as well as a recent sugar, it all works.
- 6) **Know your patients and how well they manage their diabetes.** A poorly controlled diabetic may have an altered volume status, electrolyte abnormalities and be metabolically unstable. How will you know? Just ask them.

continued on page 11

Perioperative Management of Patients with Cardiac Rhythm Management Devices – Recent Guidelines

by Michael Brody, M.D.



Patients presenting to the operating room or procedure room with a cardiac implantable electronic device (CIED) have become increasingly commonplace, and their devices have become increasingly sophisticated. There is an implicit understanding that patients with a CIED bring with them a complex medical history; a complete

understanding of that history is paramount to preparing a skilled anesthesia plan.

Equally important is identification of the device manufacturer and a thorough understanding of the function vis-a-vis, the programming of the implanted device. This information should be available from the cardiologist who implanted or cares for the device, who should also be in the best position to make recommendations for its intra-operative management.

Guidance for health care professionals on care for patients with a CIED is currently limited to case reports, small series of cases, and expert opinion. The American Society

of Anesthesiologists (ASA) first published a practice advisory for the perioperative management of CIEDs in 2005; it has subsequently been revised.

To review the 2011 Practice Advisory for the Perioperative Management of Patients with Cardiac Rhythm Management Devices: Pacemakers and Implantable Cardioverter-Defibrillators, visit <https://www.asahq.org/For-Members/Practice-Management/Practice-Parameters.aspx>.

Practice advisory

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. Even more recently (July 2011 Expert Consensus Statement, http://www.hrsonline.org/ClinicalGuidance/cieds_consensus-statement.cfm) the Heart Rhythm Society and American Society of

Anesthesiologists developed a consensus document on the perioperative management of CIED patients in collaboration with the American Heart Association and the Society of Thoracic Surgeons.

This document stresses the importance of effective communication between the procedure team (anesthesiologist, surgeon, gastroenterologist) and the CIED team (physician and physician extenders who monitor the CIED function), and provides detailed recommendations for the preoperative, intra-operative, and postoperative management of both pacemakers and anti-tachyarrhythmia devices. While “industry-employed” allied health professionals (CIED company representatives) can provide information gleaned from device interrogation, they are not trained or qualified to independently “prescribe” CIED management recommendations to the procedural team.

Goals

Our goal in caring for patients with CIEDs is to promote patient safety and to protect the integrity of the device during a procedure or sedation. The CEID guidelines

continued on page 13

Mark Your Calendars: Future Meeting Dates

Bi-Annual Legislative Reception in Harrisburg – October 3, 2011, 5 p.m. at Harrisburg Hilton; all PSA members are invited to attend

ASA Annual Meeting in Chicago – October 15-19, 2011

PSA Luncheon and Annual Business Meeting in Chicago – Sunday, October 16, 2011, Noon. Sunday, October 16, from 12-1:30 p.m. Pullman Room at the Hyatt Regency McCormick Place

Read More Clinical Pieces at www.psanes.org

The PSA's website, found at www.psanes.org, provides a wealth of resources to anesthesiologists and their patients. Here is a list and summary of clinical pieces that have been added to the PSA website in recent months:

Perioperative Management of Patients with Cardiac Rhythm Management Devices – Recent Guidelines

by Michael Brody, M.D.

(Read article on page 8)

TEE for Non-Cardiac Surgery

by Sheela Pai, M.D., and Juan M. Ruiz, M.D.

Intro: Transesophageal echocardiography (TEE) is increasingly becoming an important monitoring tool for noncardiac surgery. Although there are well-established guidelines for cardiac surgery, there is some controversy among clinicians regarding those for noncardiac surgery. Given the potential benefits of intraoperative monitoring with TEE, it is important that every anesthesiologist caring for high-risk patients has a basic understanding and recognizes the role TEE may play in their management. Read more at www.psanes.org.

Anesthesia Induction Agents

by Dustin J. Jackson, M.D., and Patrick J. Forte, M.D.

Intro: Induction of anesthesia is most often achieved using intravenous agents. Inhalational agents can also be used and are particularly useful in children. Propofol, thiopental, etomidate, and ketamine are the most commonly used intravenous agents. While opioids and benzodiazepines can also be used for induction, their use is less common and discussion of these agents is beyond the scope of this clinical review.

Prolonged QT Syndrome: Drug Induced

by Randy Legault D.O., and Jerry Clark M.D., FASE.

Intro: Long QT Syndrome (LQTS) is a disorder of myocardial repolarization that is displayed by a prolonged QT interval on electrocardiogram (EKG). The syndrome can be either congenital or acquired. Congenital syndromes involving QT prolongation associated with syncope or sudden death were first described in the late 1950s. EKG recordings of these events showed a rhythm of “torsade de pointes” (TdP). This term was chosen in 1966 to describe a different form of ventricular tachycardia occurring in a woman with complete heart block that often translates to “twisting of the points.” Many drugs can be responsible for causing prolongation of the QT interval. Quinidine related syncope was known since the 1920s and with the online EKG in the 1960s, the rhythm of pause dependent polymorphic ventricular tachycardia was identified as the cause.



Court Cases of Interest

by Robert Hoffman, Esq., Eckert Seamans Cherin & Mellott, LLC



Several state court decisions that will be of interest to anesthesiologists and physicians in general are coming close to resolution. A brief summary of each follows:

The “HCPRA and Mcare Funding Cases”

The *HCPRA Funding Case*—named after the Health Care Provider Retention Account (“HCPRA”)—alleges that the Commonwealth violated its obligations under the Mcare Abatement program by not funding Mcare in the amount of the abatements granted.

As background, the Commonwealth granted abatements to physicians—either 100 percent or 50 percent depending on specialty—from 2003 to 2008. The Commonwealth granted abatements worth almost \$1 billion but funded it with somewhere between \$330 and \$500 million, leaving a substantial shortfall. The Pennsylvania Medical Society and Hospital Association sued. The extra money was sitting in the HCPRA Account until October of 2009, when the General Assembly and Governor Rendell raided it to balance the budget in 2009. At the same time, the legislature transferred \$100 million from the

Mcare Fund to the General Fund. That gave rise to a second lawsuit, the *MCARE Funding Case*.

In April of 2010, Commonwealth Court ruled in favor of the Pennsylvania Medical Society and the Hospital Association in both cases. The Commonwealth appealed. After a substantial delay, the cases are (as of the writing of this article) scheduled for oral argument Sept. 14 in Philadelphia. The public dollars at stake in these cases are quite substantial—somewhere between \$430 and \$600 million, with more possibly added for interest. The Pennsylvania Medical Society and Hospital Association have strong legal arguments that have prevailed to date. But the Commonwealth has raised a large number of legal issues, and is generally defending the case aggressively. The amount at issue should be irrelevant to the legal issue, but numbers of that size are the proverbial elephant in the room.

It is reasonable to expect a decision to be issued by the spring of 2012, but it certainly could be longer. Unlike the United States Supreme Court, which essentially decides all cases before it adjourns for the summer, the Pennsylvania Supreme Court has no fixed schedule for deciding cases. The AMA, represented by the author of this article, filed an *Amicus* Brief supporting the Medical Society.

The “Mcare Assessment Case”

Separate from the *HCPRA/ MCARE* cases above, the Pennsylvania Medical Society and the Hospital Association have challenged how the Insurance Commissioner calculates the

annual Mcare assessment. Centrally at issue are the year end surpluses that Mcare has accumulated (as a result of declining claims); the issue is whether Mcare must use or ignore those funds when it calculates the annual assessment. The Pennsylvania Medical Society and the Hospital Association argued that Mcare must use the surpluses; had the surpluses been used, the assessments would have been about 50 percent less. Mcare argued the opposite position—allow the surplus to accumulate for some unspecified future use—and the Insurance Commissioner ruled in Mcare’s favor in May of 2011. The issue applies to the assessments for 2009-2011, and possibly thereafter.

The Pennsylvania Medical Society and the Hospital Association have appealed to Commonwealth Court and, as you read this, briefing should be finished. The case should be argued in October or November and Commonwealth Court should decide it within 60-90 days.

Seibold v. Prison Health Services

This case does not particularly affect anesthesiologists but it raises interesting, complicated, and far-reaching issues involving the liability of physicians to non-patients.

Prison Health Services, under a contract with the Commonwealth, hired physicians who provided medical care to inmates at Muncy State Correctional Institution. A Muncy prison guard alleges that while conducting a strip search, he

continued on page 14

PERI-OPERATIVE DIABETES MANAGEMENT FOR DUMMIES: JUST CHECK THE SUGAR!

continued from page 7

Start off with: "How often do you check your sugar?" The answer will vary from: "I use a continuous subcutaneous monitor (yeah...they exist)." to "What sugar?" See if there is a recent A1C that will give you an idea of how well the patient is controlled chronically. Look for signs of dehydration, renal abnormalities such as peripheral edema, or hemodynamic instability. Check appropriate lab values when indicated based on their history, your physical findings, or the type of surgical procedure planned.

- 7) **When using insulin intra-operatively, use an infusion alone or an infusion with boluses based on blood glucose levels rather than boluses alone.** The classic "sliding scale" treatment regimen is basically "chasing your tail." You are waiting for the glucose to rise to an abnormal level before treating it. Many studies have shown that sliding scale treatment alone leads to more frequent hyperglycemic as well as hypoglycemic episodes. Regardless of your treatment protocol, once you start delivering insulin, frequent blood glucose measurements are a necessity so have your glucometer handy. I recommend checking a glucose level at least every hour if the patient is on a stable insulin regimen with stable sugars and every half

hour with frequently changing insulin levels or unstable sugars.

- 8) **Is there a pre-operative sugar level at which surgery should be cancelled?** Yes, but I don't know what it is. Obviously, once the glucose level is 350 to 400 gm/dl, metabolic, electrolyte and hemodynamic abnormalities may be present. It would be helpful to know how long it has been "high" because the longer it has been at extremely elevated levels, the more likely that life-threatening abnormalities would be present. Well controlled diabetics can have a rare spike too, especially when their routines are altered, but it would have limited significance to their overall surgical risk. Are they orthostatic? Are they retaining fluid or has their urine output dropped? Do they have ketones in their urine? Is it a short outpatient procedure or a major inpatient procedure with expected hemodynamic instability, wide fluid shifts and a tough post-operative course? Again, know your patient and know your procedure. A single elevated glucose preoperatively may or may not be grounds for cancellation. This is where the art of anesthesia comes into play. Furthermore, is it better to have a sugar of 350 gm/dl or 30 gm/dl? We sometimes forget the dangers of severe preoperative hypoglycemia. The answer, by the way, is neither of the above. Both have their inherent dangers and can be treated quickly

and effectively in the right hands.

- 9) **If a diabetic (or their parent) tells you how best to manage their diabetes intra-operatively, take them seriously.** They know their bodies and their body's response to insulin and stress.

There are many algorithms and guidelines out there that can be used to aid your decision making with diabetics during the peri-operative period. But remember, they are guidelines only and the individual patient and procedure planned will dictate your specific plan of action. Furthermore, although it is well known that improved glucose control has substantial beneficial effects, there is a lot of debate as to how tightly the glucoses should be maintained in order to achieve the maximum benefit but not fall prey to the deleterious effects of hypoglycemia.

Back to my original point: "Knowing a recent glucose level will keep your patient out of trouble." Don't feel bad if you are uncertain of how to care for a diabetic patient or have a little fear of doing so. You are the norm and not the extreme. A true outline of peri-operative diabetes management would take this newsletter and a few others to cover effectively, but again, this is just a quick overview for dummies (like me).



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.

PERIOPERATIVE MANAGEMENT OF PATIENTS WITH CARDIAC RHYTHM MANAGEMENT DEVICES – RECENT GUIDELINES

continued from page 8

provide a complete description of the ways to accomplish these goals. However, a very brief overview of their primary recommendations may be useful as well. To accomplish these goals it is important to know the type of CIED as well as the date and details of the device's last interrogation (recommended within past six months). The device interrogation will indicate battery longevity, underlying heart rhythm and rate, and programming parameters. The convenience of using a magnet to alter the behavior of CIEDs during a procedure is often attractive, however, the health care team must understand when reprogramming a CIED is required. Many CIEDs have programmable magnet responses; devices programmed to "off" will not respond to the application of a magnet.

Boston Scientific ICDs may be permanently deactivated by a magnet, necessitating continuous cardiac monitoring until the device can be reprogrammed after the completion of the procedure. Unlike placing a magnet over a pacemaker, the application of a magnet over an ICD will not automatically alter pacing function to an asynchronous mode, potentially increasing the risk of arrhythmias and hemodynamic compromise. Interruption of biventricular pacing may result in acute heart failure in patients receiving cardiac resynchronization therapy. These are just a few examples of the importance of understanding how a particular device functions and knowing why the patient originally required CIED therapy.

Common risks

The most common adverse interaction between electromagnetic interference (EMI) and a CIED is over sensing resulting in inappropriate inhibition of pacing output or false detection of a tachyarrhythmia and unneeded therapy. EMI can also damage the pulse generator, induce the

device to reset to manufacturer specific safety backup programming, or result in lead-myocardial tissue interface damage. These risks can be minimized by utilizing bipolar electrosurgery when possible; limiting the duration of monopolar electrosurgery bursts to four or five seconds, and keeping the EMI current path from crossing the CIED.

A distance of greater than 6 inches between the current path and the CIED is recommended. The consensus expert opinion suggests that neither magnet application nor reprogramming are mandatory for procedures performed on the lower extremities of patients who have a CIED implanted in the traditional upper chest position; magnet application and reprogramming may also be unnecessary for procedures performed below the umbilicus when utilizing short bursts of monopolar electrosurgical energy.

Summary of Recommended Steps in Patient Management

The first step is to identify the patient with a CIED in a timely fashion and to identify where the patient receives regular follow-up care for his or her device, and then to determine if the patient is pacemaker dependent. When EMI may occur during a procedure, a magnet and external defibrillator equipment should be readily available for all patients with pacemakers or ICDs. The CIED may need to be reprogrammed with specific functions altered or suspended prior to the procedure. External defibrillator pads may need to be placed prophylactically for high risk patients.

Cardiac rhythm monitors and pulse detection using plethysmography, oximetry, or arterial line monitoring should be utilized during procedures for all CIED patients at risk for exposure to EMI. After completion of the procedure the CIED may require interrogation and reprogramming. Devices that were reprogrammed or possibly damaged; and patients that experienced significant hemodynamic fluctuations during the procedure will require continuous cardiac monitoring after the procedure until proper CIED function is verified.

Welcome New Members

Active

Lana G. Ankin, D.O.
Donald O. Baumann, M.D.
Melissa Ann Brodsky, M.D.
John M. Carney, M.D.
Nicholas A. DeAngelo, D.O.
Matthew C. Desciak, M.D.
Thomas M. Dunn, M.D.
Calvin Eng, M.D.
Ayse F. Genc, M.D.
Marc S. Goldberg, M.D.
Michael E. Goldberg, M.D.
Meera N. Gonzalez, M.D.
Timothy N. Hall, D.O.
Amanda G. Hargrove, M.D.
Kathleen A. Harris, M.D.
Kuiran Jiao, M.D.
Jeffrey I. Joseph, D.O.
Fnu Kailash, M.D.
Amy L. Kemp, M.D.
Tara L. Kennedy, M.D.
Yelena Korobkova, M.D.
Ashok Kumar, M.D.
Paul B. Langevin, M.D.
Phong Q. Le, D.O.
Brian A. Lefrock, M.D.
Pavel V. Lobanov, M.D.
Saninuj N. Malayaman, M.D.
Richard H. McAfee, M.D.
Stephen A. McCaughan, M.D.
Shairko Missouri, M.D.
Aaron K. Mory, M.D.
Khoa N. Nguyen, M.D.
Jolly L. Ombao, M.D.
Jay Parekh, D.O.
Andrew J. Pierwola, M.D.
Erica L. Schmitt, M.D.
Ravichandran Suppiah, M.D.
Manisha L. Trivedi, M.D.
Jeffrey M. Troutman, D.O.
Thomas A. Verbeek, MBChB
Irene J. Zervos, M.D.

Resident

Sunil A. Chandy, M.D.

Retired

James Levri, D.O.

COURT CASES OF INTEREST

continued from page 10

acquired MRSA from an inmate, and that PHS physicians had misdiagnosed the patient and failed to take precautions to prevent transmission of the disease. Superior Court ruled in the plaintiff's favor and the Supreme Court accepted the case for review. Argument is scheduled for Sept. 13, and we can look for a decision in the spring of 2012.

The issue is relatively new to the Supreme Court. In 1990, the Supreme Court decided a case in which a physician allegedly gave a woman patient with Hepatitis B incorrect information on transmission of the disease by sexual conduct; her partner unfortunately contacted the disease. The Supreme Court decided he could sue the physician for having provided the wrong advice to the woman. The Supreme Court has never addressed that principle as to a disease transmitted by less intrusive or intimate contact. The Superior Court has since applied that general principle in a case involving the asserted transmission of cytomegalovirus from an infant to an adult babysitter and then from that adult to her child in utero. The Court found the infant's pediatrician liable for the spread of CMV to the second child.

The Pennsylvania Medical Society, represented by the author of this article, filed an *Amicus* Brief, raising the following major points:

- Responsibility for an employee's safety rests with the employer. Employers at worksites, like Muncy, where there is occupational exposure to communicable disease are subject to many specific regulatory mandates and are well-versed on the steps necessary to minimize employee exposure

to disease. When the disease is acquired at the workplace, the Workers' Compensation system can address the employee's harm and there is no need for a supplemental tort remedy.

- The legislature has enacted substantial public health legislation, ranging from reporting requirements to mandating immunizations, addressing the spread of communicable diseases.
- Imposing physician duty without limit in the context of communicable diseases creates a genuine potential of liability without limit. Instead of facing liability solely from a patient, a physician faces potential liability from hundreds or more that is grossly disproportionate to the physician's actions. It is the proverbial slippery slope, with few obvious stopping points and the risk of an ever-expanding liability.
- It is counterproductive to require physicians to seek non-patients and convey information to them. Physicians are neither gumshoes nor librarians; they practice medicine and are typically busy doing so.
- Releasing information to non-patients raises serious confidentiality concerns.

Mcare § 512 Cases

Mcare § 512 was the provision that was supposed to require an expert witness in a medical professional liability case to practice in the defendant's specialty. Because of some loose language—qualifying expert witnesses who practiced “in a subspecialty which has a substantially similar standard of care for the specific care at issue”—§ 512 has not worked out as well as

hoped. The Supreme Court initially deadlocked in 2009 on whether a radiation oncologist could testify against a urologist on prostate cancer issues, and then decided in 2010 that a medical oncologist could testify against a radiation oncologist and an ENT as to treatment of tongue cancer.

The Supreme Court has decided to review two additional § 512 cases; that by itself is unusual given that it has already decided two such cases. The first case involves the ability of an OB-GYN to testify as to the standard of care for an emergency medicine physician treating a woman in the emergency department with what turned out to be an ectopic pregnancy but whose symptoms, as reported, were not suggestive of that. The second case involves the ability of a clinical pathologist to testify as to the standard of care of a general surgeon in making a discharge decision in light of, among other things, laboratory results showing a high percentage of band cells.

The Pennsylvania Medical Society, again represented by the author of this article, has filed an *Amicus* Brief in both cases and is hopeful the Court will use these decisions to give more meaning to § 512. The Pennsylvania Medical Society argues that the “exceptions” to the “same specialty” rule “must be narrowly construed lest they swallow the rule” and that allowing the experts to testify in either case “would reduce the ‘same specialty’ requirement ... to words with little practical meaning.”

These two cases will be argued together, most likely in October or November, with decisions expected in the spring or summer of 2012. Stay tuned to future issues of the *Sentinel*, or the PSA website, for updates.

Mr. Hoffman is outside counsel to 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 professional medical liability insurance, please contact Kathryn Elliott, JD, Director, Sales and Marketing.

Phone: 800 445-1212, ext. 5551

E-mail: kelliott@pmslic.com



PMSLIC

MEDICAL LIABILITY INSURANCE

ALWAYS WITH YOU

WWW.PMSLIC.COM



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