



## PRESIDENT'S MESSAGE

# The Assault Continues

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

Four short months into my term as PSA President and I already sound like a broken record. Believe me, I would much prefer writing about major advancements in perioperative medicine. However, as the ink was drying on my last president's message in our winter newsletter about our profession being under siege, Rep. Stephen Barrar (R) informed the chair of the House Professional Licensure Committee that he intends to reintroduce a CRNA scope of practice bill in the upcoming legislative session.

The bill is similar to House Bill 1866, which was introduced in 2009 by Rep. Marc Gergely (D). His HB 1256 of 2007 and HB 1866 replicates the other biennial assaults on patient safety in Pennsylvania that we have successfully defeated in the past 20 years. The primary sponsor changes as determined by which political party controls the process, but the intent and effect remain the same: independent CRNA practice.

While the legislation remains reliably consistent, the strategies are becoming increasingly aggressive, sometimes subtly and sometimes more directly. Rep. Barrar recently introduced, as a noncontroversial resolution under Rule 35, a proclamation to recognize national CRNA week. The resolution included the following language:

*WHEREAS, CRNAs provide anesthesia services in all settings in which anesthesia is delivered and are not required by Federal or State Law to be supervised or directed by physician anesthesiologists; and*

*WHEREAS, According to the American Association of Nurse Anesthetists, more than two-thirds of all rural hospitals rely on CRNAs to provide anesthesia care, and without these advanced practice nurses, some 1,500 facilities would be unable to maintain trauma stabilization, surgical and obstetrical capabilities, forcing many rural Americans to travel long distances for these services ...*

Rule 35 resolutions are universally unread by legislators for a good reason: they are largely non-substantive and generally not worth the time that can be better spent effectively representing one's constituents. While these resolutions are largely unread, they are entered into the public record, potentially gaining some degree of credibility. Fortunately, our lobbying firm, Milliron Associates, uncovered this resolution before it was enacted, and the language was revised to be more appropriate for a Rule 35 resolution.

In late January, on the first day of National CRNA Week, the AANA shamelessly outdid itself. CRNAs in hospitals throughout Pennsylvania and the U.S. distributed literature, under the guise of patient education, which blatantly overstates the role of nurse anesthetists in the administration of anesthesia. One pamphlet posed the question: "Who administers anesthesia?" and replies:

*"In the majority of cases, anesthesia is administered by a CRNA. CRNAs work with your surgeon, dentist, or podiatrist*

# Spring 2011

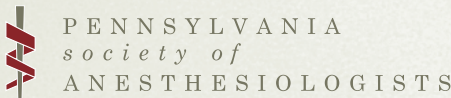


## Contents

Supervision vs. Cooperation: Here We Go Again!	PAGE 3
Commerce Clause 101: A Short Guide to Understanding Health Care Litigation	PAGE 4
Political Power: And the Fact that I Don't Have Any	PAGE 5
Know Your Officers	PAGE 6
2011 Z-PAC Contributors	PAGE 8-9
ASA Recommendations for Non-Anesthesiologist Privileging for Deep Sedation	PAGE 10
Paying Dues is Only Part of Being a PSA Member	PAGE 11
Former PSA Board Member Faces New Challenge	PAGE 11
ASA to Enlarge its Headquarters	PAGE 13

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### Sentinel

Pennsylvania Society of  
Anesthesiologists Newsletter

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# Supervision vs. Cooperation: Here We Go Again!

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

As the Sentinel was going to press in late February, the nurse anesthetists had once again introduced legislation to remove the requirement of physician supervision and replace it with the term "cooperation."

The actual bill was not in print, so we cannot give you specific language, but by the time you receive this it will be available online. It is **House Bill 212** and it was again introduced by Representative Steven Barrar of Delaware County. (You can view the legislation by going to [www.legis.state.pa.us](http://www.legis.state.pa.us) and typing HB 212 in the upper right hand box.)

This is the sixth time since 2002 that legislation has been introduced in the House of Representatives to eliminate the requirement of physician supervision for the administration of anesthesia. This is an ongoing effort by anesthetists to win independent practice. **It will only stop when you do the following:**

- Review HB 212 and see if your member of the House is a sponsor. If he/she is, immediately call his/her local office and express your opposition to the bill. **Ask them to remove their name as a sponsor.** The fewer the sponsors, the less likely Rep. Barrar will continue to reintroduce the bill.
- Everybody must send an e-mail or a personalized letter to their House member expressing your opposition to HB 212. We will be sending you specifics to include in your letters and e-mails very soon. **Please do this as soon as you receive our correspondence.**

- Mobilize every anesthesiologist in your practice. This cannot be a half-hearted response. We must have 1,000 calls or e-mails sent from our specialty to members of the state House.
- **Send your personal check to Z-PAC today!** The address is P.O. Box 823, Harrisburg, PA 17108. There is more information about the PSA's Political Action Committee in this newsletter.

Ultimately this issue will be decided by a vote of the full legislature. We have been able to kill the bill in committee for the past decade because most legislators understand the dangers to patient safety if the requirement of supervision is removed. **However, our goal must be putting the Department of Health regulation requiring supervision into statute.**

The nurses continue to mislead legislators by telling them that they merely want to put the Board of Nursing regulation into statute. What they fail to tell legislators is that the Board of



Nursing regulation is moot since it is overruled by the Department of Health regulation.

There are 110 members of the state House of Representatives who have been in Harrisburg for four years or less! That is more than 55 percent of the 203 total House members. These are the people you need to speak to about patient safety. These are the men and women who need to be educated about the safe administration of anesthesia.

We will be counting on you in the coming weeks to begin that education process.

**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.

# Commerce Clause 101: A Short Guide to Understanding Health Care Litigation

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



In all likelihood, you know that there are various court challenges to the new federal Patient Protection and Affordable Care Act, a challenge that is likely to end with a Supreme Court decision.

Those challenges

focus on the act's mandate that individuals purchase health insurance, something opponents contend Congress lacks authority to do. Supporters, in turn, point to the Commerce Clause as providing the requisite authority. This article is not about these court challenges *per se*, let alone who will or should win. It is, instead, about the Commerce Clause itself, with a few words about a few other clauses as well, with the hope that it will make you better informed as these events unfold.

As a starting point, every federal statute has to have as its source some general power granted to Congress. This requirement is inherent in the Constitution, which granted Congress only certain enumerated powers and not others. (The Constitution also contains a "Necessary and Proper Clause," which authorizes Congress to "make all Laws which shall be necessary and proper for carrying into Execution;" it has the inevitable effect of expanding somewhat the enumerated powers.)

One of those enumerated powers is the power to "regulate Commerce ... among the several States." This power comes from the so-called Commerce Clause, contained in Article I, § 8, Clause 3 of the original (unamended) Constitution. The Commerce Clause was central to creating a real *federal* government, as the Articles of Confederation had not, in which states were not loosely affiliated independent entities but were subject in meaningful ways to the overarching authority of that federal government. Regulating trade was central to the creation of the United States as we know it now.

The Commerce Clause has two distinct forms and roles. First, it has served as a source of authority for a vast number of federal statutes. This includes not merely statutes regulating trade and business *per se* but even the provisions in the Civil Rights Act of 1964 that required non-discrimination in public accommodations, like a hotel (*Heart of Atlanta Hotel v. United States*). Indeed, the listing goes on and on: the Commerce Clause has supported federal laws governing gambling, criminal enterprises, deceptive practices, fraudulent security transactions, misbranding of drugs, wages and hours, labor unions, crop control, discrimination against shippers, protecting small business from price-cutting, resale price maintenance, and professional football. (Baseball is exempt from the antitrust laws, which are themselves based on the Commerce Clause, because in 1922 the Supreme Court held that baseball did not involve interstate

commerce but instead was purely a state affair.) If Congress were to enact medical liability tort reform, it would do so under the authority of the Commerce Clause. This is the form of the Commerce Clause at issue in the health care litigation.

The breadth of that listing follows from various Supreme Court opinions. In its first ever Commerce Clause case, in 1824 (*Gibbons v. Ogden*), Chief Justice Marshall wrote that "It has ... been universally admitted that these words [of the Commerce Clause] comprehend every species of commercial intercourse" and that "No sort of trade can be carried on . . . to which this power does not extend." A 1964 decision (*Heart of Atlanta*, upholding the Civil Rights Act, referenced earlier) described "the determinative test" of the Commerce Clause's scope as whether the activity sought to be regulated is "commerce which concerns more States than one" and "has a real and substantial relation to the national interest."

Second, although the language might not suggest it, the Commerce Clause, under what is called the "Dormant Commerce Clause," has long been used to invalidate state legislation that discriminates against interstate commerce. The term "dormant" means that Congress hasn't yet acted in the area in question. (When Congress has acted, conflicting state laws are preempted, essentially nullified, under yet another Constitutional provision—the Supremacy Clause.) Many state statutes—those regulating truck size or configuration, flow control

continued on page 12

# Political Power: And the Fact that I Don't Have Any

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

A couple of months ago, the Pennsylvania Medical Society (PAMED) sent an e-mail asking for nominations for an open position on the Pennsylvania Board of Medicine (BOM).

It would be a dream come true for me to serve on the board that pens regulations that govern how we as physicians practice medicine in this state. That is, in my opinion, other than direct patient care, it is the most important job because it determines our ability as physicians to do our life's work effectively. Furthermore, what the BOM does today has an effect that lasts potentially decades. So I decided to go for it.

I began by contacting the legislators in my district as well as the board of the Pennsylvania Society of Anesthesiologists (PSA) asking for their support, and all graciously agreed to do so. I also obtained letters from the chair of anesthesiology at Penn State as well as the hospital's chief medical officer. Again, they graciously wrote letters on my behalf.

I also decided prior to the PAMED Board of Trustees meeting to ask the PAMED Specialty Leadership Cabinet (SLC), which meets just before the board, for its support since I represent them as a specialty trustee. I followed all of this with an e-mail and letter to PAMED notifying them that I wanted the Society to consider me as a potential candidate.

All was going quite well. I then received a call from the PAMED hierarchy that, in a way, seemed to discourage me from considering this position. One reason was quite legitimate: I would have to leave the board at PAMED

based on the requirements of the BOM. It was a decision that I had already thought through. Although I am proud of my position and work with PAMED, I felt that this opportunity was too important to pass up. I would only return to PAMED smarter and in a better position to move the society forward.

My other reason was weaker. The physician leaving the board was an obstetrician/gynecologist, his replacement should therefore be a surgeon as well to keep "specialty" balance. Huh? I am not sure I fully understand the reasoning behind the statement, because we are all physicians in the end, and the goal of a BOM member is to further medicine, not an individual specialty. I told the Society leadership that I wanted to continue to be considered for the position and they agreed to accept my self-nomination.

PAMED collected names, resumes and letters of support. The list grew to 15 candidates. All were to be considered at the PAMED Board of Trustees meeting. It began to get interesting at the Specialty Leadership Cabinet. I discussed my candidacy with the group and asked for their support. I was turned down, not because I wasn't a fit candidate, but because many specialties are represented by this committee and endorsing one anesthesiologist didn't seem appropriate to the members. I can understand their thinking. I never expected them to endorse just me. But I owed them the courtesy to ask because I am part of that committee and I have an enormous amount of respect for many of the individuals who make up the group.



At the board of trustees, I again stated, at their request, my reasons for seeking the position. I discussed the importance of being a physician's physician who will shape regulations that continue to promote patient safety and the doctor/patient relationship. All agreed to the sentiment, but their final decision was to recommend to the executive committee to submit to the governor all the names of those interested.

I finally had to ask "why?" I would rather see them endorse one individual who wasn't me than a list of 15. The answer was that "they didn't know what the governor was looking for so they didn't want to submit the wrong individual." They were not sure what specialty, race, creed, color or political party that he (Governor Corbett) wanted to have represented on the BOM. I said again, huh?

I told the group that I think the governor wanted the Society that represented "all" physicians in Pennsylvania to give him an idea of who they would like to

continued on page 14

# 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 Eric A. Sullivan, M.D.

## **Erin A. Sullivan, M.D.**



### **Current**

#### **Employer:**

University of Pittsburgh Physicians, Department of Anesthesiology

#### **Medical**

#### **School:**

Louisiana State University School of Medicine, New Orleans

#### **Where did you do your Residency, Fellowship?**

University of Texas Health Science Center at Houston

**What percentage of your work is clinical, teaching, research?** 45 percent clinical, 20 percent teaching, 5 percent research, 30 percent other.

#### **Who is your hero in the history of anesthesia and why?**

Arthur S. Keats, M.D., whom I had the pleasure to work with during my residency and cardiac anesthesiology fellowship training, has been and remains a role model for me. Dr. Keats, chief of cardiovascular anesthesiology at the Texas Heart Institute, St. Luke's Episcopal Hospital, and Texas Children's Hospital from 1974 to 2005, made important contributions in the 1950s to anesthetic techniques related to the emerging field of temporary cardiopulmonary support for open heart surgery. He was especially involved in the development of cardiovascular anesthesia for neonates with congenital cardiac anomalies. His keen attention to patients and sound judgment in solving complex problems led to his early success in this field. Because of his accomplishments in both the clinical and research aspects of medicine, Dr. Keats

gained legendary status in his profession. He served on the Surgery Study Section of the NIH, the Anesthesia Committee of the National Research Council of the National Academy of Sciences, FDA Respiratory and Anesthetic Drugs Committee and was editor in chief of Anesthesiology. Dr. Keats taught me that one could excel as a clinician, teacher, researcher and as a leader of our specialty but that it was extremely important to retain and nurture one's relationships with family, friends and colleagues.

**What year did you join the PSA?** 1998. I was previously a member of the California Society of Anesthesiologists during my tenure at UCLA.

**What prompted you to become involved with a PSA leadership role?** I have always been a strong advocate of our specialty and recognize the importance of involvement in the issues that affect our specialty and our patients. I was a member of the California Society of Anesthesiologists House of Delegates and wanted to remain active in the advocacy of our specialty after moving to Pennsylvania. I was fortunate enough to receive a recommendation from Dr. Carol Rose to become a member of the PSA Board of Directors in 2001 and have since served as the Society's vice president, president-elect, president and immediate past president. I currently serve PSA as alternate district director to the ASA Board of Directors along with our district director, Don Martin, M.D.

**What leadership roles have you held in the past?** See above.

In addition to my PSA leadership roles, I am the Vice Chair for the ASA Committee on Governmental Affairs.

#### **What accomplishments/issues are you most proud of during your time in PSA?**

I am very proud to play a part in maintaining patient safety in anesthesiology by ensuring that my patients have access to an anesthesiologist for their care.

#### **Other than the obvious benefits, why would you recommend that others apply for a PSA Board position?**

Those who serve on the PSA Board of Directors are leaders in our specialty who advocate for education, research and patient safety in anesthesiology. It is a great opportunity to network with colleagues from not only Pennsylvania, but with colleagues across the United States.

**How much time does being a PSA Board member involve?** Service on the PSA Board requires a minimum of attendance at the spring and fall Board of Directors meeting and the PSA Legislative Conference on alternating years. Attendance at the annual ASA House of Delegates meeting is also strongly encouraged, particularly for those who are delegates and alternate delegates. As a PSA officer, the time commitment increases with the level of activity for any pressing issues (e.g., legislative and practice issues).

**What hobbies/interests do you have outside of work and the PSA?** My favorite activities include travel, cooking, reading, fitness training, and enjoying the company of my family and friends.



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continued on page 9

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continued from page 8

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Gregory Pharo, D.O.  
William Pierce, D.O.  
William Porter, M.D.  
Rene Pristas, D.O.  
Stephen Raj, M.D.  
Victor Raj, M.D.  
Meena Raman, M.D.  
Brenda Raphael, M.D.  
Matthew Redclift, M.D.  
Subash Reddy, M.D.  
Christina Reiter, M.D.  
Joshua Rhodes, M.D.  
Ernest Ricco, M.D.  
Kenneth Richman, M.D.  
Edward Rish  
David Robinson, M.D.  
Michael Robinson, D.O.  
Nicholas Rockwell, M.D.  
Ricardo Rodriguez, M.D.  
Cynthia Rogalski, M.D.  
Ryan Romeo, M.D.  
Carol Rose, M.D.  
Eric Rosenberg, M.D.  
James Rossignol, M.D.  
Joan Ruffle, M.D.  
George Rung, M.D.  
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Jeanianne Sedlack, M.D.  
Joseph Seltzer, M.D.  
Sneed Shaddock, M.D.  
James Shaheen, M.D.  
Sean Sharkey, M.D.  
Saxena Shashank  
Mark Shulkosky, M.D.  
Jeffrey Simons, M.D.  
Allan Simpao, M.D.  
Nina Singh, M.D.  
Archie Sirianni, M.D.  
Steven Sisson  
Thomas Skeeahan, M.D.  
Kevin Slenker, M.D.  
Arthur Smalley, M.D.  
David Smith, M.D.  
Jason Soch, M.D.  
Joseph Somers, M.D.  
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Kelly St. John, M.D.  
Jonathan Stein, M.D.  
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Hai Wang, M.D.  
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Steven Whitehurst, M.D.  
LeRoy Wible, M.D.  
Andre Williams, M.D.  
E. Lynne Williams, M.D.  
John Williams, M.D.  
Michael Williams, M.D.  
Michael Wills, M.D.  
Earl Wilson, M.D.  
Thomas Witkowski, M.D.  
Wen-Shiong Yang, M.D.  
Uriel Yodfat, M.D.  
Stephen Zarrelli, M.D.  
Mark Zemanick, M.D.  
Miriam Zentner, M.D.  
John Zepp, D.O.  
Jialin Zhou, M.D.  
Lawrence Zohn, M.D.  
Janis Zvargulis, M.D.

# ASA Recommendations for Non-Anesthesiologist Privileging for Deep Sedation

## Actions of the 2010 ASA House of Delegates

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



In December 2009, CMS revised the Interpretive Guidelines for the Hospital Medicare Conditions of Participation. It required: "All services along the continuum of anesthesia services provided in a hospital must be organized under a single anesthesia service, which must be directed by a qualified

physician and consistently implemented in every hospital department and setting that provides any type of anesthesia services."

In most hospitals or health care facilities, this change would put anesthesiologists in a position to provide oversight over all providers delivering sedation and analgesia or anesthesia. These revisions in the conditions of participation provide both new authority and new responsibilities for the anesthesia services in most hospitals.

The ASA, and likely most ASA members, believe that anesthesiologist participation in all deep sedation and general anesthesia is the best means to provide the safest care. However, non-anesthesiologists commonly provide moderate or "conscious" sedation at various locations throughout our hospitals, and in some cases non-anesthesiologists also provide deep sedation, particularly in the emergency room and critical care areas. Guidelines have already been developed for non-anesthesiologists to administer minimal and moderate sedation. The ASA recently developed and approved guidelines for non-anesthesiologists to provide deep sedation.

These guidelines specify in some detail the education and training, the licensure, and the performance evaluation required before granting initial privileges, and ongoing performance improvement activities required for non-anesthesiologists to administer deep sedation.

These recommendations allow considerable flexibility for individual institutions to meet their own needs.

However, the recommendations stipulate specific training in the following areas:

- Preoperative evaluation, including evaluation of the airway and aspiration risk.
- Sedative pharmacology.
- Ventilatory and cardiovascular function.
- Physiologic monitoring and emergency management of the airway, before administering deep sedation.

These guidelines are available on the ASA website [www.asahq.org](http://www.asahq.org), and may provide very useful guidance to anesthesia departments, hospitals, or ambulatory surgery centers, as they prepare to meet their new responsibilities for maintaining similar standards of care during all levels of sedation and anesthesia, no matter where or by whom it is administered, within a health care facility.

## What's New on the PSA Website

The PSA website, found at [www.psanes.org](http://www.psanes.org), offers a variety of valuable information to members. You can use this website to stay on top of the latest clinical happenings in your field. Here are two recent examples:

- On the Clinical Updates page, Dr. Jon Anson has written an article on peri-operative corneal abrasions.
- On the Current Issues page, we have a piece from the Pennsylvania Patient Safety Authority on the management of unanticipated difficult intubation.

Some content is available to PSA members after they've created an account. You can do this by clicking on the "Log In" button at the top of the homepage, and then finding the "First Time User" button and following the instructions. If you have trouble with this process, you can call the PSA office at (717) 558-7750 or email us at [psa@pamedsoc.org](mailto:psa@pamedsoc.org).



# Paying Dues is Only Part of Being a PSA Member

by Paul J. Schaner, M.D

Your Society needs you. Annual dues statements have gone out as well as a reminder statement to those who may have forgotten. This is the easiest part of membership.

You can, of course, fulfill the dues requirement and decide that this is all that is needed. For active membership, this should be only the beginning. Just as with other facets of your life, whatever effort you put in largely determines the benefit of the outcome.

What can you do? Check the list of committees on the PSA website ([www.psanes.org](http://www.psanes.org)) to find an area, interest or concern. If you want to improve the Society's performance, don't delay, join the fray. The committee chairperson is always willing to have your input and help. While presidential approval is the final step for committee appointment, this is usually forthcoming. The website is always looking for CME material and CME material benefits all members. Please share your expertise.

As you know, it is essential to meet and know your state representative and senator. This

seems intimidating but introducing yourself and offering to be available as a physician consultant is a great way to start. Frequently your elected representatives have town hall meetings. It is a great opportunity to give input and establish a relationship. Your participation in their electoral process is the gold standard to gain recognition. Your Z-PAC contribution is certainly important because without it our legislative agenda flounders. It, however, is most effective when a constituent sends the PAC check. Please meet your elected representatives.

Be a good citizen of your hospital and community. The department of anesthesiology is charged with overseeing the sedation of patients throughout the hospital. The best PR we have is when you practice our specialty with care, compassion and dedication. Do not be a shadow physician, ensure the face behind the mask is seen and recognized. Your patient preoperative interviews and post operative are grand opportunities to be a diplomat for the specialty.

The mainstay of the specialty is vigilance backed by education; we are the spokespersons for and guardian of patient safety. Take any opportunity to speak to your community groups, such as the



Lions, Kiwanis Clubs, high school career day, church meeting, local talk or TV health shows.

Your Society has been in the forefront of this battle. You are the best PR person for our specialty. Your active participation on the home front will reap rewards. It is now time you joined the front line(s) right in your neighborhood.

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## Former PSA Board Member Faces New Challenge

Many longtime PSA members remember Don Forsythe, a former chief of anesthesia at Holy Spirit Hospital in Camp Hill. Don grew up Ireland, went to school in England, moved to Pennsylvania to raise his family that includes nine children and 13 grandchildren, and

became an active part of the PSA board for many years.

When his wife died, Don went into the seminary and became a priest in his late 60s. An article in the Harrisburg Patriot-News this January chronicles Don's newest challenge—learning to live with a

prosthetic after diabetic complications forced the partial amputation of one of his feet (read the article at [www.pennlive.com/midstate/index.ssf/2011/01/doctor-turned-priest\\_faces\\_new.html](http://www.pennlive.com/midstate/index.ssf/2011/01/doctor-turned-priest_faces_new.html)).

The PSA wishes our friend all the best.

## COMMERCE CLAUSE 101

continued from page 4

statutes, which required trash to be disposed of at a specified location, such as an incinerator, and exemptions from state tax for stock of companies doing business in a state—have all been invalidated on this basis. And yes, trash, which you have to pay to get rid of, is a product in the stream of interstate commerce.

Until the mid 1990s, very few federal statutes were invalidated on the basis that they exceeded the reach of the Commerce Clause (although courts struck down many state statutes under the Dormant Commerce Clause). That change—what a well-respected federal judge described as a “sea change in the Supreme Court’s approach to these types of questions”—is both relatively recent and the prequel to the present health care litigation.

In two cases, in 1995 and 2000, the Supreme Court invalidated federal statutes that relied on the Commerce Clause as exceeding Congress’ authority under that clause. The first, *United States v. Lopez*, invalidated a federal statute criminalizing carrying a gun within 1,000 feet of a school, establishing a so-called “gun-free school zone.” The government argued,

and the Court rejected, the contention that the presence of guns near schools substantially affects interstate commerce because possession of a firearm in a school zone might result in violent crime; violent crime imposes substantial costs that, via insurance, are spread nationwide; that violent crime reduces the willingness of individuals to travel to areas perceived to be unsafe; and that the presence of guns in schools harms the learning environment, leading to a less productive citizenry that, in turn, would adversely affect the country’s economic well being. All of those may well be true, but it is a long stretch of causation. At bottom, the Supreme Court described the statute as “a criminal statute that by its terms has nothing to do with ‘commerce’ or any sort of economic enterprise.”

The second, *United States v. Morrison*, invalidated provisions of the Violence Against Women Act of 1994 that created a federal civil remedy for the victims of gender-motivated violence, in this case a rape involving students at the Virginia Polytechnic Institute. The statute included findings that gender-motivated violence affects interstate commerce “by deterring potential victims from traveling interstate, from engaging in employment in interstate business, and

from transacting with business, and in places involved in interstate commerce; ... by diminishing national productivity, increasing medical and other costs, and decreasing the supply of and the demand for interstate products.” The Supreme Court was unimpressed: “Gender-motivated crimes of violence are not, in any sense of the phrase, economic activity.”

It seems inevitable that the Supreme Court will decide the challenge to the Patient Protection Act. The two central criteria the Supreme Court uses to choose the cases it decides are: (1) that they present an important legal or national issue; and (2) that there be a conflict among federal courts on the correct result. This case appears to have them both. The decision will likely depend on which view of the Commerce Clause – the more recent narrower view or the longer-standing broader view – is deemed to control. Hopefully, now that you have taken “Commerce Clause 101”—the basics on the constitutional provision that will likely determine whether the Patient Protection and Affordable Care Act stands or falls—you can better follow the discussion.

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

# Mark Your Calendars: Future Meeting Dates

### **Board of Directors meeting**

**in Philadelphia** – March 27, 2011,

at Philadelphia Airport Marriott, 8:30 a.m. to 4:00 p.m.;

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 3, 2011, 5 p.m.;

at Harrisburg Hilton; All members are invited to attend

# ASA to Enlarge its Headquarters

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

The ASA House of Delegates approved plans this fall to either purchase an existing office building or build a new facility in the Chicago suburbs for the Society's new headquarters. This new building would replace the current ASA headquarters, which is rapidly becoming too small to house and provide parking for the ASA's increasing number of staff.

The new building would include more than 70,000 square feet, and would be able to house an expanded Wood Library and Museum of Anesthesiology, sub-specialty societies and ASA journals, as well as have

meeting space and production facilities for an expanded ASA educational program.

In order to meet these future needs, any new building under consideration must have several features not found at the ASA existing headquarters – have high capacity broad-band Internet access, be within walking distance of high quality hotels and restaurants, be less than a 30-minute drive from O'Hare Airport, and be convenient to public transportation.

The cost of the new headquarters is expected to be as high as \$20 million.

However, this amount would be reduced significantly by the sale of the ASA's existing land and headquarters. Further, the present time appears to be one that is financially advantageous both for purchase of land and construction or renovation of a building. In addition, it is expected that the ASA's current land in Park Ridge, Ill., could be sold for a significant profit in future years. These economic realities support the construction of a new headquarters in today's housing market to serve the Society for the next several decades.

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## PRESIDENT'S MESSAGE

continued from page 1

*and may work with an anesthesiologist (physician anesthetist)."*

While this certainly represents an escalation in language, it is consistent with their repeated (although more subtle) efforts to mislead the public and establish nurse anesthetists as our professional equals. Not only did they leave out the fact that anesthesiologists supervise or personally administer the vast majority of anesthetics (and virtually all anesthetics for those in the most critical situations), but they insidiously demoted us to "physician anesthetists," thereby disregarding the additional eight to 10 years that would be required for a CRNA to become a board certified anesthesiologist.

Another pamphlet entitled "A career in nurse anesthesia" stated that:

*"Also of interest is the fact that seven nurse anesthetists can be educated for the cost of one anesthesiologist. Competitively, this gives CRNAs an advantage over anesthesiologists in a scenario where*

*manpower supply and costs to the government and society are issues."*

While the accuracy of this statement is suspect at best, even at seven times the cost, I would consider an anesthesiologist a bargain in a critical care situation. The following analogy effectively illustrates my point: For about \$2,500, an economically conscious motorist can buy a Tata, an automobile that likely will not be marketed in the U.S. because it lacks even the rudimentary safety equipment required for highway use. One can purchase seven Tatas for roughly the cost of a Ford Focus, a Chevy Cruze, or any number of equally safe alternatives. The Tata is economical, and will probably get you to your destination safely most of the time (as long as nothing unexpected occurs).

As I have stated before, and will likely state many times in the future, I value the abilities and professionalism of the CRNAs that I supervise on a day-to-day basis. Their contribution to the care of my patients is invaluable. I honestly don't believe that the actions of the AANA and PANA are representative

of the views of the majority of nurse anesthetists.

That being said, the efforts of these organizations are a threat to the practice of anesthesiology and the safety of our patients, and must be seen as what they are: an assault that must be contested at every level by all of us. Scope of practice will not be ultimately determined by physicians, but by legislators who largely believe they are acting in the interest of their constituents.

The PSA Board and its legislative and legal counsel will use every resource at our disposal to educate these legislators and preserve patient safety. This effort, however, cannot be successful without our greatest resource: *You*. There is no substitute for a one-on-one meeting between a constituent and his/her legislator.

Please develop a personal relationship with your state senator and representative today, and be prepared to educate your legislator as the need arises.



## Welcome New Members

### Active

Mirna W. Abdallah, M.D.  
 Anthony James Alarcon, M.D.  
 Subramanya S. Bandi, M.D.  
 Ellis Jay Berzon, M.D.  
 Robert D. Bricker, D.O.  
 Douglas W. Bower, M.D.  
 Arne O. Budde, M.D.  
 Brian Cicuto, D.O.  
 Arturo N. Di Nicola, M.D.  
 Udeme U. Inyang, M.D.  
 Shairko Missouri, M.D.  
 Mario I. Montoya, M.D.  
 Robin Mukerjee, M.D.  
 Gerard A. Myers, D.O.  
 Aparna S. Phadke, M.D.  
 Randall S. Rawa, M.D.  
 Mikhael H. Sarkis, M.D.  
 Jan A. Schwartz, M.D.  
 Kavitha Sharkady, M.D.  
 Musa A. Tangoren, M.D.  
 Nancy M. Vinca, M.D.  
 Gregg G. Weidner, M.D.  
 Stuart J. Weiss, M.D. Ph.D.  
 Nasr I. Yazigi, M.D.

### Retired

Jay H. Apfelbaum, M.D.  
 Nisantha M. Bandaranayake, M.D.  
 Charles R. Cortinovis, M.D.  
 Lori Dunn, D.O.  
 Alexandra I. Karetas, M.D.

## POLITICAL POWER

continued from page 5

see shape their future. Regardless of “picking the wrong person,” they needed to say that this person is the best black, white, purple or green individual to protect the doctors and patients of Pennsylvania.

If the governor decides to choose someone else, so be it. However, we as physicians representing ourselves and our patients let it be known who we wanted to do the job. After all, he is the politician and we are the health care providers treating people to the best of our ability regardless of outside pressures.

For us to try to play politics is like Tom Corbett putting in a central line. But it seems not to be. We continue to shake in fear worrying if the political powers that be will give us any say in our future instead of just saying it for all to hear. We are weak at heart. We, the same individuals who make life-or-death decisions daily, are afraid to speak up like little children staring up at our first-grade teacher, afraid to ask to use the bathroom only eventually leading to us peeing in our pants.

A couple other interesting statements were made as I worked through this process. One was that this

decision may take a while because this is a “low priority” position to fill for the governor. OK, even more reason for us to have an important role in the decision process because it is (or should be) a “high priority” position for us to have filled.

The other statement was that the person chosen will likely be a physician from a district with a “powerful” senator who more likely than others has the governor’s ear. Well, isn’t that a kick in the pants? The physician is chosen by where he decides to build his or her house? In a decade or two, my ability to take care of my patients, if I can take care of them at all, will be decided by an individual whose most important qualification is street address.

I guess I just don’t have any political power. Well, regardless of the outcome and regardless of their political weakness, my PAMED buddies are still fine physicians and can take care of me and my family anytime. I guess in the long run, maybe that’s more important. I only hope that they still have control over patient care decisions when I need them.

Oh, by the way, the gentleman leaving the BOM is actually a nephrologist, not a surgeon.

## ATTN: Dues Paying PSA Members

The percentage of your PSA membership dues for 2010 that have been devoted to lobbying expenses and are, therefore, not deductible on your 2010 Federal Income Tax Return is 14.1%. The percentage has been updated, and should be used instead of any prior percentage included as part of your 2010 Membership dues statement that you received last year.

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# Z-PAC Refresher

by Richard P. O'Flynn, M.D., and Paul J. Schaner, M.D

## What is Z-PAC?

Z-PAC is the Political Action Committee (PAC) of the Pennsylvania Society of Anesthesiologists. It is an independent non-profit, unincorporated association operated as an adjunct to the Society. Through Z-PAC, anesthesiologists are able to provide financial support for candidates for state and local elected offices who understand and appreciate the goals, objectives and values of anesthesiologists.

## Why was Z-PAC formed?

The formation of Z-PAC pre-dated the formation of ASAPAC (the PAC of the American Society of Anesthesiologists). Paul Schaner, M.D., recognized that political decisions had a direct impact on our practices when he formed Z-PAC in July 1984. Politicians play a key role in determining how anesthesiologists are paid, the regulatory

environment in which we practice and the role of non-physician providers in our state.

State law prohibits corporations (your group) and associations (PSA) from direct involvement in the political process. Only PACs can participate. Z-PAC is the legal and ethical system for political participation by anesthesiologists.

## Why do anesthesiologists contribute to Z-PAC?

They understand that political involvement is critical to their practice of anesthesiology. They see the PAC as the only effective political voice for anesthesiologists in Pennsylvania. It guarantees our presence, voice and influence in Harrisburg.

## What does Z-PAC do with its money?

With the guidance of our lobbying firm, Milliron Associates, we make contributions to pro-

anesthesiology candidates. The majority of the support goes to Senate and House of Representative candidates.

## How can I participate or find out more information?

Individual anesthesiologists can contribute in a variety of ways. Online credit card contributions, either single payment or monthly withdraws are available (visit [www.psanes.org](http://www.psanes.org) and click on the **Anesthesiologists** and **Insurance and Legislation** tabs). Personal checks can also be sent.

Pennsylvania election law also allows group payroll deduction. If you are interested in payroll deduction, please contact our lobbying firm, Milliron Associates, at (717) 232-5322.

## Yes, I want to contribute to Z-PAC

Name \_\_\_\_\_

Address \_\_\_\_\_

Contribution Amount:  \$1,000     \$500     \$250     \$ \_\_\_\_\_

I authorize the following amount to be charged to my credit card:

Monthly    \$ \_\_\_\_\_ x12 = \$ \_\_\_\_\_ (total)

Quarterly    \$ \_\_\_\_\_ x4 = \$ \_\_\_\_\_ (total)

Annual    \$ \_\_\_\_\_ (single contribution)

Credit Card # \_\_\_\_\_

Visa     MasterCard

Expiration date \_\_\_\_\_

CVV2 Code \_\_\_\_\_

Email address or phone number \_\_\_\_\_

**Mail credit card payments and checks to: Z-PAC, PO Box 823, Harrisburg, PA 17108-0823**