Sentinel
Pennsylvania
Society of Anesthesiologists
Newsletter

Spring 2016

PRESIDENT'S MESSAGE

Are We Planning for Our Future? It Isn't Just Advocacy!

by Andrew Herlich, M.D.

As I write this message, I am mourning the recent loss of a partner in our practice. He was considered the bedrock of the group and the hospital at large. I have also lost several other colleagues to either retirement or illness over the past year or so. I have learned much from all of them; I both mourn and celebrate at the same time. I celebrate since I had the honor to both know and work with them. They were mentors and helped me steer a better course in my life and my career. PSA had many mentors in the past who were not only university chairs but were also PSA Presidents, including Drs. Robert D. Dripps, Harry Wollman, Peter Winter, Joseph Seltzer, and Ephriam "Rick" Siker to name a few. On the current PSA Board of Directors, we have mentors, including many of the recent past presidents of PSA.

We rarely take stock of such incredible legacies; we should start doing so if we haven't

already. Members of the Executive Committee of PSA and the Board of Directors at large tend to be more senior in their careers. We do not have enough junior mentees nor sufficient diversity. We must start planning for our successors and train them well! Drs. Bhaskar Deb and Rich Month are our immediate future and long-term visionaries who will help lead PSA well into the next decade if we plan well. Resident members of the council of PSA need to be nurtured. There are a few younger members of the Board who have stepped up to help. However, we need more if we are to thrive. As Dr. Bob Campbell stated in a recent edition of the Sentinel, "we must become indispensable" to our specialty, to our patients, and to our legislators as well. We must plan for our successors so that patient safety, quality of care, as well as professional leadership is sustained.

Turning our attention to other issues, we must take the lead as physicians! Our specialty has led in medicine when leaders were required. Child abuse education has become a mandated course for all renewing their license this year. Many of us care for children only sporadically, if at all. Considering the cost of the Child Abuse Protection Identification, we should step up to the plate as a specialty and unequivocally state that we will do this for the sake of society at large. The

continued on page 26

Spring 2016

Contents

PENNSYLVANIA *society of* ANESTHESIOLOGISTS

Sentinel
Pennsylvania Society of Anesthesiologists Newsletter

Editor
Richard P. O'Flynn, M.D.

President
Andrew Herlich, M.D.

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

2015-2016 Officers

President
Andrew Herlich, M.D.

President-Elect
Bhaskar Deb, M.D.

Vice President
Richard Month, M.D.

Past President
Robert A. Campbell, M.D.

Secretary-Treasurer
Patrick J. Vlahos, D.O.

Asst. Secretary/Treasurer
Margaret M. Tarpey, M.D.

District IX Director
Erin A. Sullivan, M.D.

Alternate District Director
Joseph F. Answine, M.D.

Delegates to the ASA House of Delegates
Joseph F. Answine, M.D.
Joshua H. Atkins, M.D., Ph.D.
James G. Cain, M.D.
Robert A. Campbell, M.D.
Bhaskar Deb, M.D.
Edward H. Dench, M.D.
Michael H. Entrup, M.D.
Joseph W. Galassi, Jr., M.D.
David M. Gratch, D.O.
Andrew Herlich, M.D.
Richard Month, M.D.
Craig L. Muetterties, M.D.
Richard P. O'Flynn, M.D.
Margaret M. Tarpey, M.D.
Thomas Witkowski, M.D.

Alternate Delegates to the ASA House of Delegates
Albert A. Belardi, M.D.
John J. BianRosa, M.D., J.D.
Robert F. Early, M.D.
Lee A. Fleisher, M.D.
Shannon Grap, M.D.
Randy E. Lamberg, M.D.
A. Joseph Layon, M.D.
Philip A. Mandato, D.O.
Donald E. Martin, M.D.
Kristin Ondecko Ligda, M.D.
Shalish Patel, M.D.
Mark J. Shulkosky, M.D.
Anthony T. Silipo, D.O.
Kevin Slenker, M.D.
Patrick J. Vlahos, D.O.

Delegate, Pennsylvania Medical Society House & Speciality Leadership Cabinet
Donald E. Martin, M.D.

Alternate
Robert Early, Jr., M.D.

Carrier Advisory Representative
James Cain, M.D.

Z-PAC Year End Update

Richard O'Flynn, M.D., Treasurer Z-PAC

Z-PAC remains active thanks to our list of 2015 contributors. We thank all of our loyal contributors. You understand the value of a strong and active Political Action Committee. Your contribution last year helped us support candidates for legislative office who have supported bills that ensure safe anesthesia care in Pennsylvania. Our team is on the front line, working for patient protection and best professional practices.

If your name is not on this list, I simply ask, ***"Why not?"***

I'm not sure that the majority of anesthesiologists in our state, or nation for that matter, realize that our profession, **your job**, is under attack by the nurses, emboldened by the Federal government and the Affordable Care Act. There is no way that a small percentage of our members are going to be able to ward off these attacks forever. Unfortunately, the silent majority sends the message that we either don't care or it simply doesn't matter.

In this edition of the Newsletter ASA President-Elect, Jeffrey Plagenhoef describes how the apathy in our profession is unacceptable if we intend to continue to be the leaders of safe anesthesia care. Don Martin and Robert Hoffman write about proposed Pennsylvania legislation affecting balanced billing which, if passed as is, would all but eliminate negotiation of rates with the insurance companies, basically removing the option of going "non-par".

2016 will be a pivotal election year. The entire House and half the Senate will be on the ballot. In addition, many of our loyal supporters in both the House and Senate have decided to retire at the end of this session. Z-PAC must be in the vanguard of supporting good candidates who will make a difference on our issues. While it's important for each of us to support candidates who recognize and support the vital role we play, our voice is exponentially stronger when we work together through our registered Political Action Committee.

Your support is vital to our success. Please do this today.

I encourage you to make your personal maximum contribution to Z-PAC. You can also make a donation to Z-PAC online at www.psanes.org.

Working together, we will make a difference—a BIG difference for our patients and for our practices.

Z-PAC Contributors

David Adamski
Aras Ali
Kenneth Andrejko
Vivek Angadi
Juan Anigati
Joserph Answine
James Artusio
Guido Ascanio
Robert Atkins
Joshua Atkins
Christian Barotti
Richard Bartkowski
Michael Bell
David Berman
Sherna Bharucha
John BianRosa
Charles Boucek
Douglas Bower
Jason Brannen
Patrick Breen
Karen Bretz
Neil Brister
Roger Bucs
Matthew Caldwell
Robert Campbell
John Caprez
Bradford Cardonell
Aldo Carmona
Jihn Carson
Julian Castaneda
Mircea Cercega
Abdoula Chakhbazov
Jeffrey Chen
Danile Chess
Kimwai Chu
John Collins
Pietro Colonna-Romano
Louis Colozzi

continued on page 4

Z-PAC Contributors

continued from page 3

Jason Cwik
Dana Daidone
James Davis
Surendra Davuluri
Robert Day
Nicholas DeAntonio
Bhaskar Deb
Delphy DeFalcis
Richard Denovan
Craig Depoe
Robert DeQuevedo
Meena Desai
Matthew Desciak
Dennis DeStefano
John Dinger
Ruth Dombkowski
Howard Doughty
James Duckett
John Dziewit
Robert Early
Ali Ekbatani
Essa El-Maghrabi
Norig Ellison
Patrick Fall
Frederick Flaccavento
Adam Fleckser
Danny Forsythe
Patrick Foster
Henry Galaska
Joseph Galassi
Theresa Gelzinis
David Geyer
Edward Ginley
Steven Glasser
Sheryl Glassman
Stanley Glowacki
Allan Goldstein
Jerry Gonzales
David Goodman
Vahid Grami
Shannon Grap
Laura Graybeal
Brett Groff
Zvi Grunwald
Fernando Gutierrez
Jeffrey Haiken
Pamela Hale
Paul Halweg
Daniel Hart
Alex Hart
Andrew Harter
Dorothy Hartman
Adam Hauser
Eva Hayden-Easley
Michael He
Andrew Herlich
Paul Hester
Christopher Hetrick
Robert Hodges
Katherine Hollinger-Yurick
John Hopkins
Melody Hu
Huchun Hu
Jane Huffnagle
Asuquo Inyang
Jeremy Jaffe
Brandon Johnson
William Johnson
Vida Kasuba
Lisa Keglovitz
Sam Keller
Stephanie Keller
Fred Khalouf
Zahid Khan
Kevin Kinkead
Benjamin Kline
David Kohan
Richard Kolesky
Ronald Kratz
Michael Krawczyk
Kurampumanil Kurien
Murali Lakshmin
James Lamberg
Randy Lamberg
Charles Lancelotta
John Lang
Christopher Larson
Jacqueline Laundre
Stewart Leftow
Edward Leonard
Lee Letwin
Andrew Levette
Charles Levine
Lawrence Levit
Allen Lewis
James Li
Kirk Lindvig
Deborah Lippman
Anne Mahadeviah
Igor Maidansky
Phillip Mandato
Jeffrey Marshall
Wayne Marshall
Donald Martin
Rafael Martinez
Michael Mateo
James Mathis
Bryan Matusic
James McClain
Patrick McGannon
William McGuinn
Mary jane McIlwain
Philip McLean
Brian Melamed
Luis Mercader

David Milliner
Keith Minnich
Paul Mintz
Harry Mintzer
William Molinari
Rajikumar Mongia
Roger Moore
Patricia Morris
Aaron Mory
Margaret Motl
Craig Muetterties
Gail Munion
Shawn Murphy
Jeffrey Nachman
Stephen Nichols
Sergei Nikiforov
Anthony Nostro
Richard O'Flynn
Teresa Hayes O'Flynn
Timothy O'Grady
Patience Okolie
Gary Okum
Joseph Oliva
Isoken Osunde
Phyllis Parcella
Mukul Parikh
Bradley Parlin
Jonathan Parmet
Timothy Pastore
Shailesh Patel
Steven Pearce
Dennis Pellacchia
Ivan Perry
Christopher Peterson
Gregory Pharo
William Pierce
William Porter
Barbara Posatko
Rene Pristas
Matthew Redclift
Madhavi Reddy
Timothy Reed
Kenneth Richman
David Roberts
David Robinson
Michael Robinson
Nicholas Rockwell
Ricardo Rodriguez
Scott Rosenthal
Jonathan Roth
Marc Royo
George Rung
Jonathan Rutkauskas
Joseph Ruzbarsky
Valerie Salmons
Philip Sasso
Beverly Schantz
Phyllis Schapire
Andrea Schellenberg
Alan Schwartz
Jeanianne Sedlack
Sneed Shadduck
Sanjay Shah
James Shaheen
Sean Sharkey
Mark Shulkosky
Jeffrey Simons
Steven Sisson
Kevin Slenker
David Smith
Jonathan Stein
Nancy Sterling
Mark Stull
Nasir Suleiman
Erin Sullivan
Venkatesh Sundarajan
Joel Swanson
Margaret Tarpey
Amy Thompson
Karen Troxell
Manuel Uribe
Peter Vacca
Savitha Vonah
Tonhu Vu
Joseph Waldner
Hai Wang
Daniel Weil
Dean Werner
John Williams
Michael Wills
Justin Winas
Nancy Winikoff
Thomas Witkowski
Elizabeth Wolo
Chee Woo
Peter Yi
Uriel Yodfat
Mary Yurick
Mark Zemanick
Miriam Zentner
John Zepp
Jialin Zhou
Lawrence Zohn
Janis Zvargulis

Excerpts from ASA President-Elect Jeffrey S. Plagenhoef's Speech to ASA House of Delegates

Most of us agree that there has never been in the history of the ASA more balls in the air to juggle, all with huge potential for major impact upon the medical specialty of anesthesiology.

I've addressed many audiences in many states this year, and professional citizenship is always part of the dialogue. Why? Because lack of consistently high levels of professional citizenship among us has always hurt our mission. Causing a national level transformation within our ranks is ABSOLUTELY ESSENTIAL to our future. If I've heard one person state Pogo's line, "We have met the enemy and he is us", I've heard a hundred. So when I am asked, "What do you hope to accomplish serving on the Executive Committee of the ASA?" My answer is that I want to incite anesthesiologists to do more than JUST SAY they care — I will do all that I can to cause every anesthesiologist to SHOW they care through their level of professional citizenship displayed. I want anesthesiologists to demonstrate that they are physicians, professionals, leaders, and that they are willing to accept the responsibility that they share equally with every other anesthesiologist to advance the specialty and secure its future.

Being an outstanding clinical anesthesiologist is basic entry-level physician anesthesiologist work and is expected of all of us.

Being a grassroots foot soldier, working your hardest to protect patients and our specialty, is what all of us MUST become — not later, not soon…NOW!

What can each of us do to make this necessary transformation if we want to maintain physician leadership in anesthesia delivery?

First, look in the mirror and conduct an honest, personal assessment and ask, "Do I demonstrate an exemplary level of professional citizenship?" Our world in health care delivery is changing around us. Is it reasonable to think that you will flourish in a sea of change without changing yourself? The laws of nature are adapt, migrate or die!

Next, educate yourself on the issues and be ready to speak to anyone, including your nursing colleagues! Go to the ASA website and read all about the 'When Seconds Count' campaign, the documents on scope of practice, the anesthesia care team, AAs, and the related publications. Change the narrative on scope of practice by telling people that in eight different state or national level independent surveys (ed. note; Pennsylvania included), 80-90% want physician anesthesiologists delivering their anesthesia and want nurses supervised. This is a patients' rights issue!

Read my two ASA newsletter articles on the APRN Consensus Model and the VA Nursing Handbook proposal, or do your own online research. I maintain that you cannot be where you need to be—someone who is part of the solution, not part of the problem—without educating yourself in these two related areas.

Give $1,000 to the ASAPAC, and then make sure everyone in your group or department does the same. Oh, and don't worry about the possibility of being responded to with a good justification for why a colleague thinks they shouldn't support advocacy…because THERE ISN'T ONE.

Solid proof that political advocacy money, ASAPAC dollars, are crucial to our mission lies right before us now. You don't have to look any further than the biggest threat to patients and the medical specialty of anesthesiology than the VA Nursing Handbook proposal. The fact is, the ASA, with its well-recognized and appreciated reputation on Capitol Hill, is responsible for putting the implementation of that handbook

continued on page 26

"Surprise Billing" Limits Proposed for Pennsylvania Physicians

by Robert B. Hoffman, PSA Attorney, and Donald E. Martin, M.D., Specialty Leadership Cabinet Representative

On January 19, Pennsylvania Insurance Commissioner Teresa Miller released for comment a draft legislative proposal designed to protect consumers from "surprise balance billing". This action follows a public hearing held last fall at which PSA and many others provided testimony. This bill would limit out-of-network providers, including anesthesiologists, to billing patients only the co-pays and deductibles set by their insurers for in-network providers. Out-of-network physicians would then need to look to and negotiate with the patient's insurer to determine the remainder of their payment.

There is one central factor driving this proposal and analogous proposals, some enacted into law, in other states: patients are complaining with greater frequency and volume that they are being stuck, to their asserted surprise, with bills from out-of-network providers who provided them with care. Hence, the term "surprise balance billing."

Those bills typically arise in one of two circumstances:

- When the patient needs emergency care;
- When a hospital is in network but certain physicians who provide patient care, such as an anesthesiologist, radiologist, lab, or neonatologist, are not.

Both situations do arise and do affect anesthesiologists. Emergencies sometimes arise when patients are far from home, and thus far from in-network providers. A very recent example is the 60+ vehicle crash on I-78 in Lebanon County on Valentine's weekend; undoubtedly, the physicians at area hospitals who treated those accident victims did not participate in at least some of the relevant insurer networks.

Situations in which anesthesiologists do not participate with an insurer but the hospital at which they work at does appear relatively rare, although good data on that, in Pennsylvania, has not been collected. PSA is trying to gather that information through a survey, accessible in the Members Only section of the PSA website http://www.psanes.org. It will be very helpful to PSA's effort to better understand this issue if you would ask your practice manager to log on to the website to provide information and opinions from your practice.

As to emergencies, the federal Affordable Care Act (the "ACA") requires insurers to cover emergency care whether

or not the health care provider is a participating provider. It also prohibits insurers from charging insureds greater copays if they are treated by a non-network provider than if a network provider cares for them. Pennsylvania insurance regulations establish these same general rules, although they are more limited in their application. The Insurance Department proposal, among other things, attempts to create a rule and mechanism for reimbursing out-of-network providers.

Several trends appear to be the cause for the recent focus on this issue. First, some insurance companies, presumably to decrease their costs, have reduced the number of their in-network providers; this limitation may be accompanied by reduced reimbursements to those who remain in-network. Second, the patient's complaints reflect the fact that insurers, at least in some instances, refuse to pay out-of-network providers at all or do so using low reimbursements that the provider has not agreed to.

continued on page 8

SURPRISE BILLING

continued from page 7

This, in turn, causes the provider to look to the patient, leading to larger and more frequent balance billing invoices directed to patients. High deductible plans increase patient responsibility. An insurer's refusal to pay a "reasonable fee" would appear to violate the ACA rules discussed above. These cases make headlines. An oft-quoted New York Times article from the fall, 2014, reported that a patient who underwent neck surgery for herniated disks received a fee of $6,200 from his surgeon, who was apparently in-network, and a $117,000 bill from an assistant surgeon, who was not.

Third, patients assume that their only financial obligation for a medical service is their insurance copayment and deductible, regardless of the limitations of their insurance coverage. Insurers are in general required to provide information on policy limitations and patient financial responsibility, including costs of emergency care, but most insureds are unlikely to read and retain this information. Fourth, providers, having no contractual agreement to accept a lower rate, sometimes bill the patient their full fee in these instances, and it is often far larger than the amount they accept from third party payers. This may be done to improve their bargaining position in negotiating in-network status with an insurer, but it certainly leaves the patient in an unhappy position. The difference between that billed amount and the amount the provider commonly accepts from insurers can be substantial.

The Pennsylvania Insurance Department proposal applies in the two general circumstances referenced earlier—emergency care and a situation in which a hospital is in-network but the providers are not, or vice versa. It applies to all "facility based practitioners" or "affiliated providers" of any specialty who provide services to patients in a health care facility when the facility itself is in-network. Though physicians of any specialty are included, the legislation identifies those specialties deemed most likely to be involved—anesthesiology, radiology, pathology, neonatology, and hospital medicine. It has not yet been determined whether emergency and elective services will be handled differently under the proposal.

Instead of balance billing the patient beyond the in-network copays, under the proposal anesthesiologists (and all other providers) would be required to accept assignment from the insurer. This parallels the current process for in-network care. The proposal then creates a mechanism or rules to get the provider paid. Providers would have the option of accepting as payment in full either an amount established by the statute, most likely as a fixed percentage of the Medicare or other established fee schedule; the insurer's usual in-network payment rate; or a rate negotiated with the insurer or set by binding arbitration.

PSA's written testimony at the public hearing emphasized the need for insurer and health care facility transparency in disclosing all expected costs to patients before services are provided. Out-of-network providers, of course, need to also do their part by readily providing expected costs to prospective patients.

The complete text of the Bill proposed by the Insurance Department and PSA's letter of comment as well as background information on the implications of the proposal for anesthesiologists; prior testimony on the issue from PSA, the Pennsylvania Medical Society and the Hospital and Health care Association of Pennsylvania; and similar bills from other states are available on the PSA website. **For this more complete information and an opportunity to provide your feedback to PSA on this proposal's implications for your practice, as well as your opinions on this issue, log on to the Members Only Section of the PSA website at http://www.psanes.org or ask your practice manager to do it for you. Information you provide will be helpful in establishing our legislative position on this issue**. The Insurance Department proposal alone can be found at http://www.insurance.pa.gov under the heading "Proposed Balance Billing Solution".

In early February, the authors of this article met with Insurance Department representatives to clarify the intent of the latest Insurance Department proposal and to discuss the unique aspects of anesthesiologists' relationships to their patients and their billing process. Since Medicare rates have been included as one possible payment option, those discussions included the longstanding problem regarding the unusually low rates paid to anesthesiologists under Medicare, as well as facility and insurer responsibility for "surprise" balance billing. Since this issue and the Department's proposal affects almost all physicians providing any services in facilities, the Pennsylvania Medical Society and specialty organizations have discussed a joint approach to the

issue at the recent Pennsylvania Medical Society Specialty Leadership Cabinet meeting.

Pennsylvania is not the only state that is looking to address this issue or has legislation in place dealing with balance billing. Participating physicians, by their provider agreement, are prohibited from balance billing insureds (except for copay and deductible amounts) and almost all states prohibit that practice. However, only approximately 13 states currently have any limits on balance billing by out-of-network providers, usually for emergency situations. At least five to six states, and perhaps closer to 10, are now considering, or have recently passed legislation regarding out-of-network providers. New York State passed a financial services law that took effect on March 31, 2015 that was designed to limit patient liability for balance billing especially for emergency services. The bill also was designed to reduce patients' surprise associated with out-of-network billing by providing for patient notification before elective services were performed.

Out-of-network billing is a real concern for anesthesiologists nationally. It is becoming not only a state issue but a federal issue. The ASA has established an Ad Hoc Committee on Out-of-Network Billing that is addressing this issue at the national level. Sharif Zaafran of Texas is the committee chair. The greatest concern for anesthesiologists nationally is that if balance billing is limited or prohibited at the federal level (or even at individual state levels), insurance companies will have the authority to set payment rates unilaterally and physicians will have absolutely no ability to negotiate.

In Pennsylvania, a proposed fix is likely to be introduced in the legislature in the spring/summer. Given the nature of the issue, it is reasonable to assume that some proposal to end or at least limit "surprise balance billing" will be enacted, although the current impasse between Governor Wolf and the Republican majorities in the legislature add uncertainty. PSA will stay involved and keep our membership informed.

MEDICAL PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS BY PHYSICIANS

NORCAL MUTUAL®

SAY HELLO TO NORCAL

EXPERIENCE THE MUTUAL BENEFIT

PMSLIC Insurance Company is transitioning to its parent company—**NORCAL Mutual Insurance Company**. Same exceptional service and enhanced products, plus the added benefit of being part of a national mutual. As a policyholder-owned and directed mutual, you can practice with confidence knowing that we put you first. **Contact an agent/broker today.**

HELLO.NORCALMUTUAL.COM | 844.4NORCAL

PMSLIC®

Legislative Update

by Charlie Gerow, Quantum Communications

Physician Anesthesiologists Week

To coincide with the national observance, we were successful in securing Resolutions in both the Senate and the House of Representatives designating January 31 to February 6 as "Physician Anesthesiologists Week" in Pennsylvania.

Senate Resolution 270 was introduced by Sen. Tommy Tomlinson and passed unanimously in the Senate. House Resolution 675, introduced by Rep. Jim Christiana, passed unanimously in the House.

Sen. Tomlinson's Senate resolution described the Pennsylvania Society of Anesthesiologists as "a physician organization with over 1,400 members dedicated to promoting the highest standards of the profession of anesthesiology, fostering excellence through continuing medical education and serving as an advocate for anesthesiologists and their patients."

The House resolution was authored by Rep. Christiana, who last summer introduced House Bill (HB) 1277, a measure supported by PSA that would codify existing state Health Department regulations requiring physician supervision of CRNAs in the administration of anesthesia.

Christiana's Physician Anesthesiologists week resolution said, "Anesthesia is safer than ever before, yet there remains potential for complications and side effects during procedures,

PSA President Andrew Herlich, M.D., and Kristin Ondecko-Ligda, M.D. with a cake made by CRNA Shari Zavarella at UPMC Mercy for Physician Anesthesiologist Week

and physician anesthesiologists have the training and expertise to help minimize these risks, monitor for any problems and take quick action. During surgeries or procedures, when seconds count, physician anesthesiologists have the highest degree of training to respond to emergencies and ensure the best patient outcomes."

Call your legislator and ask for passage of HB 1277.

In an unprecedented move, a Pennsylvania governor has delivered his annual budget address without having an approved budget for the current fiscal year. To say that there is an ongoing "budget battle" between Gov. Wolf and the legislature greatly understates the tension that exists in our state Capitol.

In spite of the current legislative logjam, it is critically important that we continue to work with legislative leaders and members of the House Professional Licensure Committee to build support for HB 1277. When the budget stalemate is resolved, lawmakers will again be churning out new legislation, and we want our bill to move as quickly as possible.

Contact your legislator. Urge him or her to see that HB 1277 is reported out of committee and sent to the floor of the House for a vote. Legislators need to hear from members of PSA that this is a vital issue. Physician supervision protects patient safety by ensuring that the most highly trained medical professional is on hand, especially in the event of an emergency during surgery—when seconds count.

This legislation has been our priority for many years. Now is the time for legislators to hear from each of us! If you are not certain who to contact, go to http://www.legis.state.pa.us/ to find your legislator's name and contact information. Do it NOW while you're thinking about it.

Your voice will make a difference in this critical issue!

Generic Drugs: Low Supply and High Prices

by Robert Campbell, M.D., Past-President, Pennsylvania Society of Anesthesiologists Chairman, Physicians Against Drug Shortages

pop quiz

1. The root cause of drug shortages is multifactorial and complex.
☐ TRUE ☑ FALSE

2. Drug shortages have been a menace since 2006.
☑ TRUE ☐ FALSE

3. Kickbacks are good for markets and good for consumers.
☐ TRUE ☑ FALSE

4. Kickbacks are the root cause of drug shortages.
☑ TRUE ☐ FALSE

5. Congress knows the root cause for drug shortages.
☑ TRUE ☐ FALSE

6. Congress is acting to end the drug shortages.
☐ TRUE ☑ FALSE

As a practicing physician in Pennsylvania, I have become simultaneously intrigued and disturbed by the ever-increasing drug shortages I am experiencing in my practice. As an anesthesiologist, I am perhaps disproportionately affected, as most of the drugs in short supply are generic injectables. I am not alone, as oncologists and emergency physicians have experienced dramatic shortages in their practices as well.

As I began investigating drug shortages, I found that medical experts and their summits never really provided an answer that made sense. The question of course is why do we have so many shortages? They began in 2006 and have only escalated over time. This is in spite of multiple drug summits, a Presidential Executive Order, and numerous remediation strategies by the FDA. The root cause according to the smartest medical minds in the room is that it is multifactorial and complex. In fact, it is so much so, that we must simply learn to ration and make do with the scarce resources available at any given time.

In fact, their opinion is that it is so much so, that we must simply learn to ration and make do with the scarce resources available at any given time. Mitigate and manage the shortages is our best hope. But maybe, just maybe, there is a cure for this ill. In fact, I am convinced that there is one root cause and one action needed to end all the shortages and price spikes.

Looking for answers

I have chosen to look for answers beyond the medical establishment. This has turned out to be very valuable in understanding drug shortages. I suggest other doctors do the same. I have made inquiries with attorneys, marketplace historians, economists, journalists, and supply-chain specialists. What I have discovered is most useful. Universally, all these non-medical parties describe the condition as a marketplace failure. While the FDA repeats the mantra that it is "beyond the purview of the FDA to consider economic causations", those outside of medicine say it is simply an economic marketplace failure. There are multiple articles in law review journals, supply chain management textbooks, health policy and law publications, and a white paper published by the American Antitrust Institute. Every resource says the same thing. And the explanation in no way resembles the explanations

emanating from the political and medical spheres!

So what is the real root cause of drug shortages?

The question should be more broadly phrased. What is the cause of this economic marketplace failure? There are only two causes for marketplace failures: government price fixing or anti-competitive market behavior. The most common form of anti-competitive market activity is a monopoly. It turns out there is a monopoly in the supply chain. But this monopoly is not a run-of-the-mill monopoly like say AT&T, Standard Oil, Microsoft, or Google. Those are all vendor monopolies. It turns out the health care supply chain is subject to a very rare kind of monopoly. It even has its own name and one that I have never heard before and am willing to guess you have never heard either. It is called a 'monopsony'. What is that? It is a middleman monopoly also known as a buyers' monopoly. It is exceedingly rare in marketplaces. Because of its rarity, this health care monopsony has been studiously observed, characterized, and written about by many authorities. It turns out it just is not written about in medical circles. Drug shortage experts in health care only reticently refer to this monopsony, if ever.

Economists will argue whether specific market failures are a result of price controls or anti-competitive behaviors. In this case, there are two root causes proposed by economic experts, including the February 2014 Government Accountability Office (GAO) report. So is it a result of price controls or a middleman monopoly? One thing is sure, no one is endorsing the so-called multi-factorial and complex cause as espoused repeatedly in medical circles and the media. That's right, no one endorses the multifactorial and complex hypothesis we read about in the medical literature all the time. This is good. I would rather it be a simple problem (a failed marketplace) with a simple solution. Nothing complex for me please.

Well it is a little complex but not so hard to understand.

Some economic marketplace scholars will argue the ASP+6% rule placed on the marketplace by the government is a price control. This is a little bit policy wonk talk, but this is a 6% cap above average wholesale price that providers can charge to insurance companies and other payers. Others argue it is not. I have studied this and there are very convincing arguments this is not a price control. In fact, it was created with the intent to prevent price gouging without being a price control. Economists know that price controls destroy markets. I do not think the ASP+6% rule is a price control, but some people do.

Some say the presence of the Group Purchasing Organizations (GPOs) middleman cartel is the only market force powerful enough have caused this unprecedented marketplace failure. Yes, that is unprecedented. Yes, this is the biggest market failure ever. Not just the biggest medical marketplace failure, but the biggest marketplace failure ever. The middleman here is the GPOs. Not only do the GPOs enjoy a middleman monopoly but they thrive on it. In 1987 the federal government granted GPOs a "safe harbor" allowing them to receive payments from the vendors of goods that the GPO is purchasing and then reselling to hospitals. Those payments would otherwise likely be illegal under the "anti-kickback" provisions of the Social Security Act. Those provisions make it a crime to receive any remuneration in return for purchasing, any good for which payment is made by a Federal health care program. This is when things really went wild. Rather than explain everything here, there are plenty of great articles written in lots of media outlets about GPOs. The most recent ones are two articles in *Fortune Magazine* http://fortune.com/2015/02/05/theres-a-national-shortage-of-saline/. They describe the state of affairs pretty well. Plus, my intent here is not to just give you my opinion.

So what should doctors do?

Put on your critical thinking cap and read some articles yourself. There are plenty of links at physiciansagainstdrugshortages.com. Once you start reading, something funny will happen. When you hear complex and multifactorial you will instinctively stop listening. Either your source is conflicted or uninformed (or as I prefer to say, conflicted or confused). So if you hear that everything under the sun causes drug shortages, well you are being distracted from the real cause. If you hear a marketplace failure with a simple solution, then you are onto a good source. Keep listening to or reading those sources.

Physicians Against Drug Shortages

Physicians Against Drug Shortages has a web page at physiciansagainstdrugshortages.com. Anyone can join this organization. There are no

continued on page 14

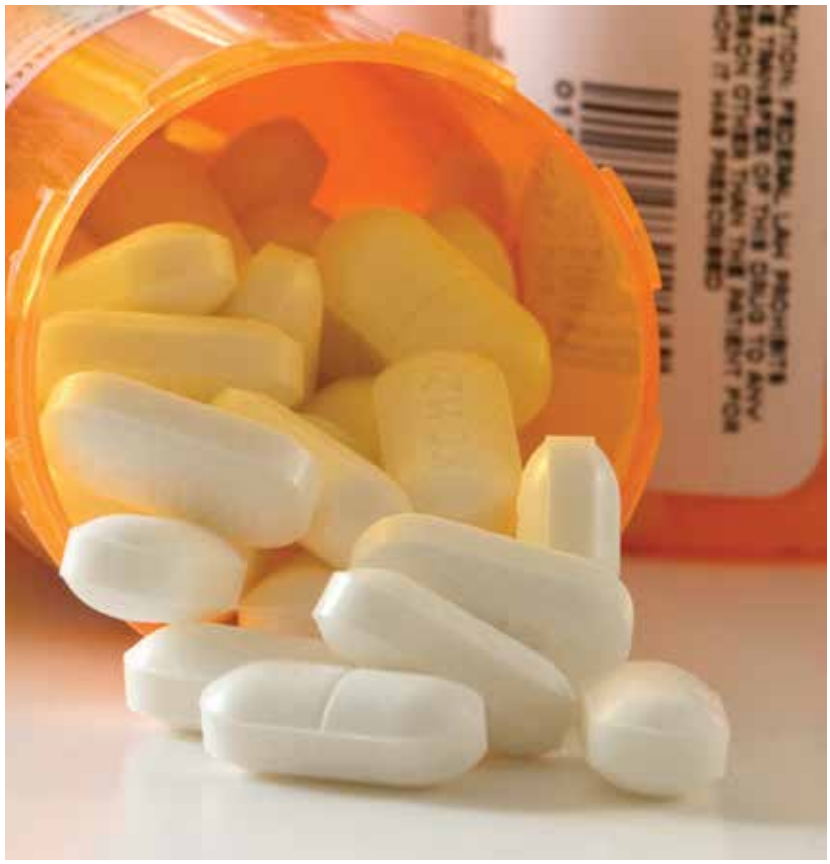
continued from page 13

membership fees and you do not have to be a doctor to join. The "Physicians" part of the name is meant to imply that we are smart people and not prone to extremes of opinion.

There will come a time when some powerful stakeholders will step forward and take action to end the drug shortages. If it is a price control, then repeal the ASP+ 6% rule. If it is a middleman cartel, then bust up the cartel. These arrangements usually are very profitable for the cartel participants and obliging politicians. That is why the shortages have persisted. It may be that the only way to end the shortages is for enough individuals to understand that a middleman cartel enabled by government crony capitalists is responsible for all the shortages. Yes, it is simple; the opposite of complex and multi-factorial. A handful of shrewd people are making a lot of money from this masterpiece of crony capitalism. As long as there is no public outcry over shortages then it will persist.

The kickbacks are powerful.

In nine out of ten industry groups tracked by Standard and Poors even asking for kickbacks, much less collecting kickbacks, is a felony. Only in health care are they "allowed" and only when conducting business via the GPO middleman. Let's say doctors get together to end the kickbacks. For those in opposition, have them explain the added value of the kickbacks in the health care supply chain. Yes, let's focus the discussions on the value-added proposition for concealed contractual kickbacks and safe harbors to be certain that these practices are maintained and furthered in the health care marketplace. Let's fully vet the merits of these practices and then if possible, let's extend it to all industry groups outside of health care. On the other hand, if we conclude after vigorous debate that kickbacks are bad, then let's eliminate them and see if the generic drug marketplace is restored. I am sure it will be. I have spoken to some of the most respected anti-trust attorneys in the nation and they assure me this action will end the shortages. Even the American Anti-Trust Institute agrees whole heartedly—eliminate the kickbacks and there will be no more drug shortages or price spikes. Abundant and affordable generic medications for all would likely be restored.



The public it turns out is not aware we have drug shortages. Doctors, nurses, and pharmacists are all so busy with their jobs and even more so now that we have to manage the shortages that we have not taken the time to really use our critical thinking skills and read the proper literature on this problem. We must take that step. This is the greatest threat to patient care in my career. In the name of quality care and saving precious health care dollars, we need to first understand the problem. Only then can a group like Physicians Against Drug Shortages end the shortages.

www.physiciansagainstdrugshortages.com (Ed. Note: Go to the PSA website for more information on the topic, www.psanes.org)

THE NATION'S PREMIER ANESTHESIA BILLING COMPANY

Medac®

ANESTHESIA BUSINESS PARTNERS

ANESTHESIA BILLING & COLLECTIONS

PENNSYLVANIA'S LARGEST ANESTHESIA BILLING SERVICE PROVIDER

SERVICING OVER 1,100 PROVIDERS IN PA, & 8,000 PROVIDERS NATIONWIDE

INDUSTRY LEADING COMPLIANCE

EXPERIENCED PROVIDER ENROLLMENT

EXPERT PRACTICE MANAGMENT

COMPLETE FINANCIAL MANAGEMENT

AAPC CERTIFIED CODING

ROBUST REPORTING

THANK YOU, PENNSYLVANIA - FOR MAKING MEDAC #1

www.medac.com 800.883.8003

Pro/Con: Routine Preoperative Pregnancy Testing

PRO

Authors: Kathryn Hall, M.D., Anesthesiology Resident (CA-3) with the University of Pennsylvania Health System, and Richard Month, M.D., Assistant Professor of Clinical Anesthesiology, Chief, Obstetrical Anesthesiology, with the University of Pennsylvania Health System, and Vice President of the Pennsylvania Society of Anesthesiologists

Preoperative pregnancy testing is quick, inexpensive, and provides valuable information that could alter or suspend perioperative management. This non-invasive test empowers a patient of childbearing age and her perioperative team to make the safest and most informed plan possible.

The literature exploring the safety of anesthesia during pregnancy is at best nascent. Exposure to halogenated anesthetics affects the developing rodent brain,[1] and emerging evidence suggests it acts similarly in humans, particularly in the first and second trimesters.[2] Although much of the literature in this field is inconclusive, with so many unknowns, why unnecessarily expose a fetus to possible harm?

Performing surgery on a parturient involves much more than exposing a fetus to anesthetic drugs. Factors such as surgical stress, transient hemodynamic variation, intraoperative fluid management, and postoperative pain have the potential to affect the growing fetus. The stress of surgery itself carries with it a small but significant risk of pregnancy loss. In the event of unforeseen complications (blood transfusions or advanced resuscitation efforts), the knowledge of a pregnancy may alter clinical care.

Ultimately, however, above considerations of risk, effects of anesthesia on the fetus, or anesthetic management, preoperative pregnancy testing allows the most important tenet of modern medicine to be fulfilled: true patient autonomy. A positive pregnancy test coupled with a discussion of the risks of a particular surgery, including possible risks to the fetus, empowers a patient to give fully informed consent for the procedure, the associated anesthetic, and their risks and benefits, or decide to postpone elective surgery. Furthermore, a positive pregnancy test to an otherwise unaware mother gives the patient an opportunity to seek appropriate prenatal care, a known benefit to the fetus and mother.

In the end, the question becomes, simply, why expose the fetus to potential harm when a pregnancy test would empower the mother and her care team to make a fully informed choice?

References:

1. Boscolo A; Milanovic D; Starr JA et. al. Early Exposure to General Anesthesia Disturbs Mitochondrial Fission and Fusion in the Developing Rat Brain. Anesthesiology. 118(5):1086-1097, May 2013.
2. Yu CK, Yuen VMY, Wong GT, Irwin MG. The effects of anesthesia on the developing brain: a summary of the clinical evidence. F1000Research. 2013;2:166. doi:10.12688/f1000research.2-166.v2.

Testing: Should it be Performed?

CON

Authors: Kathleen Coy, M.D., PGY2 Resident, University of Pittsburgh Medical Center, and Kristin Ondecko Ligda, M.D., Assistant Professor, University of Pittsburgh Medical Center, UPMC Mercy Hospital

Approximately 2% of pregnant women in the Unites States will need non-obstetric surgery during pregnancy.[1,2] Medical conditions often presenting with a need for surgery during pregnancy include appendicitis, cholecystitis, pancreatitis, nephrolithiasis, and bowel obstruction. Although there is an increased risk of spontaneous abortion and prematurity in patients undergoing surgery during pregnancy, the risk of complications associated with not pursuing surgical intervention often outweighs the risk of fetal loss and other adverse outcomes in these cases.[1,2]

There is a lack of data to support increased incidence of congenital malformations in infants born to pregnant women who underwent surgery during pregnancy. Additionally, no anesthetic agents are currently known to have teratogenic effects; however, no studies exist that prove their safety.[1] Elective surgical procedures are generally deferred until the postpartum period to avoid unnecessary, if somewhat unclear, risk to the fetus.[2]

The 2002 Practice Advisory for Preanesthesia Evaluation issued by the ASA Task Force on PreAnesthesia Evaluation determined that there was not enough literature to assess the benefits or harms of routine versus selective pregnancy testing.[3]

There will be women who will present for elective, urgent or emergent surgeries with previously undiagnosed pregnancies. The rate of discovering a new pregnancy at the time of surgery has been reported to be between 0.15 and 2.0%. (1,2) When pregnancy is discovered, surgery is often delayed or cancelled, unless emergency circumstances dictate that the risk of cancellation outweighs the risk of proceeding as planned.[2]

To use routine, institution wide pregnancy testing in the preoperative assessment of a patient, especially when such testing is compulsory, has several implications. First, the legal and ethical issues exist regarding consent for pregnancy testing. Palmer et al. indicated, "a patient should be allowed to refuse the test without coercive consequences, such as automatic cancellation of scheduled surgery."[5] Hospital-wide policies mandating pregnancy testing for reproductive age women may not sufficiently address issues of consent for pregnancy

testing, may not address issues regarding pregnancy testing in minors, and may fail to address actions that should be taken in counseling women who have positive pregnancy tests. In emergent situations, it may rarely be practical for an appropriate physician to discuss the risks and benefits with a patient who has just learned that she is pregnant. These policies often fail to address privacy issues, including to whom results can be revealed. Failure to consider these implications places the physician at risk of violating the woman's right to manage these sensitive results.[4,5]

Detecting an early, unknown pregnancy is not always straightforward, and false negatives may lead to false reassurance extending beyond the perioperative period. Standard pregnancy tests are designed for the purpose of confirming pregnancy after a missed period rather than to exclude it prior to

continued on page 18

PREGNANCY: CON

continued from page 17

a missed period. With natural variations in cycle length as well as natural variability of the time to implantation of the blastocyst following fertilization, the exact interval from the onset of the previous menstrual period to the point of detection of an early pregnancy is inherently difficult to predict.[6,7]

In a study by Wilcox et al., a sensitive assay for hCG (using a detection limit of 0.01 ng/mL, approximately 0.13 mIU/mL) was unable to detect 10% of clinical pregnancies on the first day of missed menses.[6] It can be determined that an even larger percentage of clinical pregnancies may go undetected early on as there is wide variability in sensitivity of hCG tests and because there may be uncertainty regarding the date of her last menstrual period. Most urine pregnancy tests have hCG detection limits of 25-50 mIU/ml, far above the detection limit of 0.13 mIU/mL used in the Wilcox study.[6]

Another study estimated that pregnancy tests with detection limits of 25 mIU/mL would only begin to detect pregnancy around 3 or 4 days after implantation.[8] Because implantation occurs by the first day of a missed period in only 90% of pregnancies and by 7 days after the first day of a missed period in 97% of cases, it can be concluded that a woman who has missed the first day of her period may have a negative pregnancy test due to natural variations in day of implantation, and would not be protected by mandated preoperative pregnancy testing.[7]

Counseling women regarding potential pregnancy-related anesthesia risks prior to scheduling elective surgery may be an alternative to mandated pregnancy testing on the day of surgery. It may also be beneficial to identify women at particular risk of pregnancy based on historical data and to provide pregnancy testing with proper consent on a case-by-case basis.

References:

1. Wingfield M, McMenamin M. Preoperative pregnancy testing. Br J Surg. 2014 Nov;101(12):1488-90. doi: 10.1002/bjs.9637. Epub 2014 Sep 10. PubMed PMID: 25209586.
2. Maher JL, Mahabir RC. Preoperative pregnancy testing. Can J Plast Surg. 2012 Fall;20(3):e32-4. PubMed PMID: 23997593; PubMed Central PMCID: PMC3436097.
3. Committee on Standards and Practice Parameters, Apfelbaum JL, Connis RT, Nickinovich DG; American Society of Anesthesiologists Task Force on Preanesthesia Evaluation, Pasternak LR, Arens JF, Caplan RA, Connis RT, Fleisher LA, Flowerdew R, Gold BS, Mayhew JF, Nickinovich DG, Rice LJ, Roizen MF, Twersky RS. Practice advisory for preanesthesia evaluation: an updated report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation. Anesthesiology. 2012 Mar;116(3):522-38. doi: 10.1097/ALN.0b013e31823c1067. PubMed PMID: 22273990.
4. Bodin SG, Edwards AF, Roy RC. False confidences in preoperative pregnancy testing. Anesth Analg. 2010 Jan 1;110(1):256-7; author reply 257. doi: 10.1213/ANE.0b013e3181c07098. PubMed PMID: 20023186.
5. Palmer SK, Van Norman GA, Jackson SL. Routine pregnancy testing before elective anesthesia is not an American Society of Anesthesiologists standard. Anesth Analg. 2009 May;108(5):1715-6; author reply 1616. doi: 10.1213/ane.0b013e31819b34cf. PubMed PMID: 19372363.
6. Cole LA. New discoveries on the biology and detection of human chorionic gonadotropin. Reprod Biol Endocrinol. 2009 Jan 26;7:8. doi: 10.1186/1477-7827-7-8. Review. PubMed PMID: 19171054; PubMed Central PMCID: PMC2649930.
7. Wilcox AJ, Baird DD, Dunson D, McChesney R, Weinberg CR. Natural limits of pregnancy testing in relation to the expected menstrual period. JAMA. 2001 Oct 10;286(14):1759-61. Erratum in: JAMA 2002 Jan 9;287(2):192. PubMed PMID: 11594902.
8. Chard T. Pregnancy tests: a review. Hum Reprod. 1992 May;7(5):701-10. Review. PubMed PMID: 1639991.

Pennsylvania Patient Safety Authority and Pennsylvania Society of Anesthesiologists Take Aim at Wrong Site Nerve Blocks

by Donald E. Martin, M.D., Specialty Leadership Cabinet Representative

Wrong site surgery and wrong site nerve blocks are on the short list of so-called "never events". They should never happen – but they still do happen, and more often than we would like. Wrong site procedures constitute approximately 13% of all Sentinel Events reported to The Joint Commission in the last decade.

The Pennsylvania Patient Safety Authority (PPSA) began tracking reports of wrong site procedures in 2004. Figure 1 shows the number of wrong site procedures reported to PPSA by Pennsylvania healthcare providers each calendar quarter through 2015. Several organizations, including PPSA, then began a concentrated effort to combat wrong site procedures beginning in 2005 - 2006. You can see that the number of wrong side procedures did slowly but steadily decline from 2007 to 2014. However 2015, and especially the last quarter of 2015, recorded the greatest number of wrong site procedures since 2007. So, this problem is anything but solved.

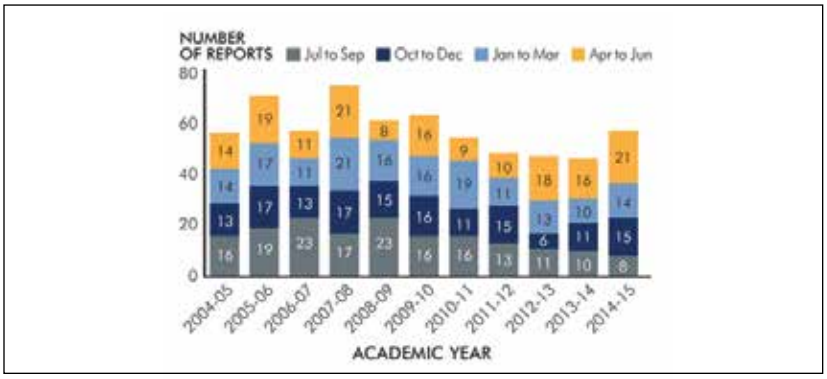


Figure 1 – Trend – Number of Wrong Site Procedures

Furthermore, this is not only a surgeon's problem. Since 2004, as shown in Figure 2, nerve blocks performed by anesthesiologists or surgeons made up 27% of all wrong site procedures in the PPSA database, and another 11% were chronic pain procedures. In addition, procedures performed at the wrong spinal level, some of which were chronic pain procedures, made up another 13% of the total. Therefore almost half of all wrong site procedures may have involved nerve blocks of some type.

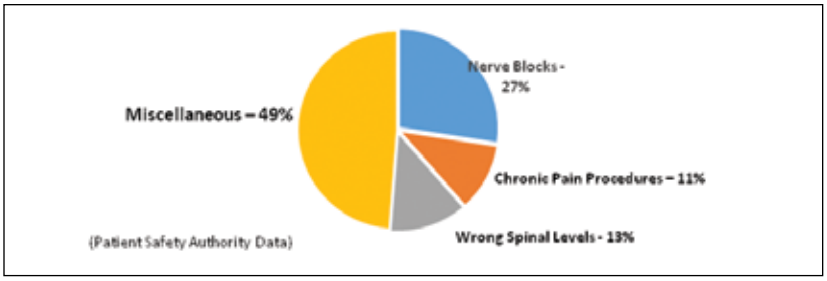


Figure 2 – Types of Wrong Site Procedures Since 2004

Perhaps even more striking, Hudson, Chelly, and Lichter reported in the British Journal of Anaesthesia in 2015 that the prevalence of wrong site nerve blocks at the University of Pittsburgh between 2002 and 2012 was 1.28/10,000 procedures, significantly higher than the prevalence of wrong site surgery. (Hudson ME, Chelly JE, Lichter JR: Wrong-Site Nerve Blocks: 10-Year Experience in a Large Multi-Hospital Health Care System. Br. J Anaesth 2015; 114:818-824), (Figure 3). One reason for this difference may be the fact that new and more rigorous

continued on page 21

To Be Like The Borg!

by Joseph F. Answine, M.D.

Remember the Borg, that alien race from Star Trek? The Borg are a collection of species turned into drones controlled by "the Collective". They are assimilated to think as one like mind. The Borg's ultimate goal is to achieve perfection by using the intelligence and skills of those they assimilate. Okay, we don't want to think (or not) like drones, and we don't want to necessarily be assimilated; however, it is my opinion that there are benefits to thinking and acting as one like mind and using our individual talents in a more coordinated manner.

Scenario 1: In a meeting with the hospital pharmacy, I plead my case for the necessity of IV acetaminophen for a multimodal pain management protocol. Study after study demonstrates that using a non-narcotic based, multi-drug and site-directed analgesic regimen reduces pain as well as medication-induced complications. The pharmacist states that the cost of this route of administration would negatively impact the pharmacy budget, therefore I was turned down.

Scenario 2: As a patient is getting a pre-op IV for his knee replacement, the anesthesiologist asks if his abnormal ECG had been evaluated. The patient answers, "Well, yes. I get echocardiograms frequently for my failing heart function. I had one a month ago. They said it was stable. Don't you have those records?" The anesthesiologist asks the preoperative nurse to see if she can obtain those records from the surgeon or primary care doctor. The surgeon obtains the records through a series of phone calls and the study does demonstrate a reduced but stable heart function. The surgery eventually proceeds after a prolonged delay with a change in anesthesia management based on the patient's health. The surgeon asks the anesthesiologist how a delay such as the one that just occurred can be avoided in the future.

Scenario 3: The anesthesiologist during the preoperative evaluation describes a regional technique commonly used for the intended procedure. The patient asks if that is something new because he never heard of it before nor was it discussed as he was being evaluated and scheduled for surgery. The patient eventually refused the technique, stating he just wasn't prepared for such an "unexpected" anesthesia plan.

Scenario 4: When going over the patient's long list of medications in the preoperative area, the anesthesiologist asks the patient which meds were taken that day. The patient states that she was somewhat confused as to what to take so she decided it was best not to take anything.

Scenario 5: The procedure was changed in the operating room due to some unexpected intraoperative findings, resulting in the decision to place a catheter for post-operative pain management. When the PACU nurse reported to the floor nurse, the floor nurse stated that "the floor" was not prepared for the utilization of such a catheter, and the patient was placed in the ICU overnight just for pain management.

Obviously, I could go on and on with examples of disconnects among the perioperative team, including the patients themselves, that lead to confusion, delays, unnecessary care and potential patient harm.

Currently, with each department having its own budget and therefore its own budgetary constraints, as well as our current fee-for-service payment model, the financial incentive to share time and resources isn't there. The potential patient benefit of doing so isn't ignored by those involved; however the age-old idea that if we all do our part to the best of our abilities, all will be well in the end.

For the most part, outcomes have been reasonable and acceptable when thinking this way. Why? Because, we don't know what we don't know. Until we actually realize the benefits, whether financially, in improved efficiency, and/or in better

continued on page 21

PATIENT SAFETY AUTHORITY AND PSA TAKE AIM

continued from page 19

procedures designed to prevent wrong site surgery were implemented in the operating room much earlier than on many nerve block or acute pain services.

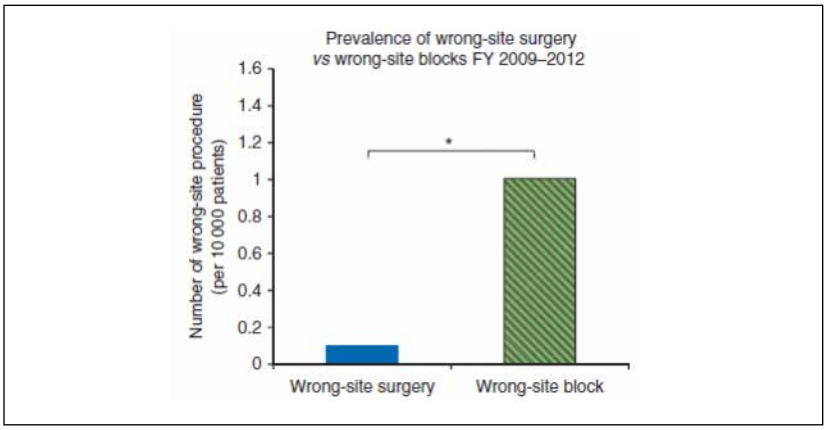


Figure 3 – Relative Prevalence – Wrong Site Surgery and Nerve Blocks

The PPSA has an extensive array of online resources for individual physicians and hospitals to use to help prevent wrong site procedures, including:

- Principles for Reliable Performance of Correct Site Surgery
- Toolbox of Four Wrong Site Surgery Prevention Tools
- Wrong Site Surgery Prevention Compliance Monitoring Tool
- For Surgeons' Offices: What You Can Do to Prevent Wrong Site Surgery

In addition, several resources have been developed for anesthesiologists specifically:

- Self-Assessment Checklist for Program Elements Associated with Preventing Wrong Site Anesthesia
- Wrong side Anesthesia Prevention Observational Monitoring Tool
- Anesthesia Timeouts – Why Are They Necessary?

This year the PSA and PPSA have joined forces to update and focus the processes to prevent wrong site nerve blocks and to develop further online and in-person consultation and educational networks for hospitals and physicians seeking to do more to eliminate this rare but serious problem.

This project is being led by a Project Management Team including Dr. Theresa Arnold, Manager of Clinical Analysis, PPSA; Ellen Deutsch, M.D., Medical Director for PPSA; Christina Hunt, Director of Collaborative Programs for PPSA; and Bob Yonash, Patient Safety Liaison for PPSA in the southwest region of Pennsylvania. Joshua Atkins M.D., PhD, is head of the effort for the PSA, working with Don Martin, M.D., both from the PSA Board.

The effectiveness of the effort will depend on the knowledge and the practical experience of an Expert Task Force appointed in September of 2015, and representing some of the major regional anesthesia and acute and chronic pain centers in the state, including:

- Nabil Elkassabany, M.D. University of Pennsylvania (acute pain)
- Joseph Galassi, M.D., Lehigh Valley Health System (acute pain)
- Arjunan Ganesh, M.B.B.S. F.R.C.S., Children's Hospital of Philadelphia and University of Pennsylvania (acute pain)
- Vitaly Gordin, M.D., Penn State Hershey (chronic pain)
- Kristin Ondecko-Ligda, M.D., University of Pittsburgh (acute pain)
- Kiernan Slevin, B.Ch., M.B., private practice affiliated with the University of Pennsylvania (chronic pain), and
- Mark Taylor, M.D., Allegheny Health System (acute pain)

This initiative was presented by Dr. Martin at the Specialty Leadership Cabinet meeting of the Pennsylvania Medical Society on February 9, and will be an effective resource available in 2016–2017 to help to make wrong site nerve blocks, as they should be, truly, "never events".

BE LIKE THE BORG

continued from page 20

outcomes, it will be difficult to convince ourselves to put the time and effort into the implementation of more coordinated care. Our hands may soon be forced by the institution of payment bundling. It is inevitable. The increasing amount of outcome data and the interest of payers, whether private or government, in that data, will demand that we seek out input from "the Collective".

"The Unofficial Handbook for Resident Involvement"

by Robert S. Schoaps, M.D., Secretary, PSA Resident Component, Penn State Hershey Medical Center

A recurring theme many of us in the PSA Resident Component hear from our colleagues is a desire to "get involved" without knowing where to start. At first glance, getting involved as a resident on a national or even state level may seem out of reach, but there is a plethora of opportunities for resident involvement on various levels.

Running for an officer position in the PSA Resident Component (PSARC) is one way to get directly involved on a statewide level. The PSARC is a committee composed of resident delegates from each of the seven residency programs in the Commonwealth, and serves as the liaison between those programs and the PSA. To be appointed as your program's PSA resident delegate, start by expressing interest to your program director. Each year prior to the ASA's Annual Meeting, the PSARC elects two new officer positions, President-Elect and Secretary. The President-Elect is a two-year position, serving the following year as President. As an officer in the PSARC, you are expected to attend PSA meetings in Harrisburg biannually to represent the residents across the Commonwealth, and attend the ASA National meeting each fall as one of Pennsylvania's delegates to the ASA Resident Component. Travel reimbursement is supplied by PSA for attendance at each meeting. A full list of officer responsibilities can be found in the Member's Section at http://www.psanes.org.

Another way to get involved with PSA is through contribution to the Sentinel newsletter. The Sentinel is published quarterly and is open to contribution from all PSA members, including residents. The ASA's national newsletter, the Monitor, has a dedicated "Residents Review" section as well and is open to submissions from any resident member of the ASA. Although any topic is welcome for either publication, resident-authored CME review articles of high-yield clinical topics are highly sought after—and make great additions to your CV!

On a national level, there are a large number of opportunities for resident involvement with a broad range of associated commitment. The ASA also has a Resident Component (ASARC) which meets annually at the national meeting; the ASARC is composed of delegates appointed by each state society and is overseen by the Governing Council, a group of officers elected each year by the voting delegates. To be appointed as a Pennsylvania delegate to the ASA, start by expressing interest in the position to your program director. Every national officer position is elected by the delegacy at the national meeting and is open to any resident in good standing with at least 18 months remaining in their residency. Executive Committee positions can be competitive, as are the Delegates to the AMA, so be prepared to campaign prior to the Annual Meeting if you are interested in pursuing them! A full listing of responsibilities for each position is available on the ASA Resident Component website.

Appointment to ASA subcommittees is an excellent (and often overlooked) opportunity for resident involvement in a specific area of anesthesiology. There are more than 70 ASA Subcommittees, covering all the anesthesia subspecialties as well as various topics ranging from Rural Access to Anesthesia Care to Uniformed Services and Veterans Affairs. Each committee has its own requirements for appointment, but the complete list of ASA subcommittees as well as how to apply can be found at http://www.asahq.org/about-asa/governance-and-committees/asa-committees.

A rapidly growing area of resident involvement is in advocacy for our specialty and for the physician-led care team model. One of the easiest ways to get involved in advocacy is

spreading the word on a local level. Helping to keep your fellow residents informed about advocacy topics, encouraging enrollment in the Grass Roots Newsletter program, and working to achieve 100% contribution to ASAPAC are just a few ways to boost involvement in advocacy. Attending the annual Legislative Conference in Washington, D.C. is also an excellent opportunity for advocacy and affords residents the opportunity to sit down with national policymakers face-to-face to discuss issues vital to our specialty. PSA provides travel reimbursement for attendance of the Legislative Conference, and more information can be found at https://www.asahq.org/.

An emerging opportunity for formal policy and advocacy training exists in the ASA Policy Research Rotation in Political Affairs. This rotation is approved by the ABA to count for residency credit and involves working directly under the ASA's Director of Congressional and Political Affairs in Washington, D.C. ASA provides a stipend for living expenses, but the deadline for the coming year's application is April 15, so visit the ASA's website for the Policy Research Rotation now for more information!

The ASA Practice Management Conference offers practical training in the transition from residency to practice and the nonclinical responsibilities encountered during that transition. Attendance is recommended for upper-level residents (CA-2 and CA-3) and fellows as they prepare for graduation, so be on the lookout for registration deadlines for the 2017 session next winter.

For more opportunities for involvement with ASA, visit http://www.asahq.org/about-asa/component-societies/asa-resident-component/get-involved.

Welcome New PSA Members

Effective November 4, 2015 – February 18, 2016

ACTIVE

Sarat Allanku, MD

Andrew Beyzman, MD

Nitin Chopra, MD

Michael S. Marcus, MD

George A. Pepe, DO

RESIDENT

Sanshalee Zenobia McKay Mathews

Christopher Lam, MD

Save the Dates!

ASA Legislative Conference
May 16-18, 2016
Hyatt Regency Capitol Hill
Washington, D.C.

ASA Annual Meeting
October 22-26, 2016
McCormick Place
Chicago, IL

PSA Annual Membership Luncheon
October 22, 2016
TBD
Chicago, IL

Operation Walk in Havana Cuba

by Jonathan Weiss, D.O.

In the late 1980s, as a first-year anesthesia resident at Thomas Jefferson University Hospital, I became interested in volunteer medical work. The residents were asked to collect unused IV start kits for an attending who was going on a mission with Operation Smile. This opened my eyes to medical missionary work, and I knew that after I completed my residency I wanted to try to get involved in any way possible.

My first opportunity came in 1994, when I traveled to China with Operation Smile. I will never forget the excitement and sense of fulfillment I had on and after that first mission. After four Operation Smile missions, one trip with Orbis, and one trip with Healing the Children, I learned about a group called Operation Walk.

Operation Walk was founded in 1995 by Dr. Lawrence Dorr, a leading joint replacement surgeon in Los Angeles, CA. The mission of the organization is to provide total knee and hip replacement surgery to patients in the US, and developing countries, who would otherwise be unable to receive such procedures. Over the years, the organization has grown to include 14 chapters across the United States. Each chapter independently organizes, raises money for, and staffs trips throughout the world.

In November, 2015, I participated in my third Operation Walk mission, in Havana, Cuba, with a group of 70 people, including surgeons, anesthesiologists, nurses, surgical techs, physical therapists, implant reps, and many other volunteers. We spent the week at Cimeq Hospital in Havana where we screened 75 patients, and operated on 53. During the course of the year, the hospital otherwise only performs 30 joint replacements on their own.

Dr. Weiss (center) and Tampa orthopedic surgeon Ken Gutske M.D. (left) with members of the Operation Walk preop team at Cimeq Hospital, Havana, Cuba.

To maximize our efficiency, all of the surgical and anesthesia equipment, medication, and prostheses, were delivered prior to our arrival in Havana. Local physicians spent months screening and choosing patients that we would later evaluate as potential surgical candidates.

On our first OR day, we arrived at the hospital early, and were given a quick tour. We then broke up into five groups, each consisting of an anesthesiologist, two orthopedic surgeons, a nurse, and an interpreter, and spent the morning evaluating patients. Patients were carefully assessed medically and surgically, including their previously obtained imaging studies. Anesthesiologists took medical histories and performed routine pre-op physical examinations. Fortunately, many of the patients with significant cardiac disease brought stress test and echocardiogram results with them. Each patient was then scored on a scale of 1 to 3 by the surgeons and the anesthesiologist. Medically, a score of 1 was equivalent to an ASA 1 or 2, a score of 2 was equivalent to an ASA 3, and a score of 3 was equivalent to an ASA 4. Anyone assigned as a score of 3, was automatically excluded from having surgery that week. Surgeons evaluated

patients, and categorized them based on surgical complexity.

After screening was completed, the groups reconvened, and each team presented on the patients they evaluated, so that the entire group could discuss them together. Patients were excluded for medical reasons, the complexity of their surgical cases, and even due to unavailability of an appropriately sized joint. A schedule for the week was created, we divided into four surgical teams, and each of the four operating rooms performed one joint replacement surgery that afternoon.

Dr. Weiss taking a break from providing anesthesia care.

Over the next three days, we performed an average of four surgeries, either a bilateral knee, unilateral knee, or total hip, per day in each room. Every patient received a spinal anesthetic. We had hyperbaric and isobaric bupivicaine as our choice of local anesthetic. Each OR had an anesthesia machine that was a bit outdated, and fortunately, only one patient required a general anesthetic. We always had a local anesthesiologist and resident to assist us with translation and patient care. It was very helpful to have the local physicians by our side, and we all benefited from exchange of ideas and teaching. In an attempt to simplify postoperative management and avoid postoperative complications, pain management was limited to an intra-articular injection of a combination of morphine, bupivicaine and ketorolac prior to closure. No peripheral nerve blocks or epidurals were used as is typically done in the United States. Despite this, patients appeared remarkably comfortable postoperatively otherwise receiving only post-op narcotics. After discharge from the PACU, patients were cared for in wards with an average of 4 to 6 patients per room. Operation Walk nurses provided post-op care during the day and early evening, with local nurses present overnight. Physical therapist began working with patients immediately after surgery, and all patients were ambulating the following day.

Dr. Weiss (right) and Tampa orthopedic surgeon Ken Gustke, M.D. (left) with Carmen.

One of the more memorable patients I cared for was a woman named Carmen, a 45-year-old pharmacist I first met on screening day. She had a wonderful smile and told me that she had been experiencing progressively worsening right hip pain for the past 10 years. She worked in a clinic in Varada,

continued on page 26

EXCERPTS FROM ASA

continued from page 6

on pause for the last 2.5 years. Seriously, we stopped it by going to our friends on Capitol Hill and getting 90 of them to send letters of disapproval to the VA's leadership.

So on this reality alone, let's cast political correctness aside and analyze the facts honestly. The 10-20% among us who have given generously to the ASAPAC over the last 10-15 years have undeniably fostered the building of influential relationships that make it so much more likely that politicians will listen to our concerns…So what is the counterpoint? The 80% who do not give likely did nothing to help the ASA's interruption of implementation of the APRN Consensus Model within the VA. So once again, apathy, complacency and not giving your fair share of time and money can readily be argued as not being part of the solution. As is so often the case in life, no action on a worthy cause is action against it.

PRESIDENT'S MESSAGE

continued from page 1

cost is minimal; slightly greater than $41 for the process and confirmation takes as little as two weeks. Once completed, it doesn't have to be repeated for five years.

Speaking of children, we should join our pediatric colleagues and assure that as many children as possible are immunized against transmissible diseases. Despite our beliefs in the politics of immunization, the simplest means of preventing disease is to immunize against them. Early in the 20th century, the most common cause of childhood mortality were the triad of diphtheria, pertussis, and tetanus. Pertussis has made quite a comeback in Pennsylvania due to loss of herd immunity. Many of us in our 40s, 50s, and 60s lost our immunity to these diseases years ago. PSA members should help protect our children by encouraging early immunization of children in lockstep with our pediatric colleagues.

The ethics of drug shortages have finally made it to the halls of the State House and our Congress. Egregious increases in common medication prices have made many of our practices more challenging. Dr. Campbell and colleagues of Physicians Against Drug Shortages have awakened a number of legislators as to how this is affecting patient care and our practices. If we were to arbitrarily raise our fees, the public and the insurers would be enraged and would refuse to pay for our services. How do drug companies get away with this? We need to unite to prevent further behaviors that are no less than price gouging.

Finally, we are leaders in the House of Medicine. By helping our constituents maintain their health, assure access to care (97% of hospitals in the Commonwealth have physician anesthesiologists) prevent child abuse and abuse of prescription medications, we will guide the way to a brighter future in health care.

OPERATION WALK IN HAVANA

continued from page 24

Cuba, and had been finding it more and more difficult to walk up and down multiple flights of stairs each day. Because she only earned about $150 per month, she could never afford to have her hip replaced on her own. She travelled about two hours to have us take care of her. I was happy to be her anesthesiologist. When I went to find her on her first post-op day, she was up and moving around, and was excited to tell me that she had gotten out of bed, with a walker, only hours after her surgery. The following morning, she was able to walk using crutches. She was so appreciative and thankful to have received her new hip, and relieved to be able to walk with less pain than she had in years.

I was lucky to be able to witness the first steps of many of my patients, and will never forget the smiles on their faces as they realized that they were moving with so much less pain. At the end of the week, we were rewarded with a view of all of the patients as they walked down the hall for a group picture with our team. I am extremely fortunate to have been able to participate in the delivery of this much needed care. Being a part of this surgical team has allowed me to focus on providing medical and surgical care in the purest sense, and has reminded me of the reason I became a physician, and that is simply to be able to deliver care from one person to another.

For anyone interested in exploring volunteer work, the following websites offer opportunities:

www.opwalkUSA.com
www.orbis.org
www.healingthechildren.org
www.operationsmile.org

PRACTICE Challenges

by Mark F. Weiss, J.D.

The Disruptive Physician – You Know Who! (He/She Works For You)

When you think of a medical group failing, you often think that a competitor crushed them. That's sometimes what happens. But often the rot started from within — a disruptive or megalomaniacal or bad-mouthing group member. Benjamin Franklin is said to have quipped that house guests and fish smell after three days. Crappy group members stink a lot faster than that.

Sure, it's all PC to "counsel" these guys. To tell them how much you love them if only they will toe the line and be good boys or girls and get along with everyone while singing Kumbaya. Go ahead, try it once. But after that, realize that these people just can't help themselves. In your group they are a rot that will spread. In some other setting they may be perfectly happy, highly productive, good citizens. Do them a favor and get them started on their journey to find their perfect spot: it is somewhere else. Fire them.

The corollary is that you must make certain that your group's contracts, your employment agreement, partnership agreement or other applicable agreements, create the ability to save your group from this rot.

Does Your Employment Contract Have Teeth?

Your practice has worked hard to expand to a second location or a third or a fourth.

But what happens when one of the members of your group who is assigned to work at different sites, acts out on his or her bias against working at a particular location, perhaps by showing up late, or by making untoward comments to the staff, or by engaging in some other type of disruptive behavior?

The answer, of course, is that slowly but surely it begins to destroy your business opportunities. An anesthesiologist showing up late at a surgery center can be the beginning of the end of your group's entire relationship with that facility.

Certainly, there are personnel, management, and contractual issues involved. But on the purely contractual side, your practice's employment agreement or subcontract agreement with physicians must either delineate level of service expectations or make reference to policies and procedures that must be complied with. And your group must have "teeth" to enforce compliance as well as the will to do so.

Practices fall apart from the inside more often than most realize.

Take the time to analyze the contractual protections your group has developed, or hasn't developed, now, before you need to start looking at what you can enforce.

Contracts Don't Contain Extra Baggage

Imagine that you are an engineer packing a space vehicle for flight. You'd include what you'd intend to be used and toss in some backups – but you certainly wouldn't include anything that won't be required.

The same rule holds true with provisions in contracts, from seemingly simple employment agreements to inch-plus, thick exclusive contracts.

No matter what the other negotiator says, no matter how lovingly she explains that section such-and-such is simply "corporate policy," and no matter how wonderful your relationship with her ("She'd never screw the group over, we've known her for years!"), each provision in an agreement is a tool that's intended to be used.

For your safety, consider the phrase "intended to be used" as including "against you." Just as in packing for a space flight, there is no extra baggage in that contract.

About the Author: *Mark F. Weiss is an attorney who specializes in the business and legal issues affecting physicians and physician groups on a national basis. He served as a clinical assistant professor of anesthesiology at USC Keck School of Medicine and practices with The Mark F. Weiss Law Firm, a firm with offices in Dallas, Texas and Los Angeles and Santa Barbara, California, representing clients across the country. He can be reached by email at markweiss@advisorylawgroup.com. Complimentary resources are available at advisorylawgroup.com.*

PENNSYLVANIA
society of
ANESTHESIOLOGISTS

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

Follow PSA on Facebook

To sign up for a new account, enter your name, birthday, gender and email address into the form at https://www.facebook.com. Then pick a password.

After you complete the sign up form, Facebook will send an email to the address you provided. Just click the confirmation link to complete the sign up process.

How do I follow PSA on Facebook?

First, sign in to your Facebook account. At the top of the screen, in the "Search for people, places, and things" box, type "**PA Society of Anesthesiologists**" and press "Enter." This will take you to the PSA Facebook page.

On the PSA Facebook page, click "Like" under the cover photo. Doing this will add you to the list of PSA followers, so to speak, and through your Facebook account, you will be alerted about any activity or updates made to the PSA Facebook page.

Follow PSA on Twitter

Visit https://twitter.com/signup to create a Twitter account.

Twitter will send a confirmation email to the address you entered on sign up. Click the link in that email to confirm your email address and account.

How do I follow PSA on Twitter?

First, sign in to your Twitter account. At the top of the screen, in the "Search" tab, type "**@PSAnesth**" and press "Enter." This will take you to the PSA Twitter page.

On the PSA Twitter page, click "Follow" under the cover photo. Doing this will add you to the list of PSA followers, so to speak, and through your Twitter account, you will see all of the new items posted by PSA.