Sentinel
Pennsylvania
Society of Anesthesiologists
Newsletter

Spring 2017

PRESIDENT'S MESSAGE

Change Is Blowing In The Wind

by Bhaskar Deb, M.D.
PSA President

"It is not the strongest of species that survive, nor the most intelligent, but the one most responsive to change."

Charles Darwin

The healthcare environment is evolving at such a rapid pace, that much of what I am writing may be outdated by the time you are reading this newsletter. I will attempt to summarize and meld our current state issues with what I heard at the 2017 ASA Practice Management Conference.

Issues haven't diminished, some have been put to rest for the time being, others have mushroomed, while some future issues are beginning to surface. One issue put to rest for now is the VHA Nursing Handbook update. Veterans WON! CRNAs will NOT be in VAs "full practice authority" or nurse only model of care initiative under the final rule. The rule became effective

January 13, 2017. Our grassroots campaign enabled us to successfully block independent CRNA practice. Thanks to the many of you who made this possible and for standing up and having your voice heard.

The mushroom cloud descending upon us now is balance billing ("surprise billing", out-of-network billing). This is serious.

This topic is unlike any topic ASA or physicians have engaged in previously. It is a top-tier issue and it is insurance-company driven. There is unprecedented coordination occurring between insurance companies, consumer groups, and labor. For our part, consumers must be made allies, and legislative solutions for insurers' inappropriate, or highly inadequate networks found. Nearly half of states considered legislation in 2016. Several states have been successful in crafting legislation or opposition.

Key points to consider are: 1) Medicare payment is not an appropriate benchmark for any specialty; 2) Benchmarking to a non-conflicted/independent database of billed charges within a specific geographic area for a specific service is the preferred approach; 3) Monitoring adequate networks for all providers and services is the key to solving the problem and; 4) Insurance companies should be held accountable for making payments based on real market values. The FAIR Health Database provides one good guide for payment options. PSA is currently working with the other hospital-based

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Richard O'Flynn, M.D., Editor

At the October ASA meeting, the incoming President, Jeffrey Plagenhoef, M.D. introduced the points that would frame his term as our leader. Breaking it down to the most basic tenets, the message was that a strong ASA is essential to the future of our specialty. He reminded those present that **we all wear the title "anesthesiologist" and therefore we all possess a shared and equal level of responsibility to advance our specialty and secure our future.**

This is true for the PSA as much as for the ASA. PSA represents all our members and is only as strong as our membership. As we have heard the famous quote from the Pogo comic, repeated numerous times, "we have met the enemy and he is us."

Apathy and complacency have no place in this if we expect our specialty to remain the leader in patient safety. Dr. Plagenhoef urged everyone to move past the concept of "political advocacy" replacing the thought with what he called "comprehensive advocacy". Similarly, he suggested that the concept of scope of practice issues are not political efforts, but patient safety and quality-of-care issues. For this reason, we need to have engaged members in the realm of patient safety and counter those who say that politics don't belong in our societies. **Scope of practice is not about politics, it is about patient safety.**

So, what are some of the issues facing our specialty?

The recent Veterans Administration ruling on the proposed policy change implementing independent CRNA practice was a "win" for our Veterans. This patient safety issue was directed by our ASA leadership. PSA District Director, Erin Sullivan, M.D. reports on this important advocacy win.

As I'm sure most are aware from reporting by numerous news agencies, there is a movement to ban out-of-network or surprise billings. This issue is being discussed at both the national and state level and would basically allow price fixing by insurance companies. That single issue alone could destroy private practice anesthesia. Dr. Martin provides an excellent historical review of the "33% Medicare problem" and how that is being used by multiple sources to inaccurately portray anesthesiologists as having the highest excess charges.

Dr. Plagenhoef closed by describing two possible future scenarios, a bright future and a not-so-bright future. The determining factor is never dependent on a single person, ASA staff, Board of Directors or House of Delegates, but depends on the involvement of every practicing anesthesiologist. Each of us need to become involved in "patient safety advocacy" and say "I take personal responsibility for the future of anesthesiology". Robert Schoaps, M.D., the PSA Resident Component President-Elect, takes this to heart encouraging his fellow residents

to get involved in political advocacy as an investment in their future.

The old norm of 20% of members carrying 100% of the load can no longer be tolerated. Every anesthesiologist has an obligation to our patients and specialty. It is time to realize that we can either show up in Washington and Harrisburg and have a voice in the future, or simply sit back and let others decide that future for us.

It is your call!

Also in this issue, Dr. Answine describes the tragedy of physician depression and suicide and thoughts on why this has come to be. The Continuing Education article by Drs. Eck and Green provides an interesting review of non-pharmacological and alternative therapies. Finally, Dr. Campbell describes the political process and the money involved in campaigning for office.

As always, we welcome your comments and encourage any submissions for consideration for publication. Send them to Richoflynn@psanes.org.

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specialties as well as with PAMED to develop cooperation amongst physicians. PSA is also interested in developing language for legislation regarding this topic. We must not allow the insurance industry to rein chaos on the House of Physicians and ultimately destroy it.

The recent Presidential election raised questions and concerns regarding uncertainty facing healthcare. What we do know: Donald Trump is the President, Congress and the Executive Branch are now in Republican control, there are 51-52/100 Senate Republicans (not enough to override a Democratic filibuster), and 236/435 House Republicans. HHS Secretary Dr. Tom Price, retired Orthopedic Surgeon and sponsor of the Empowering Patients First Act, a proposed GOP alternative to ACA, and CMS Administrator Seema Verma will head the Health Policy Team. ACA is at a crossroad—a wholesale immediate repeal or piecemeal change. Both strategies have numerous obstacles and pitfalls.

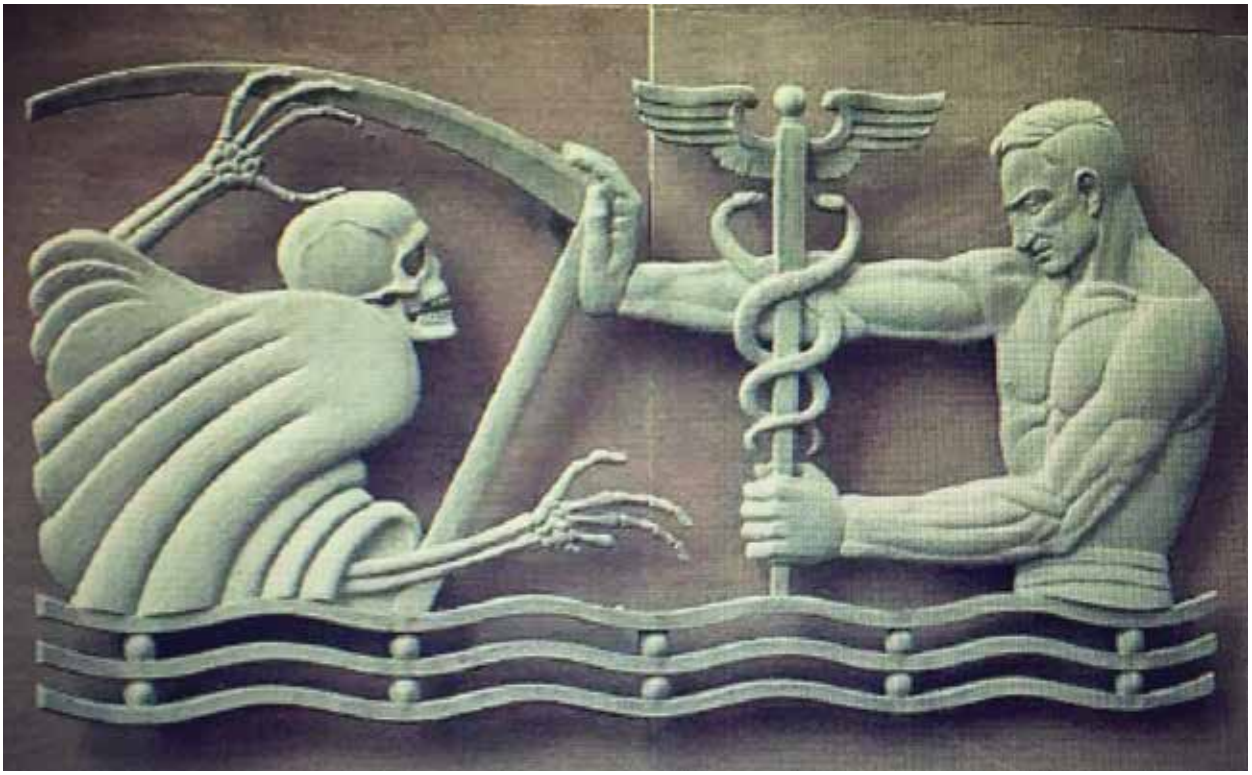
Most importantly, performance or quality-based incentives aimed at controlling healthcare costs were formulated by, and enjoyed overwhelming bicameral and bipartisan support. Therefore, it is unlikely that MACRA (MIPS/APM) will go away. Four key principles likely to guide GOP reform efforts will revolve around reducing federal entitlement spending, reducing federal government's role in healthcare, use free markets to provide sector competition, and promote transparency of cost and quality. We will be moving toward a patient-centric paradigm fueled by accessibility, affordability and reliability. To paraphrase Jeff Bezos, CEO of Amazon, "… If you are competitor focused, you tend to slack off when your benchmarks say that you're the best. But if your focus is on customers, you keep moving."

Finally, and briefly, Governor Wolf recently announced a proposed merger of DOH and HHS in his budget plan. This change will require passage by the General Assembly. The implications of this merger are impossible to speculate upon at this early hour. Be assured PSA already has it its eyes and ears open to regulatory changes affecting anesthesiologists that may arise as a consequence.

Adapt to coming changes. Stay involved with PSA, ASA, your workplace, community, and with your state legislators. Thank you.

"If you don't know where you are going, you will wind up somewhere else!"

Yogi Berra



2016 - The Most Successful ASA Grassroots Network Advocacy Year on Record

by Erin A. Sullivan, M.D.
ASA District IX Director
Chair, ASA Committee on Governmental Affairs

As a result of advocacy by more than 104,000 ASA members, Veterans and their families, the Department of Veterans Affairs amended a proposal that would mandate "independent" practice for all Advanced Practice Registered Nurses (APRNs), effectively abandoning the VA's proven model of physician-led team-based anesthesia care. The original VA APRN rule, otherwise known as the "VHA Nursing Handbook", granted independent practice to all APRNs, including nurse anesthetists. After an enormous outpouring of opposition, VA revised this plan in the Final Rule that was published in the Federal Register on December 14, 2016. The Final Rule specifically excludes nurse anesthetists and preserves the current model of the physician-led anesthesia care team.

Although the APRN rule was finalized in December, VA opened a new 30-day comment period in January to analyze whether any future action may be needed regarding access to anesthesia care. ASA solicited more than 25,000 comments regarding access through www.SafeVACare.org and in support of maintaining physician anesthesiologist-led care. Between the two comment periods, the voices of those supporting safe anesthesia care were clear and overwhelmingly strong.

ASA President, Jeffrey S. Plagenhoef, M.D., thanked all ASA members who took part in the Safe VA Care initiative. In a letter addressed to members he said, "Your participation, enthusiasm and record-breaking advocacy are a testament to the professionalism of this specialty, and I am honored to share in this achievement with you. Your commitment to advocacy on behalf of Veterans, all of our patients, and our profession is deeply appreciated. Numerous challenges lie before us, and I pledge my continued passionate, convicted leadership towards advancing our specialty and securing our future."

Here's a closer look at ASA Grassroots Network's 2016 highlights:

- Advocates representing all 50 states, Guam, Puerto Rico and the District of Columbia took action to preserve physician-led anesthesia care for Veterans by participating in the Protect Safe VA Care initiative.
- During the Department of Veterans Affairs (VA) 60-day public comment period on the APRN proposed rule, ASA members, along with their friends, family members, and colleagues, submitted more than 104,000 comments to the Federal Register against granting nurse anesthetists the authority to practice outside of the team-based model of care. This is 10 times the number of comments written in support of granting nurse anesthetists the authority to practice outside of the team-based model of care (9,613).
- More than 6,500 messages regarding VA's APRN proposed rule were sent to lawmakers by 2,159 ASA members.
- More than 140 members of Congress showed their support for Veterans by urging VA Secretary McDonald and Secretary for Health Shulkin to preserve VA's current policies included in the VHA Anesthesia Service Handbook.
- The ASA Legislative Conference, attended by more than 600 ASA members,

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The Days of the Iron Men

by Joseph Answine, M.D.

Years ago, during my training, a mentor of mine commonly would reminisce about the "days of the iron men"—a time when the doctor could work days and nights on end, rarely sleep, eat only when absolutely necessary, and stomp out sickness regardless of the extent of the malady. The body and mind of the physician were invincible; super-human.

I latched onto the idea, seeing myself as one of those ancient medical "gods". Furthermore, I frowned upon those that would let illness keep them from showing up in the morning or succumb to any form of psychological weakness. Outside stressors should be unable to penetrate our psyche. Physician burnout is absolute nonsense.

Yes, it was a rude awakening. I am not sure if it was the extreme depression or anxiety that I would feel when there was a poor outcome in the OR; or the realization that I was a potential danger to patients when I was suffering from a fever, light-headedness or pain. Regardless, I know now there are no iron men, iron women, or iron anything. Physicians are sufferers of all the same physical and psychological illnesses as "normal folks". Doctors have a high likelihood (in most cases higher than the general population) of depression, alcohol and drug abuse, poor marriages, and suicide. An article from 2000 entitled, "The Painful Truth: Physicians Are Not Invincible" described the suicide rate among physicians as greater than two times the rate of the general population (four times more for women), and the yearly numbers are the equivalent of one to two average-sized medical school classes. Can that be correct?

We need a couple medical school classes per year just to keep up with the attrition rate due to doctors killing themselves!

I have to believe that the increased stress since 2000 with changing payment models, HIPAA, all that comes with EMR, the institution of the ACA, and so on hasn't made the statistics any better. In fact, more recent studies show this to be true, and it may be under-estimated due to coroner reports of the deaths of colleagues as unintentional when likely they were. Furthermore, the odds of completing a suicide attempt are much higher for physicians because sadly, we are better at it due to our knowledge of drugs and the human body.

The same article reviewed studies that physicians are more likely to have traits of dependency, pessimism, passivity and self-doubt. Add in perfectionism, and an unforgiving attitude, and it becomes obvious that we are poised for self-destruction and the destruction of those around us. To throw gas on the impending fire, our colleagues, due to the same traits within themselves, are less likely to be forgiving of others' frailties and mistakes. Many times, I have heard an anesthesiologist describe a student, resident, or even partner as less-than-adequate because they "almost gave vecuronium instead of neostigmine" or even "gave ephedrine instead of phenylephrine when the heart rate was 99". Our over-critical nature of ourselves and our associates has led to an inability to admit, discuss and seek help for our health issues whether physical or psychological. So, we choose to brood, suffer silently, self-medicate, destroy our relationships and die instead.

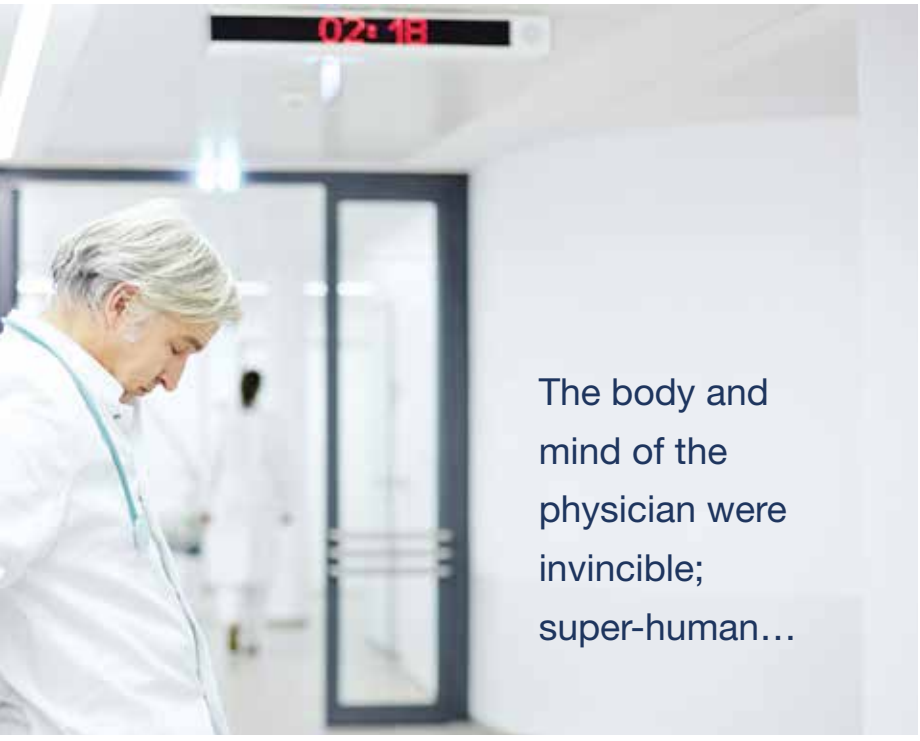
Days of Iron Men…a time when the doctor could work days and nights on end, rarely sleep, eat only when absolutely necessary

What can we do?

I don't think "hardening" ourselves to the suffering we are exposed to in medicine is adequate or even effective. First, we need to be less critical and more forgiving of ourselves and others around us. We need to be open to accepting and giving help when it is obviously needed, without judgment. We cannot turn a blind eye to those within our ranks in obvious need. There are signs of an increased understanding of this within training programs with the limiting of resident work hours and opening up better communication between trainees and instructors. Also, every state, whether through medical societies or government agencies, has programs for "impaired physicians".

Your first thought when faced with a colleague's near-miss or mistake is to think "I've done that". Accept the fact that the blood pressure dips to its lowest, the heart rate tanks and the patient chooses to move and spit out their airway device usually at the time a colleague enters the room; and they don't think less of you.

So, who was that individual that would reminisce about the days of the iron men? That was Michael T. Snider, MD, PhD. Although I may not agree with him about the once existence of iron men; he is a mentor, role model, scholar and exceptional physician. As an educator, he looked at those less than adequate as potential superstars and made them superstars. He taught me that perfect may be unachievable; accept failure; but strive to continue to learn and advance myself and others.



The body and mind of the physician were invincible; super-human…

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Amelia Fiastro, MD
Kathryn C. Hall, MD
Nicole M. Hollis, DO
Sanford Littwin, MD
Robert J. Lucking, MD
James Marco, MD
Maxim Novikov, MD
Manda C. Null, DO
Sara K. Pieren, MD
Adeola O. Sadik, MD

Residents

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Nidhi Agrawal, MD
Adekemi Akano, MD
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Anesthesiologist Charges and Our "Medicare 33% Problem" In the News

by Donald Martin, M.D.

Increasing healthcare costs and decreasing insurance coverage lead to higher patient out-of-pocket expenses and are extremely important to our patients and the general public. **Insurers have succeeded in characterizing the problem as one of "surprise balance billing", shifting the spotlight from lack of coverage to physician bills.**

Over the past month, the primary controversy regarding the level of physician charges has been in the press. Anesthesiologists have been central figures in this controversy because of a study published as a "research letter" in JAMA on January 17 ["Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region" by Ge Bai, PhD, CPA, and Gerard F. Anderson, PhD from the Johns Hopkins Carey Business School and Bloomberg School of Public Health]. Anesthesiologists should be familiar with this letter because of what the authors conclude and imply about our specialty and how the letter may be interpreted by patients.

This JAMA research letter compared medical specialties according to what the authors called each specialty's "excess charges". They defined "excess charges" as the ratio of "total charges divided by the total Medicare allowable amount". As most anesthesiologists would expect, this ratio was significantly higher for anesthesiology than for any other specialty. Anesthesiology's median charge-to-Medicare-payment-ratio was reported as 5.8, with the ratio for the next highest specialty, interventional radiology, being 4.5 and that for a majority of primary care specialties being 1.8 – 2.2. However, the conclusions reached by the authors of this letter are based on their assumption that Medicare is a reasonably equal benchmark for bills and payments across specialties. Drs. Bai and Anderson clearly state their basic premise that "to our knowledge, there is no study indicating that Medicare systematically underpays these specialties [including anesthesiology] compared with other specialties".

However, this basic premise is not supported by the facts. Beginning in the early 1990s, errors in the application of the RBRVS methodology to anesthesiology led to systematic underpayment for anesthesia services, as compared to both other medical specialties and to the managed-care contracted payment rates of the time. A Federal GAO report documented this underpayment by Medicare nationally. (GAO report to the Subcommittee on Health, Committee on Ways and Means, House of Representatives, MEDICARE PHYSICIAN PAYMENTS: Medicare and Private Payment Differences for Anesthesia Services GAO-07-463, July, 2007).

Similarly, claims data gathered by the Pennsylvania Society of Anesthesiologists (PSA) from within Pennsylvania between 2000 and 2003 consistently showed that anesthesiology payments by the state's Workers Compensation program (set by a 1994 law at **113% of the Medicare rate**) was on average only **51% of the average payment rates used by the 27 major managed-care insurers within Pennsylvania**. Furthermore, there was a high level of consistency in the level of anesthesia reimbursement among all of these 27 payers. Finally, the data also showed that for virtually all other specialties, the level of Medicare-based Worker's Compensation payments were at least within 90%, if not greater than 100%, of the level of payments in the managed-care market. Anesthesiology was the only specialty with significant, systematic, underpayment.

On December 4, 2004, the Pennsylvania Insurance Commission ruled that Medicare rates resulted in significant underpayment of the specialty of anesthesiology, and increased the reimbursement rate for anesthesiology by 63% for Pennsylvania's Medicare-based Workers Compensation program fee schedule. Their action supports the contention that the **Medicare payment rate represents only 30% - 50% of the managed care or average contracted payment for anesthesiologists**. At the same time, the Medicare rate is much closer to the average contracted rate for other specialties. This discrepancy has persisted until the present time. Therefore, Medicare payments cannot be used as a benchmark to reasonably compare anesthesiologist charges, or their "charge/Medicare rate ratio", to that of other specialties. Specifically, the facts do not justify the implications of Bai and Anderson's statement that "Physician excess charge was higher for specialties in which patients have fewer opportunities to choose a physician or be informed of the physician's network status (e.g., anesthesiology)". The primary reason for anesthesiologists' high charge/Medicare ratio lies in aberrancy of the denominator, not

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the numerator.

Multiple electronic and print publications have used data from the JAMA article, despite its limitations, to characterize anesthesiologists as having "excess charges" higher than any other specialty, and more than double those of primary care physicians.

Recent publications from such sources as the *Baltimore Sun*, CNN, and United Press International, have appeared to place blame on physicians in general, and anesthesiologists in particular, for unreasonably high charges. It is very likely that physician anesthesiologists may hear concerns, and receive questions regarding their charges, payments, and network status, from patients or their families. ASA President Jeffrey Plagenhoef, MD is responding directly to the JAMA letter, and the ASA Communications Office is responding to other articles in the popular press and social media, as are state medical societies and other medical specialties. One of the most effective responses that we have seen on social media in recent days is sponsored by the Texas Medical Association and is found at the link: https://youtu.be/8MbWYz7nZWo

PSA is working with the Pennsylvania Medical Society (PAMED) and other specialties including the four hospital-based specialties in our state to get more exposure for similar messages in the press and to solidify the positions of other physicians.

However, each of us as an individual anesthesiologist is in a good position to respond to inquiries from individual patients, and groups within our communities. Anesthesiologists need to reinforce information now beginning to appear in the press regarding what patients can do to make sure that their insurance coverage is adequate to cover their out-of-pocket expenses and includes a sufficient number of all medical specialists. We may even want to refer patients specifically to the higher-quality insurance companies with which we participate.

Numbers, Numbers, Numbers

by Robert Campbell, M.D.

For the 2016 Presidential campaign, Donald Trump garnered $247 million in hard money contributions and an additional $75 million in Super PAC money. Hillary Clinton, for all her efforts, collected $498 million in hard money campaign contributions and a whopping $206 million in Super PAC contributions in support of her unsuccessful campaign.

In the recent Pennsylvania Senate campaign, Senator Toomey won his race against challenger Katie McGinty with a stronger-than-anticipated margin. In the campaign funding sweepstakes, he leveraged his incumbency status to the tune of $32 million versus McGinty's donations totaling $16 million. The going rate for a Congressional campaign every two years is anywhere from $1M to $4M dollars depending on the competitiveness of the race.

Indeed, politicians are collecting unprecedented sums of money. Politicians want to get elected. Citizens want to have favorable laws and regulations governing their professional and personal lives. Government in the United States has grown over time and has an ever more pervasive influence on more and more of our activities. Regardless of whether one sees this as government tyranny or alternatively, the just role of a benevolent government in our society, one conclusion remains the same. **If you wish to have a say in the direction of government policy it is a necessary first step to become engaged with the government apparatus**. It turns out doctors are not so good at this kind of thing.

As a physician and anesthesiologist, it turns out that all of our "special privileges" to practice medicine is nothing more than a state-granted privilege. You see, the state has oversight to protect its citizens and has a fundamental domain over the regulation of all healthcare delivery in the state. Your degree and training and demonstration of specialized skills is a necessary but insufficient demonstration of qualification to be rendered authority by the state government to practice medicine. Without that authority from the state, you can do none of your professional activities. So, while doctors are relatively underrepresented and proportionately less engaged than the average citizen, it turns out we are disproportionately affected by the laws and regulations

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promulgated in Harrisburg by the Commonwealth of Pennsylvania.

So, state politics is very important to all practicing anesthesiologists. Here in Harrisburg, the political dollar numbers are thankfully smaller and more comprehensible than at the federal level. Governor Wolf had raised $2.5 million in 2016. In 2013 and 2014, respectively, he raised $13 million and $20 million. My State Senator Folmer raised $44,000, $24,000 and $36,000 over the last three years for his campaign war chest. My first-term Representative Ryan raised $71,000 for his 2016 campaign victory.

PSA is your representative organization in Harrisburg. Volunteer anesthesiologist board members govern the organization and all of its advocacy efforts. This strategy is formulated and executed by the volunteer Board of Directors and the professionals hired by our Society. Our lobbying group is the Quantum Communications team and our legal representation is Charles Artz of the firm, Artz McCarrie Health Law.

Our Political Action Committee, Z-PAC, is a separate entity from PSA with an independent Board of Directors. Z-PAC is responsible for collecting voluntary donations from our 2,124 PSA members. **The success of our specialty in the state is directly a result of the success of our advocacy efforts in Harrisburg**. We rely upon a wise and experienced volunteer Board of Directors, expertly-chosen motivated professional representation by our lobbyist and legal counsel, and lastly a well-funded PAC.

We will never be a big spender and command attention just because our PAC is so well-funded that politicians will be fearful to cross us. Fortunately, our success does not require that level of funding. As it turns out, our messaging in Harrisburg is consistently concise and our "ask" of politicians is consistently "the right thing to do." None the less, we need a strong PAC to make the case that our 2,124 members care enough to be engaged. **So, my message after all this is we do not have to be the biggest spenders, but we must show up with some political engagement. In politics today, engagement means PAC dollars**.

If you have never given to the PAC, then contribute $250 this year and every year. We will be excellent stewards of the contribution. If you feel you need to be engaged more meaningfully or if you are afraid of what Harrisburg politicians can do to your patients and your livelihood, then give $500 or $1,000. Doctors can no longer assume that just showing up with your degree is going to be enough. The state can inadvertently or intentionally (at the request of another Harrisburg stakeholder) dramatically impair our ability to deliver quality anesthesia care with reimbursement commensurate to the work and skills required to perform as well as we do. None of us want to see that happen. As the size and influence of our state government grows, the vital role of PSA grows.

PSA and Z-PAC are your institutions uniquely dedicated to serving you and your patients. I am hopeful the more you learn about PSA and Z-PAC, the more engaged you will become.

CONTINUING EDUCATION

Anesthesia Non-pharmacological and Alternative Therapies

by Philip O. Eck M.D., CA-3 Drexel University, Department of Anesthesia
Michael Green D.O., Chairman & Program Director, Drexel University, Department of Anesthesia

Anesthesia, as commonly practiced today, is a delicate art employing the effects of potent pharmacological agents. However, occasionally, the side-effect profiles and patient-related contraindications render these agents less desirable or non-viable for use. It is worth considering some non-conventional therapies otherwise perceived as shams, but which offer evidence-based alternatives and complements to the practice.

Hypnosis

A major objective of anesthesia is to induce 'hypnosis', a feat reliably and readily accomplished for centuries through pharmaceuticals. Yet, the notion of altering a patient's consciousness, sensation and behavior through verbal suggestion for surgical purposes is even older. 'Mesmeric anesthesia', as it was termed, was first validated for surgery (a mastoidectomy) in 1828, eighteen years before the first use of ether. It's most prolific use today is in Europe, as the sole or adjunct mode of anesthesia. Faymonville et. al. has recorded thousands of surgeries where general anesthesia was replaced by 'hypnosedation', complemented by local anesthesia and mild sedation[1]. The benefits are notable: avoidance of toxic pharmacological side effects, reductions in pre-operative anxiety, blood loss, overall post-surgical complications, post-op pain, drug dependence, recovery time and even mortality[1].

The neurophysiological basis of hypnosis is characterized by imaging studies of regional cerebral blood flow showing activation of occipital, parietal, precentral, prefrontal and cingulate cortices. Reduction in pain perception during hypnosis was specifically correlated with activity in the anterior cingulate cortex (ACC). Putatively, this region is involved in modulating the interaction between cognition, sensory perception and certain aspects of motor control[2].

The hypnotic process itself can be lengthy and involving. Before it begins, rapport and trust between hypnotist and subject is crucial for success. Prior to surgery, the subject is required to rehearse being induced into a trance several times, with detailed, specific suggestions surrounding the various events to occur peri-operatively. To improve recovery both physiologically and emotionally, the concept of the 'inner healer' has shown influence. Anecdotally, a kidney transplant patient who was rejecting her new organ despite immunosuppression, was hypnotized to believe: "this part is mine". She subsequently stopped rejecting the organ and lived off immunosuppression for more than 10 years. It is also beneficial to have the hypnotist themselves present in the OR, a role ideally but not necessarily played by the anesthesia provider[1].

Unfortunately, although there are hypnosis training courses available, there is a dearth of hypnotherapists with specific training in the surgery indication, resulting in the lack of education and use by hospital personnel. Another limitation of hypnosis is that most, but not all people, are hypnotizable. It is thought that about 60% of people can be hypnotized to some degree, with an additional 15% highly so[3]. Hypnosis is demonstrably a viable and satisfactory option for anesthesia for some patients. However, it requires planning, a multidisciplinary effort, and the right patient.

Music therapy

Music is an enjoyable form of entertainment associated with feelings of security, familiarity and predictability. Not surprisingly, it shows efficacy in anxiety and pain management in various clinical settings, even in patients that

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weakly respond or seem resistant to other conventional treatments[4]. The sense of well-being created by listening to music appears to improve patients' perception of treatment, subjectively reducing pain and anxiety, as well as objectively improving behavior and amount of required analgesia. Koch et. al.[5] in two randomized-controlled trials showed that awake patients undergoing urological procedures had reduced patient-controlled analgesia and sedative requirements when listening to music through headsets. A systematic review by Brandt et. al.[6] of randomized and quasi-randomized trials showed that music therapy improved anxiety by 5.72 units on average per the Stait-Trait Anxiety Inventory index, compared to standard care[6]. Physiologically, research has also shown that music therapy can improve respiration, blood pressure, cardiac output and muscle tension[4].

In terms of procedure, music therapy can involve simply listening to either live or recorded music prior to or during surgery. Conditioning however provides the best benefit, where the patient practices pairing the listening experience with deep relaxation and pleasant visual images[4]. Music therapists can be found in many hospital settings including surgical units, and can serve as useful auxiliary staff for anesthesiologists.

Aromatherapy

Synthetic volatile agents are a mainstay in induction and maintenance of anesthesia. However, the use of natural essential oils as volatile or topical agents is scarce, though evidence shows their potential efficacy as adjuncts. Lavender alone or in combination with other essential oils such as chamomile and orange has been shown to reduce pre-operative anxiety, induce sleep and maintain stable blood pressure during procedures such as dental surgery or cardiac stent insertion[7]. Both animal and clinical models have implicated the GABA inhibition pathway for this effect.

With respect to post-op nausea and vomiting (PONV), peppermint, ginger and cardamom have been shown to reduce requirement for antiemetic agents after ambulatory surgery and post-caesarean section. Peppermint alone is known for its antispasmodic effect during endoscopy[7].

There is less convincing evidence for use of aromatherapy for pain control but a reasonable 'distraction' hypothesis purports that environmental stimuli alone can reduce cognitive resources focusing on pain, thus reducing pain sensation. Ginger, lavender and mandarin orange essential oils have all been described to have some analgesic properties[7]. Given that certain patients are already culturally or anecdotally familiar with such naturopathics, it may be advantageous to include these in their anesthesia experience, even if only to maximize patient satisfaction.

The balanced, multimodal approach to anesthesia has gained favor over the years as a more comprehensive and safe method. Including non-pharmacological modalities such as hypnosis, music therapy and aromatherapy among others, may potentially extend the quality of our care and our patient' satisfaction.

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Legislative Update

by Kevin Harley, Quantum Communications

A New Legislative Session Begins

The Pennsylvania General Assembly has begun a new two-year session. The House and Senate members were sworn in on January 3rd with Republicans in control of both chambers with historic majorities.

The legislature returned for a few session days in February but the big event was Gov. Wolf's annual budget address that he delivered on February 7. The tone and substance of Gov. Wolf's speech was a marked departure from his previous two budget addresses where he proposed significant increases in spending and increasing the personal income and sales taxes.

This year Gov. Wolf took personal income and sales tax increases off the table and recommended a more modest spending increase of 3.2 percent. His plans call for a spending reduction of $2 billion to help close a projected $3 billion deficit.

As part of his cost-saving measures, the Governor has called for consolidating the departments of Health, Aging, Drug and Alcohol Programs and Department of Human Services to create a new Department of Health and Human Services. His proposal requires legislature approval and the leadership of the both the Senate and House have indicated that they are open to the consolidation.

Department of Health Review of Hospital Regulations

The Wolf Administration is continuing its review of potential changes to the Hospital Regulations as it relates to nurse anesthetists. PSA and Quantum have been extremely active in educating and lobbying the administration to keep the current regulation in place that requires supervision of the administration of anesthesia in hospitals by a physician.

PSA President Dr. Bhaskar Deb has written letters to Gov. Wolf, copying the entire legislature, and Secretary of Health of Karen Murphy detailing why the current regulation is working and why it is vitally important to patient-safety.

PSA's Dr. Don Martin and the Quantum staff have held meetings with DOH officials detailing the importance of physician-led anesthesia care. Our legal counsel has written the department explaining that the department lacks the constitutional and statutory authority to promulgate any regulation that expands CRNAs' scope of practice.

We are monitoring what impact the proposed merger of the Department of Health into the current Department of Human Services will have on the DOH review as well the timing of the release of the regulations.

Big Change to House Professional Licensure Committee

Speaker of the House Mike Turzai appointed Rep. Mark Mustio of Moon Township, Allegheny County, as the new chairman of the House Professional Licensure Committee, replacing longtime chair Rep. Julie Harhart, who retired.

Mustio was first elected to the House in 2003 in a special election. A 1979 graduate of Grove City College, he is the president of HHM Insurors, a home, auto and commercial insurance business based in Moon Township.

Rep. Mustio has a history of supporting anesthesiologists' issues and we are working closely with him to advance our agenda.

Supervision

We have been actively gaining co-sponsors in the House for the introduction of our "supervision" bill. The legislation places into the Medical Practice Act the Department of Health regulation that a physician must supervise

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The Importance of Ongoing Resident Advocacy

by Robert S. Schoaps, M.D.
PSA Resident Component President-Elect

Residency will be one of the most trying periods of your life as a physician. Between clinical duties, research endeavors, and a constant attempt to pursue a somewhat normal personal life, it often feels as though we are pulled in a dozen different directions. In these times of change and transition on the political landscape, it is more important than ever to bolster resident involvement in political advocacy for our role as physician anesthesiologists.

We recently witnessed what was arguably one of the greatest political victories in the history of the American Society of Anesthesiologists when the Society successfully defended our position as leaders in the peri-operative setting during the "Advanced Practice Registered Nurses Rule", formerly known as the "VHA Nurses Handbook" update. As a national society, we organized our membership to amass over 100,000 comments in response to a potential mandate for independent APRN practice. This ultimately prompted the Committee on Veterans' Affairs to amend the rule, effectively removing the portions of the new handbook which relate to anesthesia care. This was an enormous victory for our members, our specialty, but most importantly for our veterans and patients who are entitled to receive the highest level of care available.

This issue has unfortunately not been put to rest. The Committee on Veterans' Affairs opened an additional comment period in January to determine if further consideration on this matter is warranted, stating "VA's position to not include the CRNAs in this final rule does not stem from the CRNAs' inability to practice to the full extent of their professional competence, but rather from VA's lack of access problems in the area of anesthesiology." Rest assured, this issue will resurface in the future; this is a battle we will likely continue to fight for the entirety of our careers. With that in mind, I want to take this moment to urge you all to contribute to the ASAPAC for the 2016-2017 fiscal year. As your President-Elect, I would like to see the Commonwealth of Pennsylvania's Resident Delegacy reach a 100% contribution rate statewide. After all, the suggested resident contribution is only $20 annually, a meager price to pay for the support of the team tasked with ensuring the continued integrity of our careers.

I also want to take this moment to broach the topic of resident contributions to Z-PAC, the Political Action Committee of the Pennsylvania Society of Anesthesiologists. Z-PAC is a non-profit organization tasked with advocacy for our Colleagues in the Commonwealth on state legislative issues, including bills which could alter regulations regarding who may administer anesthesia in Pennsylvania and how different tiers of providers are defined. Z-PAC resident contributions have not been broadly encouraged in the past, but if each of us gave just $5 this year we could easily set a new precedent for resident support at the state level. For anyone currently administering anesthesia in the Commonwealth, this should be a no-brainer: such a small amount, when contributed by each resident in the state, could result in monumental strides for our specialty on these vital issues. For anyone planning to practice in Pennsylvania after residency, there really is no acceptable excuse for neglecting to invest in our futures through a contribution to Z-PAC.

Finally, I would like to encourage my fellow Pennsylvania residents to make every effort to attend two events over the coming months. The first is the PSA's biannual Board of Directors Meeting on March 18 in Harrisburg, where all residents are welcome to attend and have their voice heard by the Board of Directors for the PSA. The second is the ASA Legislative Conference

in Washington, D.C. It takes place May 15-17, and if you have ever had any doubt about why you should get involved in advocacy for physician-led anesthesia or felt like your ASAPAC dollars don't really make a difference, I implore you to make every effort to attend. Given our proximity to the D.C. area, there is no reason we can't have at least one resident from each program in the Commonwealth in attendance. I assure you, after you have walked the halls of our nation's Capitol, and met with our elected leaders and their teams to discuss our issues, you will understand what a monumental undertaking it is, and finally understand why we must continue to make our voice heard.

The PSA has allocated a fund for travel reimbursement for residents to both the Board Meeting and the Legislative Conference, so please contact myself (rschoaps@hmc.psu.edu) or one of the other Resident Component Officers for further information!

2016 Most Successful ASA Grassroots

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concluded with more than 270 Congressional visits.

- The ASA Key Contacts Program grew by 21.47% percent, from 503 at the start of the year to 611 contacts at the end of 2016. This includes 381 unique contacts and 357 congressional offices with at least one key contact.

These are just some of the actions taken by the ASA Grassroots Network in 2016 that continue to prove that our members are closely involved and engaged on political, legislative, and regulatory affairs impacting the future of the specialty.

Thank you again for all of your efforts throughout 2016! We could not have achieved such great results without advocates like you who continue to show perseverance and dedication to your patients and the specialty. We anticipate the new challenges and opportunities that will present themselves with the start of the 115th Congress, and look forward to working together to create another year of strong advocacy and success.

Access to Anesthesia Care Is Not Improved When States Eliminate Physician Supervision, Study Finds

Patient access to anesthesia care for seven common surgical procedures is not increased when states "opt-out" of the Medicare rule that requires anesthesia to be administered with physician supervision, reports a study published in the Online First edition of Anesthesiology, the peer-reviewed medical journal of the American Society of Anesthesiologists (ASA). The study showed that "opt-out" states did not experience a reduction in the distance patients were required to travel for their procedure — a common measure used to gauge access to care.

"The assertion is that by opting-out of the federal rule requiring physician supervision, the pool of potential anesthesia providers will be expanded, and patients will not have to travel as far for procedures, surgery or anesthesia care," said Eric Sun, M.D., Ph.D., study author and assistant professor of anesthesiology, Peri-operative and Pain Medicine at Stanford University Medical Center, Stanford, California. "It would be advantageous to decrease the distance patients must travel for surgery and anesthesia care, especially older patients, but our research is showing that 'opting-out' may not be accomplishing this goal."

Since 2001, 17 state governors exercised the option to "opt-out" of the federal rule that physicians supervise the administration of anesthesia by nurse anesthetists, citing increased access to anesthesia care as the rationale for the decision. However, until the current study, and a previous paper published by the same researchers in February 2016 that found a lower growth in anesthesia cases in "opt-out" states versus non-opt-out states, no research had looked at whether opting-out of the federal rule achieved improved access.

In the study, researchers used Medicare administrative claims data from more than 1.1 million cases to determine the distance Medicare patients traveled for five common elective procedures: total knee replacement, total hip replacement, cataract surgery, colonoscopy/ sigmoidoscopy, and esophagogastroduodenoscopy, as well as two common urgent procedures for which timely access to care is important: appendectomy and hip fracture repair. Procedures were performed between 1999 and 2011. Access to anesthesia care was measured by the percentage of patients who had to travel outside of their residential zip code for their procedure, and the average distance these patients traveled (variances in land area for each zip code were adjusted). Researchers examined distance traveled for these procedures before and after the decision to "opt-out" in "opt out" states. To rule out more general changes in travel distance (for example, due to trends in hospital closures occurring nationally), the researchers compared these changes to changes in the distances traveled for patients in non-opt-out states.

There was no reduction in the percentage of patients who traveled outside of their residential zip code for the seven procedures examined in "opt-out" states, except for total hip replacement (2 percentage point reduction). However, the authors note that since more than 80 percent of total hip replacement patients traveled outside their residential zip code, this effect is of little practical significance. For those who did travel outside of their zip code, "opt out" had no significant effect on the distance traveled.

"Patients in 'opt-out' states were no less likely to avoid traveling further distances to undergo

these common procedures, than those in non-opt-out states," said Dr. Sun. "By looking at distance traveled as a measure of access, we're adding to the body of literature that increasingly shows 'opt-out' is unlikely to be a silver bullet when it comes to improving access to care."

The study, "Opt Out and Access to Anesthesia Care for Elective and Urgent Surgeries Among U.S. Medicare Beneficiaries," was funded by a Mentored Research Training Grant from the Foundation for Anesthesia Education and Research (FAER).

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THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS

Founded in 1905, the American Society of Anesthesiologists (ASA) is an educational, research and scientific society with more than 52,000 members organized to raise and maintain the standards of the medical practice of anesthesiology. ASA is committed to ensuring that physician anesthesiologists evaluate and supervise the medical care of patients before, during, and after surgery to provide the highest quality and safest care that every patient deserves.

For more information on the field of anesthesiology, visit the American Society of Anesthesiologists online at asahq.org. To learn more about the role physician anesthesiologists play in ensuring patient safety, visit asahq.org/WhenSecondsCount.

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Legislative Update
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the administration of anesthesia. We are educating legislators that the bill is particularly timely and we need this regulation codified in light of the Wolf Administration's possible changes to the regulation.

Rep. Jim Christina of Beaver County is the prime sponsor in House and we are working to have companion legislation introduced in the Senate for the first time.

Balance Billing

The PSA Executive Committee, PSA Insurance Committee and Quantum are actively working on the issue of out-of-network payment or balance billing. Often referred to as "surprise" balance billing, the issue has received national media attention and is the on the minds of members of the General Assembly who have received complaints from their constituents.

We have had numerous meetings with other medical specialty practices and members of the Senate and House. We are working with Sen. Tom Killion of Delaware County and others to craft a legislative solution that addresses the needs of anesthesiologists and also protects consumers.

CRNA Titling

As they have done every session, the nurse anesthetists again introduced their titling bill. We are actively opposed to their bill this session because, like previous version of the bill, this version fails to clearly define scope of practice and supervision.

Dr. Deb wrote a letter to all Senate Professional Licensure and Consumers Affairs Committee members stating PSA's opposition but noting that PSA is open to supporting the titling bill if it was amended to include scope of practice and proper supervision provisions.

Nurse Independent Practice

The nurses' lobby is back this session with legislation to give independent practice to nurse practitioners. Their bill does not include CRNAs. Last session the Senate passed their bill but it never came up for a vote in the House Professional Licensure Committee.

Advocacy

The Pennsylvania Society of Anesthesiologists has an aggressive legislative agenda. Your personal relationships with the members of the General Assembly are our most effective lobbying tool. You are the expert. We want them to turn to you for advice on issues of anesthesia and other healthcare polices. Please take the time to schedule a meeting with your Representative and Senator.

If you need help making an appointment with your Senator or Representative please call us at 717-213-4955 and we will help schedule a meeting.