



PRESIDENT'S MESSAGE

In Business and Politics, Communication is a Two-Way Street

by Margaret M. Tarpey, M.D., President

"What we've got here is failure to communicate." From the 1967 movie, Cool Hand Luke.

It appears that failure to communicate is an endemic condition in our society. Our current generalized discontent (disgust?) with government, regardless of political affiliation, stems in large part from an unwillingness to listen to one another. We seem to be continually shouting at each other, believing that if we just talk louder, the "other side" will either suddenly **a.)** agree with our position or **b.)** disappear. I think we can all agree that neither option is realistic.

Successful communication does not demand that groups come to complete agreement with each other. However, it does involve the accurate exchange of information. To communicate successfully requires that both parties actively participate. Communication compels that the message be transmitted in a way that can be understood. However, if one group

does not hear what the other has to say, transfer of information will not occur. Without both parts of this equation, effective transmission of information and accurate comprehension of the message, communication doesn't happen.

Why is communication important? Effective communication is critical to our ability to take care of patients. For example, the effects of poor communication during transfers of care have been well documented. Misunderstandings between members of the OR team can also easily lead to disastrous consequences.

But at its most basic level, communication is the means by which we function as a civilization. The interchange of ideas and information between individuals leads to further development and refinement of these processes. This activity has resulted in the phenomenal developments in medicine and science that we see today. Without communication, each person truly is an island.

Our elected leaders and those who aspire to be elected all have numerous methods of sharing their views on various topics, including newsletters, web pages, Twitter and Facebook accounts. You can let them know what you think of their opinions by e-mail, snail mail, phone, or fax. While voting for the candidate of your choice is the most critical method of communication, remember that financial support of the candidates that support your positions is also crucial. This can be achieved by contributions to Z-PAC at the state level and ASAPAC at the federal level.

The PSA thinks that communication between members and our society is also essential. We want to know about your important professional concerns and how we may assist. We also want to know the best ways to contact you, so that we can promptly notify you of developments that may affect your practice. As you renew your annual membership, please be sure that your contact information is accurate.

Let us know your concerns.

Spring 2012



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ANESTHESIOLOGISTS

Sentinel

Pennsylvania Society of
Anesthesiologists Newsletter

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Another PSA Resource: Practice Registry

The Pennsylvania Society of Anesthesiologists is compiling another online resource for members.

The creation of a practice registry will include a comprehensive database of individual practices, groups, and hospital departments across the state. It will also serve as a central online information center for those seeking employment in Pennsylvania, particularly residents and fellows.

We encourage you take two minutes to submit the information below so that your group can be included in the registry. You can return it to the PSA administrative office one of three ways:

- **Fax:** (717) 558-7841
- **E-mail:** psa@pamedsoc.org
- **Mail:** PSA, 777 East Park Drive, P.O. Box 8820, Harrisburg, PA, 17105-8820

Should you have any questions about the practice registry, you can contact Joshua Atkins, M.D., PhD, PSA President-Elect, at jhatkins@psanes.org.



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PSA Practice Database Information Submission

(please print)

Practice Name: _____

Practice Location:

Address: _____

City: _____

State: _____

Zip: _____

Practice Administrator/Contact Person:

Name: _____

Phone: _____

Fax: _____

Email: _____

Highmark Change Could Lower Reimbursement Rates for Anesthesiologists

Highmark has announced in its December 2011 newsletter, "PRN," that it plans to change



its basis for calculating anesthesia base units on its claims from the American Society of Anesthesiologists (ASA) Relative Value Guide to the listing of anesthesia base units on the Centers for

Medicare & Medicaid Services (CMS) website. For most procedures, CMS's anesthesia base units are the same as the ASA's; however, for certain

anesthesia procedure codes, the CMS base unit's value is lower. The change will take place beginning April 2, 2012, although it is unclear if that relates to dates of service or claims processing. It will apply to all Highmark business, including Highmark Blue Cross Blue Shield of western Pennsylvania, Highmark Blue Shield of central Pennsylvania and Highmark Blue Cross Blue Shield of West Virginia and Medicare Advantage.

Listed below are those anesthesia procedure codes where CMS and ASA anesthesia base unit values differ. Since the CMS relative value units are either equal to or lower than the ASA value in every case, this change will result in a reimbursement

reduction. The magnitude of the reduction for any practice depends on several factors, including the case mix of the practice and other factors impacting anesthesia reimbursement, that is, anesthesia time units, modifying units, etc.

In response to member questions, PSA is investigating Highmark's action, and determining what recourse we may have both as individual practices and as a state professional society.

Highmark will adopt the CMS anesthesia base units in effect at the time of implementation, April 2, 2012, but it is likely it will adopt any changes that CMS makes thereafter.

Anesthesia code	Procedure	CMS Anesthesia Base Units	ASA Anesthesia Base Units
00147	Procedures on Eye-Iridectomy	4	6
00326	Procedures on Larynx & Trachea – child < 1 year old	7	8
00537	Cardiac Electrophysiologic Procedures	7	10
01924	Arterial Therapeutic Radiologic Interventional Proc.:	5	6
01925	Carotid or Coronary	7	8
01926	Intracranial, Intracardiac, Aortic	8	10
01932	Venous Therapeutic Radiologic Interventional Proc, Intrathoracic or Jugular	6	7
01933	Intracranial	7	8
01963	Caesarian Hysterectomy without labor analgesia	8	10
01968	Caesarian Delivery following labor analgesia	2	3

Assigning Value to Your Z-PAC/PSA Investment

by Michael Brody, M.D.

Z-PAC contributions are used to support state legislative candidates, just as ASA-PAC contributions are used to support candidates at the national level. Our political action committees (PACs) rely on this mechanism to support Democratic and Republican candidates who concur that the anesthesiologist is the key to patient safety. According to a recent Federal Election Commission report the ASA-PAC has out-raised all other physician PACs for the third year in a row. This accomplishment raises the bar that our Pennsylvania membership should expect for Z-PAC!

Each of us receives multiple financial contribution requests from a variety of worthy campaigns. While considering the merit of the each cause, we also assess the expected return from each disbursement of our limited capital. As a new member of the PSA Board of Directors, I have come to understand that there is much to learn about the business of representing the PSA membership and protecting patient safety.

I now also have much deeper respect and gratitude for the dedicated and talented individuals that make up our Board. Many members have served for more than 20 years and are responsible for the PSA political action committee as we know it today. I set out to better understand the value of our PSA political action committee. I was shocked by what I learned. It may sound cliché, but the return from grassroots activism and Z-PAC contributions has been priceless! What I also learned was that while **all** of the PSA membership is a beneficiary of

PAC effectiveness, often less than a third of the membership actually contributes to Z-PAC!

Relationships

My first realization has been the considerable value of the relationships that have been built through Z-PAC over the past 27 years. John Milliron, Esq., whose lobbying firm has been representing PSA's interest since 1985, is a key player in our legislative agenda. Andy Goodman, a Milliron associate, along with legal counsel Bob Hoffman of Eckert Seamans in recent times, continue daily work that results in "open doors" at legislative offices in Harrisburg.

An advocate is only as good as their reputation, a reputation earned from honest, instructional and timely information. Our legislative team enjoys the priceless benefits of many long-term relationships with legislators. We should also understand that their work of developing new "trusted" relationships is never ending as evidenced by the recent election of 29 freshmen legislators. Remember, too, that biennial PSA Legislative Receptions offer all PSA members a recurring opportunity to reach out to state legislators, new and old, to cultivate relationships. This activity is critical for our legislative efforts.

PAC relationships extend across health care specialties. Although struggling to reconcile our differences with PANA about the Anesthesia Care Team model, we have enjoyed success in working with them on other topics such as the PSA-PANA Joint Statement on the Administration of Propofol to



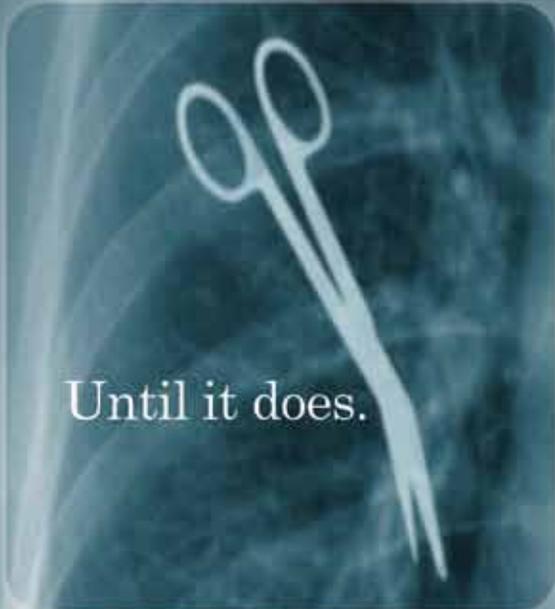
Unintubated Patients. We have deepened relationships with Pennsylvania ophthalmologists and otolaryngologists in response to similar "scope of practice" challenges from nurse anesthetists, optometrists, and audiologists, not to mention the broader concerns raised by recent CRNP scope of practice legislation. Consider that there was a near crisis in professional liability insurance with a \$708 million dollar raid of the Health Care Providers Retention Fund to help balance the Governor's budget.

We have a consistent voice on the Pennsylvania Medical Society's Specialty Leadership Cabinet. Two of our past PSA Presidents, Ed Dench and Carol Rose, have served as President of the Pennsylvania Medical Society. Carol Rose currently serves as a member of the Pennsylvania State Board of Medicine.

Just as we understand that America's financial future is

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Changes in Legislature Could Impact PSA

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

The Pennsylvania House of Representatives has had significant turnover in the past five years. More than 50 percent of its members are new, due to retirements or defeat at the polls since 2007. This is a rare occasion in Harrisburg where the status quo has more often been the norm.

How does that affect your profession and your patients? For starters, very few new members know the difference between an anesthesiologist and an anesthetist. The lines have been so blurred by the nursing community that most new legislators have a major learning curve for our specialty. It also means that many solid supporters of physician supervision have gone and we need to continually educate their replacements.

The 2012 elections will also add to this turnover. Six House members were elected to other political posts last November and have resigned from the state house (Denny O'Brien and Kenyatta Johnson were elected to Philadelphia City Council, Jewell Williams is the new Sheriff

in Philadelphia, Josh Shapiro is now a Montgomery County Commissioner, Chelsa Wagner is the new Allegheny County Controller and Doug Reichley is now "Judge" Reichley in Lehigh County). Their seats will be filled in special elections this primary.

At least 10 House members have announced they will not seek reelection and three others are running for either Auditor General or the Senate. All of this before a single vote is cast in the November elections!

The Pennsylvania Senate has had slightly less turnover with 14 new members (out of 50) in the past five years. The constant factor, however, was that the Senate remained firmly in Republican control throughout this period with 30 Republicans and 20 Democrats. However, there will be at least five new faces next January due to the retirements of Jane Earll (Erie), Mary Jo White (Venango), Jeff Piccola (Dauphin), John Pippy (Allegheny) and possibly Jim Brewster (Allegheny). This seat is in doubt since it was initially eliminated in Allegheny



County due to a loss in population and moved to Monroe County (Poconos area) where much growth has occurred. The problem is the Supreme Court threw that new map out as unconstitutional and nobody knows right now what will happen next.

Many of you may recognize some of these names: Mary Jo White, Jane Earll and Jim Brewster are longtime sponsors of PANA legislation that proposed removing physician supervision. We have some great supporters running for these open seats. We will keep you informed in the coming months of their success!

Read More Clinical Pieces at www.psanes.org

The PSA's website, found at www.psanes.org, provides a wealth of resources to anesthesiologists and their patients. Here is an example of content that's been recently added to the website:

Management of Postoperative Nausea and Vomiting

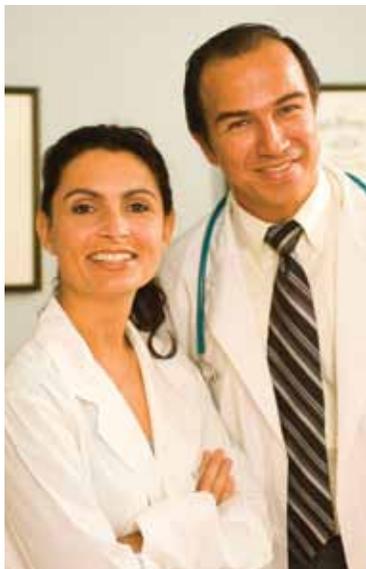
By **Jeremy Bengert, D.O.**, and **Andrew Herlich, D.M.D., M.D.**

Postoperative nausea and vomiting (PONV) is a common problem that affects approximately 30 percent of patients undergoing surgery, but can be as high as 80 percent in high risk patients. PONV is one of the most common reasons for unanticipated admissions after surgery. It can be such a horrific experience that patients say that it is worse than postoperative pain. Some patients are even willing to pay out of pocket to prevent experiencing PONV. Reported rare, but serious, complications of postoperative vomiting include aspiration, suture disruption, esophageal rupture, subcutaneous emphysema, and pneumothorax. The annual cost of PONV is estimated to be on the order of several hundred million dollars.

Read the full article at our Clinical Updates page at www.psanes.org.

Topics Impacting Anesthesia Discussed at PAMED Meeting

by Joseph Galassi, Jr., M.D.



Please be aware that the Pennsylvania Medical Society (PAMED) has a Specialty Leadership Cabinet that meets several times a year to discuss issues. After issues concerning all of medicine, specialty societies also offer items of concern to their respective

societies for discussion and support.

PAMED has been supportive of the PSA on various issues over the years. The meeting is divided into various common interest topics as they arise throughout the course of the year, but there are other issues that address opportunities for collaboration between specialties and a forum for specialty concerns that are brought before the cabinet. While there are a number of issues discussed at these meetings, only matters pertinent to anesthesiology will be addressed in this article. This article will summarize the most recent meeting of the SLC that occurred on Tuesday, Feb. 7, 2012.

First off, the matter of the impending SGR cuts was discussed and all cabinet members were asked to write their U.S. Senators and members of Congress asking for a definitive resolution to this ongoing problem. To reiterate, there was an impending 27 percent cut in

Medicare reimbursement effective March 1, 2012, but congress delayed this until the end of 2012.

The next important matter was House Bill 838, which proposes to amend the practice of optometry to define “ophthalmic surgery” and exclude it from optometrist’s scope of practice. The definition includes laser eye surgery. This bill is supported by PAMED. It has passed the state house and is currently bottled up in the senate.

The next issue is the intrusion of the Federal Trade Commission (FTC) into State Boards of Medicine (SBOM) licensure activities. This matter was an FYI item, but those of you who follow national anesthesiology and pain medicine politics already know about these issues in other states. This was just one of the examples used where the FTC is stating that SBOMs are restricting free trade between physicians and mid-level practitioners of all types. The FTC is ignoring the fact that SBOMs were set up to protect the public from unqualified practitioners in the first place and that it is intruding on state matters.

The PSA thanked PAMED for their support in opposing HB 1570. This bill would allow hospitals to substitute Joint Commission certification for licensure by the Department of Health. PSA opposes the bill out of concern that this might lead in short order to independent CRNA practice.

Scot Chadwick, vice president for Governmental Affairs at PAMED, gave the group an update on the state of malpractice insurance and the MCare fund. PAMED was informed that no changes are planned this year for

the coverage amounts provided by private insurance and MCare, currently each at \$500,000. However, if the malpractice environment remains steady, the Pennsylvania Insurance Commissioner will likely reduce MCare coverage and increase primary coverage next year. This is part of the phase out of MCare. This would take place in two steps, not necessarily over two years. The first step would be a transition of \$250,000 coverage to private insurance, and the second step would be the same amount, thereby eliminating the MCare portion of malpractice insurance. PAMED continues in discussions with the Insurance Commissioner to develop an alternative plan to lessen the financial burden of the current method planned for the transition.

Finally, there was a progress report by Capital BlueCross (CBC) on quality measures with six specialty societies. Urology, obstetrics and gynecology, ear, nose and throat, gastrointestinal, general surgery, & orthopedics are discussing defining quality metrics which in part will determine future payment models. CBC is attempting to have the physician specialties initiate the quality metrics and will engage the other three Pennsylvania Blues Insurers to get them on board as well.

My question to CBC was why go through with these quality measure discussions before we know that the other three Blues are on board with it? Their answer was that they are working to get Highmark on board and are contacting IBC and NEPA BC as well. The goal

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PSA Organizes Job Fair for Resident Members

It is with great pleasure that we announce the creation of the first ever PSA-sponsored, Resident Anesthesia Job Fair. Coordinated by the president and president-elect of the PSA Resident component, Adam Thaler and Stanislav Kelner, this event will take place May 12, 2012, after the annual Pennsylvania Anesthesia Resident Research Conference (PARRC). We invite all Pennsylvania anesthesiology residents and fellows to attend the job fair at Hahnemann University Hospital's Geary Auditorium.

The event will begin at 4 p.m. with an informative panel discussion on the various practice options within the field of anesthesiology. Afterward, free time will be given to attendees to peruse

academic practice, private practice, locum tenens, and hiring firm representative kiosks. Beverages and hors d'oeuvres will be served compliments of the PSA.

This will be an excellent opportunity for residents and fellows to gain a crucial understanding of the various avenues in anesthesia, as well as gain important contacts for landing that dream job. On behalf of the PSA Resident Component, we hope to see all of you at the Resident Anesthesia Job Fair this spring!

Adam Thaler, D.O., President
PSA Resident Component
Stanislav Kelner, M.D.
President-Elect
PSA Resident Component

Welcome New Members

Active

Shauna W. Bomer, M.D.
Erik A. Cooper, D.O.
Nicole C. Henwood, M.D.
Christopher J. Hodge, M.D.
Michael K. Idun, M.D.
Lei Li, M.D.
Jiabin Liu, M.D.
Richard C. Kinney, M.D.
Ramesh Kodavatiganit, M.D.
Kelly A. Machovec, M.D.
Allison W. Nassif, D.O.
Soheyla Nazarnia, M.D.
Anna Ng, M.D.
Samuel H. Plummer, D.O.
Subramanian Sathishkumar, M.D.
Yanfu Shao, M.D.
Chitra Sivasankar, M.D.
Karen S. Troxell, M.D.

Resident

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Ryan LeVasseur, M.D.
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Garth C. Skoropowski, M.D.
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Kathleen M. Tyson, M.D.
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May 18 - 20, Boston	October 26 - 28, Atlanta
June 8 - 10, Chicago	November 16 - 18, Las Vegas

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Resident Learns Valuable Information at ASA Practice Management Conference

by Adam Thaler, D.O., University of Pennsylvania-CA2,
PSA Resident Component President



Thanks to the generous support of the Pennsylvania Society of Anesthesiologists, I had the opportunity to attend the ASA Practice Management Conference in Orlando, Fla., January 27-29. It was such a great

experience that will pay dividends in my future career as a consultant anesthesiologist.

The conference began with an address from our eloquent ASA President Jerry Cohen, MD, about the future of anesthesiology. As the conference continued, I was able to follow the resident track, learning necessary and important skills and gaining valuable knowledge, all of which will be helpful as I seek future employment.

The resident track was specifically geared toward the approximately 50 residents attending from around the nation. It allowed us to meet each other (as future leaders of our specialty) and to learn from excellent speakers about the future that

awaits us. There were forums on compliance, contract negotiation, evaluating a prospective practice, and how to best prepare a CV. It was especially enlightening to hear about the anesthesiology job market today, especially the opportunities available in the various sub-specialties such as pain management, intensive care, and obstetric anesthesia.

Equally helpful was spending the day with residents from other institutions, learning how their programs ran, and being able to brainstorm about plans for the resident components. This led me to exchange contact information with a resident from the University of Miami, who was interested in my input as president of the PSA Resident Component, as he worked toward forming a resident component in Florida.

All in all, I was very fortunate and thankful to attend the Practice Management Conference. I again thank the PSA for the opportunity to attend. I gained a wealth of valuable information that I will share with my colleagues at my program and around the state to better prepare us for our future as consultants in anesthesiology.

3 pearls worth mentioning from the Practice Management Conference:

1. It is important to figure out early on your goal for after residency. Do you want to work in an academic institution, private practice, or fellowship? Based on this decision, it is key to find a mentor and make contacts in this field to see what you can do to give yourself the best opportunity to find your dream job that awaits your future.
2. Gasworks is not the best place to find a job. Speak with your fellow residents at your program, residents from other programs that you might meet at conferences, your attendings from the new ones to the senior faculty, and even your program director and chairman. Keep in touch with them all. They have a lot of knowledge about what is out there and the contacts to give you a great opportunity to get an "in." You also never know who will be your future colleagues, boss, or recruiter.
3. Anesthesia residency does not provide training to make good business decisions. We are 30+ years old when we are about to have our first "real" job. We receive a contract and it's long and we don't know what to do with it. Don't sign it right away. Get some help, preferably a lawyer who has been accustomed to anesthesia (or at least medical) contract law. Interpret the contract. Find out what is important to you, whether it's vacation weeks, salary, call days, years until partnership, covering OB, etc. There is a lot of jargon in contracts and it usually is to the benefit of the hospital/employer. A contract is negotiable!

Upcoming PSA Events

- May 12, 2012:** Philadelphia Regional Meeting Philadelphia Racquet Club, 215 South 16th Street, Philadelphia, PA
- September 16, 2012:** PSA Board meeting, 8:30 a.m., Bedford, PA
- October 13, 2012:** PSA Annual Luncheon at the ASA meeting, Washington, D.C.

Supreme Court to Hear ObamaCare Challenge

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

In an article in the Spring, 2011, edition of The Sentinel (“Commerce Clause 101: A Short Guide to Understanding Health Care Litigation,” which can be accessed online at http://www.psanes.org/Portals/0/docs/Newsletters/PSASpringNewsletter_WEB.pdf on page 4), I gave an overview of the constitutional principles that I thought would likely govern the outcome of the then undecided challenges to the Patient Protection and Affordable Care Act, better known in this election year as ObamaCare. Now that the Supreme Court is about to hear and decide these challenges, this article tries simply to inform you as to the who, what, and when, with a little prediction at the end.

Over three days beginning March 26, the Supreme Court will hold 5½ hours of oral argument to consider the constitutionality of the Health Care Act. Normally, the Court devotes one hour per case, so the scheduling makes clear that the Court thinks there is a lot to listen to and to decide.

The Supreme Court gets to choose which cases and what issues it wants to hear, and it did so carefully here. It chose four issues from among a broader array that various parties in various cases wanted it to decide. The lead plaintiffs in the matters before the Court are the State of Florida and 25 other state attorneys general, including Pennsylvania’s, and the National Federation of Independent Businesses. In somewhat non-legalese, the issues to be decided are:

- Is the individual mandate—the requirement that individuals purchase health insurance or

pay a penalty—constitutional under the Commerce Clause? Those challenging the Act, including at this stage all Republican candidates for President, say this provision in unprecedented fashion regulates inactivity or, alternatively stated, forces people to engage in a financial transaction whether they want to or not. Defenders see it as consistent with the government’s broad authority under the Commerce Clause and note that the failure to purchase health insurance both imposes a cost on others and is central to many of the Act’s other goals. This is the highest profile issue before the Court.

- Can the challenges to the Act’s individual mandate even be in court at all at this time, when the individual mandate that is being challenged is not yet in effect? This argument centers on what is called the federal Anti-Injunction Act, which generally prohibits courts from enjoining the assessment or collection of taxes. The issue is whether the penalty the Act imposes on people who don’t buy the required insurance is a tax. No party to the cases raised this issue, and the Court, on its own, raised the issue and appointed counsel to brief and argue it. The Court could use this issue to avoid deciding the case during the election year, where it is, and will be, a big issue.
- Can the rest of the Act remain in effect if the Court invalidates the individual mandate, a question referred to as

“severability?” The individual mandate has been viewed by many as a linchpin to making the system work actuarially, eliminating the problem of the system’s insuring only non-healthy persons. All of the parties have agreed that the mandate is not severable, which means that if the provision is invalidated, the entire Act would be invalid. Nonetheless, the Supreme Court decided it wanted argument on this issue and has also appointed counsel to argue the contrary side of that issue.

- Does the Act’s expansion of the Medicaid program violate the Constitution’s Spending Clause? In general, the federal government has broad powers to offer funds to states, with strings attached; the premise being states can always decline the offer. The states’ argument here is that the consequences of rejecting the offer are so substantial, here a complete loss of federal Medicaid funding, that the option to do so is illusory and the result is an unconstitutional exercise of Spending Clause authority.

For those interested in a more in depth analysis, the briefs filed in the case—and there are more than 25 as of early February, most from “friends of the court” filing *amicus* briefs, and probably as many more yet to be filed—are available at <http://www.scotusblog.com/case-files/cases/u-s-department-of-health-and-human-services-v-florida/>. Additionally, the Supreme Court posts the transcript of oral argument at

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Register to Vote in the Primary Election

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If you are not yet registered to vote in PA, you must register by March 26, 2012. You may register in person at your county voter registration office, by mail, at PENN DOT facilities and at some other state agencies.

Further information and downloadable forms are available on the PA "Votes PA" website:

<http://www.votespa.com/portal/server.pt/community/home/13514>.

You are also able to confirm your current voter registration and voting location on that website.

If you miss the March 26 deadline, registration opens

again the day after the Primary Election—on April 25.

Absentee Ballots

If you cannot vote in person on April 24, you may request an absentee ballot.

This year the deadline to apply for an absentee ballot is April 17 and they must be received by your county board of elections by April 20.

If you have any questions, please contact Larry Light at (717) 558.7821 or llight@pamedsoc.org.

Fundamentals of Ultrasound-guided Regional Anesthesia With Hands-on Cadaver Dissection

May 5-6, 2012



Fees: \$750 per person for practicing anesthesiologists; \$250 per person for anesthesia residents or fellows, including instruction, handouts, lunch and other refreshments.

For more information: www.pennstatehershey.org/anesthesia or contact Karen Bowman, kbowman@hmc.psu.edu, 717-531-5167

Approved for 10.5 AMA PRA Category 1 Credits

Former PSA President Passes Away

Former PSA President John Paul Eichmiller, Jr., M.D., died in mid-January at the age of 88. He was survived by four children and nine grandchildren.

Dr. Eichmiller served with the Army Air Force in World War II as a crew chief flying the Hump and was a recipient of the Distinguished Flying Cross. After the war, he devoted his life to caring for people as an

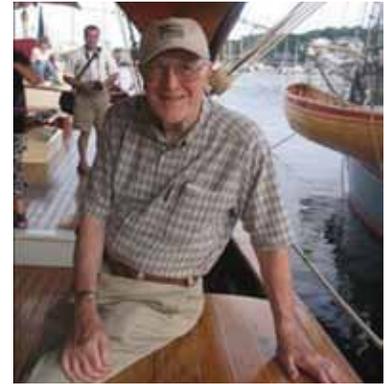
anesthesiologist at South Side Hospital.

Dr. Eichmiller served as the PSA's President in 1985-86. He was an active member of the Pennsylvania Society of Anesthesiologists for many years.

In retirement, he visited all 50 states with his wife, Brenda, in their motor home; sang bass with the Pittsburgh Swiss Singers, The Three Rivers Barbershop Chorus

and St. Justin's Choir; and became a sincere yoga practitioner.

The PSA sends its deepest condolences to the Eichmiller family.



The American Society of Anesthesiologists Physical Status Classification System: Helpful or Harmful?

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

My guess is that any anesthesiologist providing care at a surgical center in Pennsylvania has had a "discussion" with a surgical colleague about the ASA physical status of a patient. You know those cataract patients who haven't seen the healthy side of a "4" for many years, yet are easily surgical center material according to the ophthalmologist.

What about some history? In 1940, three physicians (Meyer Saklad, Emery Rovenstine and Ivan Taylor) were asked to devise a system to stratify peri-operative patient risk. Although they quickly realized that what was asked was much too complex to accomplish, they did produce a numeric system to grade a patient's overall health (physical status) prior to surgery. A "six point" system was developed with the first four being for the most part unchanged from today, and the last two being for emergencies. A 5 was for emergency surgery on a previously classified physical status 1 or 2, and a 6 was for emergency

surgery on a previously classified 3 or 4. In 1963, the classification system was published with two modifications: physical status 5 was added for moribund patients, and the original 5 and 6 were replaced by an "E" for emergency cases. Eventually, a 6th was added for organ donors.

- **ASA Physical Status 1** - A normal healthy patient
- **ASA Physical Status 2** - A patient with mild systemic disease
- **ASA Physical Status 3** - A patient with severe systemic disease
- **ASA Physical Status 4** - A patient with severe systemic disease that is a constant threat to life
- **ASA Physical Status 5** - A moribund patient who is not expected to survive without the operation (some definitions state "with or without surgery")
- **ASA Physical Status 6** - A declared brain-dead patient

whose organs are being removed for donor purposes

Although the system was developed as a means to share patient information among anesthesia providers, it currently is also used by other health care providers (surgeons and proceduralists), hospital systems, regulatory agencies, payers and law firms as a way to assess risk and appropriateness for surgery. Should the patient have surgery? Should the patient have surgery here? Or, as a lawyer would ask, should a patient have had surgery or why did a 2 die?

The problem arises in the fact that the system is far from perfect. Imagine attempting to accurately place seven billion people (the world's population) into one of five categories. Furthermore, category definitions are vague at best; therefore, there is extensive variability in assigning physical status values between providers. Many questions easily arise.

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April 24: Your Primary Concern

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

The primary season continues. Will it ever stop? Often times the voter involvement is the least in total numbers. This process, however, is the most crucial to the election process. It is the time when the voters decide who best represents their ideals and concerns. If the candidate doesn't get on the ballot, there is no chance to be elected.

It is the time when candidates are most accessible to the voters. It is a time when questioning reveals the background information from candidates to provide voters with an intelligent basis for choosing someone to represent them in their hometown, Harrisburg and ... Washington. This does presume that the inquirers have thoughtful questions to provide useful information. Generation of the question list should be from public input and selected on the basis of major concerns.

The questions should be posed by "neutral" moderators. While a public debate has some benefit, I think like the old style \$64,000 question format would be beneficial for most of the "debate." The candidates are all asked

the same questions, each in an isolation booth, so they could not hear each other's answers. This precludes audience input, other candidates' potential advantage in answering last and exposes all to the same set of questions. The answers could then be openly debated. I feel this would provide a more productive method for the voters and a fairer situation for the candidates.

What does this have to do with anesthesiologists in Pennsylvania? The political base for any candidate is LOCAL constituents. This is the time for you to meet up close and personal with your hopeful candidates. Offer your expertise as a physician and willing input to medical considerations, which will abound in this coming election. Offer to place a sign in your yard, host a neighborhood coffee, brunch or cocktail party, offer to work the polls, involve your family. This is invaluable education for your family.

If your candidate pick is successful, keep up the support through the election. If he or she is not, follow the same plan for the candidates you select who

are successful and help them get elected. While political cash contributions are important, your personal involvement is even more valuable. Most importantly, make sure you and the voters in your family vote. Your elected representatives cannot tell how you voted but can tell if you have voted. Votes make the difference and every vote counts.

Recent primaries in other states have demonstrated how a single vote changes the result. An election can be won by a single vote. This most precious right must not be unused. When you do not cast a vote, you get what you deserve and you may well not like it. Your local activity is key to the success of a political agenda. Your future, your family's and your patients' care are in play.

Please remember to be registered to vote. If you are away during an election, you can cast an absentee ballot. This year the primary election in Pennsylvania is April 24. The county elections boards must receive your ballot by 5 p.m. on April 20. The postmark does not count. Mail it in plenty of time. See you at the polls. **VOTE!!!**

SUPREME COURT TO HEAR OBAMACARE CHALLENGE

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http://www.supremecourt.gov/oral_arguments/argument_transcripts.aspx. Go to "Oral Arguments," then "Transcripts," and look for the case by name or argument date sometime after March 26.

The Court, with rare exceptions, clears its document by the end of June, with an occasional spill-over into early July. Commonly, the most important cases,

of which this clearly is one, are released in those last days. Given the date of oral argument here, the timing of a decision is one of the few near certainties: it will be late June or early July.

Predicting the result itself, rather than its timing, is much harder. It seems, however, a safe bet that the Court's core conservative bloc—Chief Justice Roberts and Justices Scalia, Thomas, and Alito—will find the Act unconstitutional on some basis or another. Equally likely, the more liberal grouping of Justices—Justices

Breyer, Ginsburg, Sotomayer, and Kagan—will not. Justice Kennedy is less predictable. It seems unlikely but not impossible that the Court will avoid the issue entirely by a ruling based on the Antijunction Act, and likely that, if it finds the mandate unconstitutional, it will find that decision invalidates the rest of the Act.

Hopefully a little better informed, stay tuned to see our constitutional system at work.

Mr. Hoffman is outside counsel to PSA

Introducing the Anesthesia Incident Reporting System (AIRS)

by Richard P. Dutton, M.D., M.B.A, Executive Director, Anesthesia Quality Institute

On October 1, 2011, the Anesthesia Quality Institute activated the first nationwide system for collecting individual adverse events from anesthesia, pain management and perioperative care. We're calling it AIRS: the Anesthesia Incident Reporting System. Here's how it happened, and how it works:

Background and Rationale:

Anesthesiology is characterized by a very low rate of serious complications. This scarcity makes it difficult to recognize recurrent problems and to achieve the statistical power necessary to understand risk factors and test potential solutions. Paradoxically, the very safety of anesthesia has reduced our ability to improve. Consider the example of post-operative visual loss (POVL). By the late 1990s most experienced providers had seen or heard of at least one case, but very few providers knew of more than one. It was not until enough cases had accumulated in the ASA Closed Claims Project Registry that we realized this was a recurrent safety issue, more common in certain kinds of cases, and potentially influenced by our anesthetic practice.

The problem with relying on closed claims for our safety "signal" is that not all serious events result in lawsuits, not all malpractice insurers make their records available, and only those events that result in a patient injury are ever captured. It can take many years for a malpractice case to run its course and for the records to be abstracted. Hence the need for a more timely system.

Anesthesia registries, such as the National Anesthesia Clinical Outcomes Registry (NACOR) function at the opposite end of the spectrum. By capturing every case, every day, they will inevitably include some with serious adverse outcomes. Over time, a picture will emerge of the relative rate of serious occurrences, and the kinds of cases they occur in. But registries are lacking in different ways: granularity of reporting. Standardized data entering the registry does little to identify the nuances of patient disease, evolving clinical circumstances, and anesthesiologist judgment that contribute to an unusual occurrence—and these are the things that we would most like to know. Nor do registries capture near misses, when no adverse event occurs.

This is why critical incident reporting, based on either actual adverse events or "near misses," is a common concept in anesthesia department quality management (QM) at the local

level. Most hospitals and most anesthesia departments mandate the reporting of critical or "sentinel" events, and most academic departments have regular "Morbidity and Mortality" conferences to discuss unusual cases. Such systems work best when there exists a "safety culture" among practitioners, with free and open discussion about negative events.

The desire for improvement must outweigh fear of the consequences of reporting. Yet even when such systems flourish at the local level there is still an unfilled national need. Many serious anesthesia events occur at such a low frequency that a given group of providers might never see more than one occurrence. And the closed mouth nature of the legal system makes it difficult for one group to learn from the experience of another.

The AQI believes the time is ripe for a national system for reporting critical events in our

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Theresa O'Flynn, M.D. (pictured at left), Rich O'Flynn, M.D. (second from left), and Joshua Atkins, M.D., PhD (right), attended an event in December with Congressman Patrick Meehan (second from right). This came as a result of ASA-PAC support. A primary topic of conversation was the SGR fix.

ASSIGNING VALUE TO YOUR Z-PAC/PSA INVESTMENT

continued from page 5

linked to a global economy, we should also understand that Pennsylvania's health care future is coupled to a national political agenda. Addressing anesthesia drug shortages, "Truth and Transparency" legislation to empower patients with accurate information, ensuring fair Medicare payment and resolving the tremendously flawed SGR formula, and expanding patient access to physician anesthesia services in rural areas are but a few of the important issues on a busy federal legislative agenda. As a result, important relationships are advanced through concerns that will affect us all. Pennsylvania's PAC works in parallel with political action committees of other states and the ASA-PAC.

At the end of the day, what value can we assign to a seat at the table and a voice in the conversations that will decide the future practice of medicine? PRICELESS!

Financial

For those less interested in relationships and more likely to say "show me the money," the return from the investments of PSA and its members are again impressive. Consider the financial impact of The Workers' Compensation Act-Provider Fees; Payment for Anesthesia Services that took effect in December 2004. Quoting PA Bulletin, Doc. No. 04-1134, "Over the course of 8 years, the PSA submitted substantial amounts of data, including expert reports, and through counsel, participated in a multitude of meetings with the Department to carry its initial burden of having the anesthesia conversion factor reviewed for reasonableness...based on the extensive, credible, and persuasive nature of the data and expert reports submitted by the PSA ..." As a result of this 8+ year effort anesthesia workers' compensation reimbursements were increased by 63 percent! Dr.

Schaner, Z-PAC Chairman, estimates that depending on payer mix this amendment resulted in a \$20,000+ per anesthesiologist per year increase in reimbursements. How's that for a return on our investment?

In 2008, PSA worked with an alliance of physicians from the Mid-Atlantic States to rescind policies of Aetna, Humana, and Health America withholding reimbursement for anesthesia services for "routine" endoscopic procedures. What dollar figure would you assign to the loss of "routine" endoscopic procedures from your anesthesia practice (not to mention the adverse impact on patient safety)?

One last example: The PSA political action committee worked with ASA-PAC to change the CMS teaching physician reimbursement rules for anesthesia services. Since January 2010, teaching anesthesiologists have been able to work with two residents and bill both cases as personally performed. This not only increased reimbursements to teaching anesthesiologists and strengthened training programs in Pennsylvania; it also improved our ability to train new doctors in Pennsylvania who will someday be the future physicians in our community hospitals.

Education

We live in an era of "spin." We now have "Pinocchio Scales" to distinguish levels of truth, e.g. "shading of the facts ... significant omissions and exaggerations with some factual error ... significant factual error and/or obvious contradictions ... whoppers." Add this to the conflicting priorities of our government that is trying to balance the budget and hospitals that are looking for new revenue streams and providers that are struggling to remain "fairly" compensated. Then consider our legislators who, in an effort to effectively represent their constituents, need to remain current on health care issues, the environment, schools, and jobs. These legislators depend on legislative counsel (remember our 27-year **trusted** relationships) to help them find "truth."

The most important truth we hope to bring to every Pennsylvania legislator is that **patient safety** should take precedence above all other agendas. Legislators are barraged with misinformation. Read the article "Don't let half-truths determine patient care!" on the PSA website (www.psanes.org) to bring this point home. The PSA legislative team must review and respond to every piece of health care legislation introduced to the Pennsylvania House and Senate. Our legislative team has been an effective counterbalance to potent political agendas, such as the "Prescription for Pennsylvania" campaign seeking to broaden the scope of nursing practice and "remove barriers that have kept them from practicing to the greatest extent allowed by their education and training." The governors of 16 states have effectively campaigned to opt-out of physician supervision for nurse anesthetists. It is no accident that Pennsylvania is not counted among these opt-out states.

Conclusion/Challenge

We all understand that there is a critical link between bench research and clinical medicine. We should also appreciate the connection in the continuum between clinical medicine and political action. Please consider making an annual contribution to Z-PAC and ASA-PAC. Please make an appointment with your local Representative and/or Senator and make yourself available to them. They will genuinely appreciate hearing from you.

Our goal for Z-PAC is 100 percent participation. If you know a colleague who has not contributed please talk with them and encourage them to send in their donation. If they need additional information encourage them to contact the PSA using the "Contact PSA" icon on the PSA website homepage at www.psanes.org. If we all get involved our collective voice will continue to make a difference.

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS PHYSICAL STATUS CLASSIFICATION SYSTEM: HELPFUL OR HARMFUL?

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What is “mild” or “severe” systemic disease? Is a disease “systemic” or “localized?” Why isn’t there a number for moderate systemic disease? What is an emergency: a patient who the surgeon says has to be done now or unscheduled, or a patient whose health will deteriorate if surgery isn’t performed immediately? Is a laboring patient for anesthetic intervention due to pain or cesarean section an emergency and therefore classified as an E? Should extreme age be taken into consideration (a premature infant or the very old)? Is an otherwise healthy smoker a 2? Is an otherwise healthy person with a BMI greater than 40 a 3? Is a physical status 1 patient who was hit by a bus and now has an aortic rupture a 1E or 4E? That last question may seem extreme, however, many state that the condition that brings a patient to the OR should be ignored and only secondary diseases considered when assigning a value.

Studies have demonstrated flaws with the system. Owens, Felts and Spitznagel in 1978 demonstrated a lack of consistency among anesthesiologists in assigning a value. These findings have been reproduced over the years. Furthermore, there are widely conflicting studies as to whether there is a relationship between ASA physical status and mortality. Other studies have demonstrated that using the ASA physical status in conjunction with other variables increases predictability. For example; Cullen, Apolone, Greenfield, Guadagnoli and Cleary in 1994 demonstrated improved predictability when ASA physical status and age were used together. Others have demonstrated improved predictability when the Goldman Scoring System was added. A few have even tried to replace or modify the system. Higashizawa and Koga in 2007 described an expansion of the classification to seven categories

taking into account moderate systemic disease and surgical risk.

Regardless of the study or outcome observed, it is quite obvious that the system was truly not intended to be a predictor of risk. Therefore, it was not intended to be used by so many individuals, institutions and agencies for patient placement, payment or liability. I currently look at the value solely to see if I agree with the number others assign and to question residents as to why they assigned a particular number. As to determining risk, I look at the patient history, disease processes present, age, weight, social habits and the procedure to be performed to make that determination.

So what do I recommend? I recommend removing it in its current form entirely. It can be reinstated when appropriately modified or replaced by a reliable system. Of course, the necessary studies must be performed to determine predictive value of whatever system used. Until our current system is removed, however, I will continue to be very conservative and take great care in assigning a value. I always try to lean toward the higher number. A “healthy” smoker is a 2. A morbidly obese patient is at least a 3. If you are hit by a bus, you are probably a 4E. And an unscheduled cesarean section is an emergency.

What about the surgical center “cataract patient” dilemma. We currently have regulations in Pennsylvania pertaining to surgical centers that use the classification system to identify appropriate patients (generally 1-3) in different kinds of centers. We also have individual ideas as to how to assign a physical status value. I hate to use the term: “it is what it is,” but it fits here. You are the protector of the patient and facility. Until regulations change, there will be patients whom the regulations say should not be operated on at a surgical center. This, of course, means you will still have the long heated conversations with your surgical colleagues about a 70-plus-year-old system developed by and for ANESTHESIOLOGISTS.

TOPICS IMPACTING ANESTHESIA DISCUSSED AT PAMED MEETING

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will be to develop quality metrics for all specialties that are acceptable to all payers in Pennsylvania. The plan would need to use aggregate data across all insurers and a neutral data aggregator. CBC and PAMED will continue in discussions regarding these six specialty quality metrics and will eventually include every specialty into the equation. How this state level discussion will develop in addition to the national initiatives such as the Anesthesia Quality Institute remains to be seen.

ATTN: Dues Paying PSA Members

The percentage of your PSA membership dues for 2011 that have been devoted to lobbying expenses and are, therefore, not deductible on your 2011 Federal Income Tax Return is 32.11 percent. The percentage has been updated, and should be used instead of any prior percentage included as part of your 2010 Membership dues statement that you received last year.

INTRODUCING THE ANESTHESIA INCIDENT REPORTING SYSTEM (AIRS)

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specialty. The U.S. aviation system has had such a system in place since 1976. Called the Aviation Safety Reporting System, it is funded by the Federal Aviation Administration and administered by NASA. Blinded data gathered from reported incidents is available on the FAA website, in the Aviation Safety Information Analysis and Sharing system, and is available for public research.

History

Similar efforts have occurred elsewhere around the world. The Australian Incident Monitoring System (AIMS) was created almost 20 years ago to capture serious events and near misses in the operating room. Reporting was via paper forms, sent to a central office. This registry spawned numerous academic papers up until 2005, when it became a victim of its own success. The system was expanded to include any in-hospital adverse events (losing its focus on anesthesia) and was then expanded internationally (losing its focus on local practice).

With these changes, anesthesia providers stopped contributing to it, and AIMS ceased to be a useful tool for anesthesiologists. However, the need for such a system did not go away. The Australian and New Zealand Tripartite Anesthetic Data Committee was formed in 2006 to reintroduce national anesthesia event reporting using the tools of the Information Age. This system, now active throughout Australia and New Zealand, uses anonymous web-based reporting to gather events.

Development of AIRS

In January 2010, even as the AQI was launching NACOR, the AQI Board requested a plan for an incident reporting system. Since that time we have researched incident reporting systems in other countries, conversed with dozens of experts in the U.S. and abroad, and conducted a detailed analysis of the legal issues such a system would raise.

The AQI was designated as a Patient Safety Organization in September 2010.

We formed the AQI-AIRS Steering Committee, and recruited a select group of experts to advise us on the best approach to building the system. Aply led by James Caldwell, M.D., of the University of California, San Francisco, and Patrick Guffey M.D. of the University of Colorado, this volunteer committee of subject matter experts defined the scope of incidents we would seek, the data we would solicit, and the uses we would make of the results.

A prototype of the online reporting tool was developed this spring, and evaluated by the Committee. After several rounds of revision, a beta-test version of AIRS was launched in May, for use by the Committee members themselves and by practices already participating in NACOR. We've captured dozens of incident in the past few months, and we've ironed out the kinks in the system. Now it's time to make AIRS a truly national resource.

- **Who can report:** Any anesthesia provider
- **What to report:** Any unintended event related to anesthesia or pain management with the significant potential for patient harm.
- **How to report:** Go to www.aqiairs.org and fill out the form.

We are especially seeking events such as anaphylactic reactions, device malfunctions, medication side effects, unusual vascular or neurologic injuries, and complications of electronic health-care records. But there is no limit to the number of cases we will accept and analyze—we'll take anything you would consider suitable for your own Morbidity and Mortality Conference.

The report itself consists of three short pages. Structured data is gathered by radio-buttons, and is augmented by a single field for a free-text narrative description of the event. Reports can be made either anonymously or confidentially.

An anonymous report leaves no record of the sender anywhere in AIRS. In a confidential report, AIRS will maintain contact information from the sender

as part of the record. This allows the reporter to modify an initial report with follow-up information on the patient or event; it also allows AQI personnel to contact the reporter to elucidate important or ambiguous details. All AIRS reports are made over a secure, encrypted Internet connection, and are maintained in strict confidence (and firewall isolation) on the AQI server.

Legal protection is conferred by our standing as a PSO. Federal law protects any "patient safety work product" generated by an accredited PSO from legal discovery, and in fact imposes strict guidelines on the way in which the PSO must preserve the confidentiality of its work. Per these regulations, the AQI may never reveal the identity of any patient, provider, facility or practice gathered through either AIRS or NACOR.

AIRS Reporting

The AQI will use data from AIRS in two ways. First, we will abstract interesting cases as educational nuggets, the same way that a local M&M conference would do. Identified case presentations, and discussions of the topics raised, will be published in various ASA forums on an ongoing basis, and archived on the AQI website.

Second, we will periodically examine the entirety of AIRS for emerging trends in anesthesia patient safety. These might be related to new medications, new techniques, evolution of patient risk factors, or even the impact of electronic records. As with the Closed Claims Project, we will periodically publish our findings to alert practicing anesthesiologists to common and recurrent problems. By combining data between NACOR and AIRS we will have both a quantitative and a qualitative picture of anesthesia safety in the United States.

AIRS will enable us to find and fix the next new problem in our specialty, whether it's post-operative visual loss, bronchospasm from rapacuronium, or rare electrical interference in a new monitor. We urge you to visit the website the next time you see an unusual event, and keep our web address handy in your O.R.

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