



PRESIDENT'S MESSAGE

Lost in Translation: ACA, ACO, CCIIO, HCAHPS, SCIP... What Ever Happened to RSI and FIO2?

by Joshua H. Atkins M.D., Ph.D.

Many of us feel strongly that the core clinical issues anesthesiologists face on a daily basis have become permanently obfuscated by the new vernacular of "quality" measures, "value-based" reform, efficiency and cost-containment. Indeed, fiscal challenges in Washington and the \$2.8 trillion national health care tab have facilitated the imposition of a new paradigm for health care delivery in which challenges to old-fashioned patient care abound and often seem insurmountable.

We can't remake the system, but we can avail ourselves of an immense opportunity to lead by influencing the writing of the regulations, guidelines, and metrics that will define the system and by proactive advocacy within the hospital, state organizations, and in Washington, D.C. Here are some thoughts on how to accomplish this:

Advocate for supervision across all specialties

A common theme in the new "value-based" system is to reduce the requirements for supervision of mid-level providers across all specialties. We are not alone in this struggle and may in fact be ahead of our peers in appreciating unforeseen consequences. Mid-level providers and their valuable skill-sets are critical to patient care; but independent practice puts patients at risk and may actually increase the overall cost burden to society.

The care team model is a proven approach to high quality anesthesia care. Supervision is a critical element to patient safety and also appropriately positions physician anesthesiologists as the leaders in the evolution of peri-operative medicine, care delivery models, and policy formulation.

In this issue, PSA lobbyist Andy Goodman, MBA, highlights significant progress toward putting CRNA supervision into statute with legislation currently pending before the Pennsylvania General

Assembly. Passage of this bill is a major goal this year. We simply will not get there without significant Z-PAC contributions and grassroots action from individuals across the state. Again, we will not achieve this critical goal without you engaging local house and senate representatives personally throughout the spring legislative session.

At the same time, it can be helpful to reflect on our own individual practices and develop strategies to reinforce with each and every patient our central role as physicians in the design and implementation of the anesthetic plan and pre- and post-operative care.

Expand systems knowledge to deepen understanding of administrative, regulatory, and legislative perspectives and use these skills to position effectively for leadership and advocacy

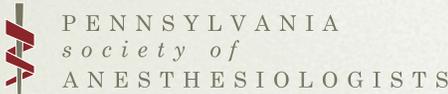
Medical simulation debriefing pedagogy teaches that the deepest understanding of learner actions during a scenario

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Sentinel

Pennsylvania Society of Anesthesiologists Newsletter

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Memorable Mentor Memories

Life lessons from Beaver County's "Mr. Anesthesia"

by Roman Y. de Jesus, M.D.

An anesthesiologist's demeanor can easily be affected by the pressures and stresses of the operating room. As the practice of modern medicine in general becomes more complicated and demanding, I think of my friend and mentor, Dr. John William Colavincenzo – the quintessential "Mr. Anesthesia" of Beaver County, PA.

Dr. John, a longtime PSA member, is retired and turns 90 years old this year. But the principles he lived by as a doctor are as relevant today as ever.

His likeable way of relating to people was apparent as he prepared a patient for surgery and anesthesia. Patients are often more worried about anesthesia than the surgery, and Dr. John had the gift of easing their concerns.

As all of my colleagues know, the initial encounter between an anesthesiologist and patient is key to a positive patient experience. Patients can be more forgiving if they have good rapport with their anesthesiologist. This is where Dr. John's skill in anesthesia is best known.

He also had amazing calm under pressure. There was no indecision on Dr. John's part. Perhaps it's because Dr. John was battle tested in a real war zone, as part of the famed "Mash Unit" during the Korean War in the 1950s.

During his tour of duty in Korea, Dr. John's "sweet-pepper" Italian personality was tested by a routine filled with some of the most harrowing critical trauma cases. With one senior anesthesiologist and two nurse anesthetists on the team, Dr. John recalls it was nothing to work non-stop for two or three days at a time.



Roman Y. DeJesus, MD, right poses with his friend and mentor John W Colavincenzo, MD during a round of golf.

After finishing his 14-month tour in 1953, Dr. John came back to Beaver County and enrolled in the anesthesia residency program of his old mentor at Mercy Hospital, Dr. Francis Foldes, one of the prominent pioneers in the new emerging specialty of anesthesiology.

After completing the two-year program, Dr. John became the first formally trained, board certified, anesthesiologist in Beaver County. Anesthesia at Rochester General Hospital was initially carried out by two nurse anesthetists under the supervision of the surgeons. Dr. John established a formal anesthesia department that he nurtured and developed into a respected integral part of the hospital.

Not only was Dr. John the only anesthesiologist in town for years, he would also take call in the emergency room at night. While on call in the ER, he would start anesthesia for emergency surgeries or give spinals for emergency caesarian sections, and then scrub to assist the obstetrician in the delivery of babies. On other occasions, after putting the patient to sleep, he would linger at

the top of the table doing dental hygiene for the patient, an "added value-service." These were early versions of his multi-tasking.

When I joined the hospital staff as his first appointed colleague, Dr. John's popularity and reputation as a leader was already established within the medical society and the community as a whole.

In 1973, when three local hospitals merged forming the Medical Center of Beaver County, Dr. John was elected the president of the unified medical staff. Prior to that, he was also elected as the county coroner, an office he held for eight years.

Ultimately, the most admirable quality of Dr. John was his enduring love of his job and people. He knew how to communicate with patients and reassure them about their fears of anesthesia.

Dr. John retired briefly in 1991 but missed his job of delivering anesthesia and being with patients, so he was hired to provide anesthesia twice a week in the eye clinic of Dr. Ronald Salvitti in Washington, Pa. Despite the long commute of more than an hour each way, this job lasted for 11 years.

One unforgettable incident he related was about a patient who had developed a heart problem and was transported from the eye clinic to the nearest emergency room. On the way, the patient deteriorated rapidly, requiring intubation (inserting a breathing tube) after vomiting, aspirating and losing consciousness. Dr. John immediately sucked and cleared her airway. I can imagine he was spitting for awhile.

continued on page 4

MEMORABLE MENTOR MEMORIES

continued from page 3

The patient ended up having emergency open heart surgery. The next day, Dr. John got a call telling him that the patient was doing fine and thanking him for his extraordinary care. That's Dr. John's personality, always placing his patient's welfare first before his own safety.

Here are other lessons that I took from my mentor that I believe are relevant in today's changing medical landscape:

First, do what is best for the patient. Practicing defensive medicine as insurance against malpractice is very expensive and difficult to change. That being said, fear of malpractice was not in Dr. John's medical decision making.

Secondly, compassion ahead of compensation. Many times, financial gains dictate our practice. Although there may be nothing wrong with that in modern medicine, it cannot become the primary driving force. Dr. John's primary concern for the welfare and well being of his patient is an ideal model.

Third, frugality in life translates to not being wasteful in medicine. Dr. John was known to

be notoriously frugal in life and in medical practice. His youngest son, Mark, recalled: "I remember growing up when Dad brought home bags of discarded hospital items like gloves, IV tubing, bottles and plastic trays that he found useful in the garden or even one time to decorate our Christmas tree."

In another example, Dr. John was proud to drive second-hand cars that he acquired from his more affluent physician colleagues. Perhaps we all need to be more conscious of the cost of care we prescribe for our patients.

As I mentioned earlier, Dr. John turns 90 this year. Except for a few minor ailments, he is physically active for his age and mentally sharp. His regular Sunday morning rounds at the hospital are dwindling as the number of contemporaries he visits has started to diminish, but his regular attendance at the monthly county medical society meetings is a welcome sight to members.

Dr. John still bowls once per week, gardens and looks forward to the next round of golf with friends. It all seems like his life is uninterrupted, but for the tears

wailing down when thoughts of his recently departed wife, Jane, come up.

Like the hundreds of people who had the pleasure of working with him and thousands of patients he cared for, we all have had the good fortune of knowing this wonderful man. Personally, the lucky privilege of having him as a friend, a mentor and father-figure was a blessing.

When Dr. John appointed me, a foreign medical graduate from the Philippines, to succeed him as the chairman of the anesthesia department, I was touched and humbly honored by his trust. I will be forever grateful for this living legend who showed me so much about the art of anesthesia and life.

To receive an expanded version of this article, email Dr. de Jesus at romanydj@hotmail.com.

Who influenced you in your career and what lessons did you learn? Submit an article for our next PSA newsletter at psa@pamedsoc.org.

Earn CME credits for free

PSA is excited to announce the launch of a new member benefit – access to CME journal articles from the PSA's website, www.psanes.org. Members must log into the website in order to access the e-learning module that contains the article, answer questions and submit for Category I CME credit.

If you have not created an account on the PSA website, contact the administrative staff at (717) 558-7750, ext. 1596, or email us at psa@pamedsoc.org. The project is a collaborative effort between the PSA and Reading Hospital.

ATTN: Dues Paying

PSA Members

The percentage of your PSA membership dues for 2012 that has been devoted to lobbying expenses and is, therefore, not deductible on your 2012 federal income tax return is 27.95 percent. The percentage has been updated, and should be used instead of any prior percentage included as part of your 2011 Membership dues statement that you received last year.

Sugammadex May Be Getting New Life in the United States

by Joseph Answine, M.D., ASA Assistant Secretary-Treasurer, PAMED Trustee

There have been many advances in anesthesia over the years, whether nitrous oxide in the 1800s or pulse oximetry within the last few decades. Scientific breakthroughs allowing for increased patient comfort and safety have continually put anesthesiologists in the forefront of medical advancement.

When looking at closed claims data for anesthesia, one particular area where we still struggle is post operative respiratory compromise, and many of the cases are directly related to residual neuromuscular blockade. It is easy to extrapolate that much of this is related to limited advances in reversal of the neuromuscular blocking agents (NMBA). Although acetylcholinesterase inhibitors move the reversal process along, it still requires the metabolism of the NMBA to safely allow for the return of normal ventilatory function. In fact, the use of these reversal agents may lead to more respiratory events when used inappropriately by leading to a false sense of security prior to extubation. Furthermore, when looking at the issue of muscle paralysis, we still rely heavily of succinylcholine with all of its side effects and potential life-threatening complications, because we have nothing else available when short periods of neuromuscular blockade are required.

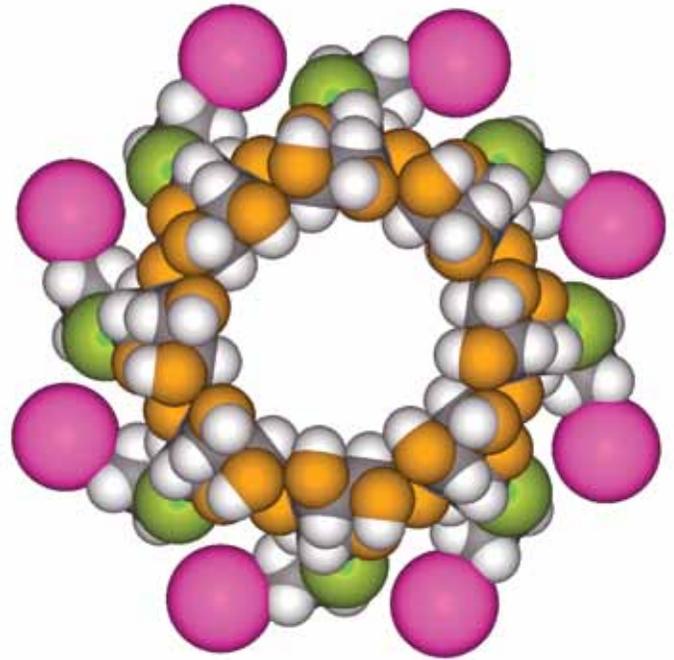
In 2008, Schering-Plough announced a new drug application for sugammadex; the first selective relaxant binding agent (SRBA). It is a revolutionary medication for the reversal of steroidal NMBAs such as rocuronium. The FDA, however, after unanimous support for sugammadex from

an FDA panel of experts as well as approval in Europe, refused to approve the SRBA. Likely, their actions at the time were guided by criticism received from their handling of drugs such as Vioxx, leading to what appears to be a more aggressive look at potential drug side effects. The FDA said its denial of approval was related to potential hypersensitivity reactions with what appears to be limited data to support the decision.

What does sugammadex do? It is a modified cyclodextrin (modified by adding eight side chains with negatively charged carboxyl groups at the end of the side chains) that has a structure resembling a donut or tube. The molecule has a hydrophobic cavity and a hydrophilic exterior.

Hydrophobic interactions trap the steroidal NMBA into the cyclodextrin, leading to the formation of a water-soluble guest-host complex within the plasma. That creates a concentration gradient and moves the remaining free paralyzing agent molecules from the receptor site back into the bloodstream where free sugammadex will bind them as well. The complex is then excreted through the kidneys intact.

Mohamed Naguib, in an article published in *Anesthesia and Analgesia* in 2007 titled "Sugammadex: Another Milestone in Clinical Neuromuscular Pharmacology," describes a dose dependent rapid and complete reversal of rocuronium. The reversal time is faster than that even seen with succinylcholine. Other



studies demonstrate lifesaving benefits in the cannot intubate/cannot ventilate situation.

Thankfully for our patients, Merck (which acquired Schering-Plough in 2009) announced in January 2013 that the FDA accepted resubmission of new drug application for sugammadex. Possibly, sometime in 2013, this potentially lifesaving drug may be available to our patients again, proving that we continue to be leaders in the advancement of medicine and, more importantly, patient safety.

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ASA Survey Shows Impacts of Drug Shortage

by Robert Campbell, M.D., PSA Vice President

Pervasive drug shortages continue to challenge Pennsylvania anesthesiologists. Want to know how we got to this point and what policymakers are doing to address the issue? Stay informed at the PSA's drug shortage web page, which can be found on the PSA website at www.psanes.org/Anesthesiologists/ClinicalResources/DrugShortages/tabid/246/Default.aspx. Below is a sample of what you'll find online.

In March 2012, the ASA surveyed its members on drug shortages. The responses to the survey totaled 3,063 anesthesiologists representing 50 states, the District of Columbia, Puerto Rico and six nations. The majority of responses (3,033) were from the United States. Respondents also represented all health care settings, including hospitals (88.5%), ambulatory surgery centers (44.7%), office-based (13.2%) and critical access hospitals (8%).

Here are some of the survey's key findings:

1. 97.6% of respondents reported they are currently experiencing a shortage of at least one anesthesia drug.
2. The anesthesia drugs with the highest frequency of reported current shortage are as follows:
 - 66.3% Fentanyl
 - 40.3% Thiopental
 - 21.1% Succinylcholine
 - 19.2% Propofol
 - 15.2% Pancuronium
3. Respondents reported that drug shortages had the following impact on patients:
 - 66.7% of patients experienced a less optimal outcome (e.g. post-op nausea and vomiting)
 - 52.8% of patients experienced longer OR/recovery times
 - 27.5% of patients complained
 - 0.2% resulted in death of a patient (6)
4. Respondents reported drug shortages had the following impacts on his or her practice:
 - 96.3% had to use alternative drugs
 - 50.2% had to change the procedure in some way
 - 7.0% had to postpone cases
 - 4.1% had to cancel cases

In addition to conducting this survey, the ASA and FDA held a town hall format meeting on December 5, 2012.



The meeting included a robust Q&A session, during which FDA and ASA officials fielded questions from ASA members. PSA members seeking to learn more about drug shortages can hear a recorded transcript of this meeting at www.asahq.org/For-Members/Advocacy/Washington-Alerts/FDA-TTH-12512.aspx

PSA members are encouraged to visit the PSA web page for this and other updates on this crisis at www.psanes.org/Anesthesiologists/ClinicalResources/DrugShortages/tabid/246/Default.aspx.

Report Drug Shortage

PSA members are encouraged to report drug shortages directly to the FDA. You can find a link on how to do that at the PSA's Drug Shortages web page, www.psanes.org/Anesthesiologists/ClinicalResources/DrugShortages/tabid/246/Default.aspx

2012 Z-PAC Contributors

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

A total of 358 physicians contributed in 2012 to Z-PAC, which PSA's political action committee. The average contribution was \$341.34. We thank all those who contributed to Z-PAC and encourage your continued support.

The 2013-2014 legislative session is already shaping up to be a busy one. We will need to continue our vigilance to ensure our patients receive the safest anesthetic possible. We are optimistic that 2013 will be the year that we finally get CRNA supervision legislation put into statute, but it will require work – both financial support and personal calls to legislators to make this happen.

If your name is not on this list, we ask you the simple question – “Why not?” Do you really feel that you practice in a vacuum, uninfluenced by the political arena? Are you that secure that others will watch out for patient safety over personal interests and feel that legislative policy should be formulated without our input? Can you really afford not to contribute to Z-PAC?

In this crucial year, we need the support of all PSA members. This is not the time to sit on the sideline and ride the coattails of the PSA members listed below. We need support from everyone.

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Nasser Sonbolian, M.D.
Ira Louis Spill, M.D.
Andrzej Trojanowski, M.D.

LOST IN TRANSLATION

continued from page 1

is gleaned from identifying the specific frame of reference in which the actions took place. In this regard, we can best effect change and demonstrate leadership by identifying the frames of reference or perspectives of our administrative and regulatory peers and then routinely jumping into these frames for advocacy and discussion.

Let's take an example. You are the head of a large group of anesthesiologists covering six facilities. As you renegotiate your contract, the COO of the health system offers renewal with a significant increase in direct salary support over three years with the following provisions for the group:

1. develop and implement a proposal for anesthesia role to improve facility HCAHPS scores with specific focus on patient-doctor communication;
2. facilitate and support the application of the health system for ACO status and propose a model for anesthesia to participate in shared savings;
3. implement an EMR/AIMS that reports on all CMS, NQF, and SCIP related quality measures;
4. and agree to join the provider network of the federal health insurance exchange with coverage and rates stipulated by CCIIO.

The ensuing board discussion focuses on several questions: Are these reasonable terms? Do we really understand what these provisions mean and what it will take to meet the expectations? What will reimbursement look like under the health exchange and does it make sense to commit?

A colleague recently asked me to stop mid-sentence and define an ACO. I am no longer

surprised when peers appear befuddled by references to HCAHPS, NQF, or IPAB. It is extremely difficult to advocate effectively from a position of ignorance, apathy, or naïveté. Hospitals that employ and contract with us have rapidly recalibrated, with laser-like focus, to new delivery models with evolving standards.

For example, physicians employed under New York City municipal contracts recently signed a ground breaking new contract that incorporated quality performance metrics directly into salary and bonus adjustments. Several of the qualifying metrics focus on clinical efficiency, and patient satisfaction with doctor-patient communications. These are metrics where anesthesiologist leadership in a care team model will demonstrate value.

These are examples of potential synergy between hospital executives, CMS directives, and anesthesiologist strengths. This may not be a great system and alternatives might be much more successful (see: www.nytimes.com/2013/01/28/opinion/keller-carrots-for-doctors.html). But the mere action of reading on these topics and learning the administrative lexicon may drive us to consider the details of new operational models at a level that will ultimately position us to innovate our way to more effective constructs.

Broaden our own spheres of interest & influence outwardly with existing skill sets

The PSA increasingly looks to cast a broader net for advocacy at the state level and position anesthesiologists to be involved in critical, multidisciplinary projects. Our training and experience equips us with the full panoply of skills

beyond provision of routine care. Many of our at-large members play crucial leadership roles outside of our specialty. PSA's board members are unparalleled in their work to broaden anesthesiology focus. Example of these activities abound.

Past-presidents and board members Joseph Answine and Joseph Galassi have broad influence and effectively advocate for anesthesiology interests within the Pennsylvania Medical Society Board of Trustees and Specialty Leadership Cabinet.

Past-president Carol Rose is a long-standing member of the influential Pennsylvania Board of Medicine; and the PSA is working to nominate a second anesthesiologist to a current vacancy on that board.

Past-president Erin Sullivan is currently chair of the high-profile ASA Committee on Governmental Affairs that works to bring our message to policy makers in Washington.

Michael Ashburn, chair of the PSA Pain Committee, is working with Pennsylvania legislators and PAMED on a bill to establish the Pharmaceutical Accountability Monitoring System (PAMS). PAMS will bring the Commonwealth into line with many other states and afford all Pennsylvania physicians the ability to monitor opioid prescribing while also creating an avenue for pain medicine practitioners and the PSA to lead in the development of opioid-related education materials and practice parameters for providers across the state.

Bob Campbell, PSA Vice-President, is active on the national stage in advocating more aggressive congressional and regulatory investigation of the critical drug shortages that stymie our provi-

sion of care in many clinical areas: www.psanes.org/Anesthesiologists/ClinicalResources/DrugShortages/tabid/246/Default.aspx.

Members of the PSA Executive Committee are working directly with the Hospital and Health System Association of Pennsylvania (HAP) to formulate quality and patient safety centered projects with broad synergy across specialties and systems.

The PSA has collaborated directly with the Pennsylvania Patient Safety Authority (PPSA) to address the growing contribution of anesthesia wrong-site regional and pain blocks to the statewide incidence of wrong-sided surgery (www.asaabstracts.com/strands/asaa-abstracts/abstract.htm?jsessionid=2478AEBB04F804423F9F65E7AE79E52D?year=2011&index=15&absnum=6368).

And this year, I have appointed the PSA Quality Leadership Ad-Hoc Working Group that will bring Pennsylvania anesthesiologists skilled in QA activities together to advance the cause of patient safety and quality for all of our patients and extend opportunities for collaboration with the Pennsylvania Safety Authority, HAP, the Anesthesia Quality



Institute (AQI), and the Anesthesia Patient Safety Foundation (APSF).

Concluding Thoughts

We have every reason to remain optimistic about the future of our specialty. It is even important to periodically express frustration, protest the system and vehemently argue for a better one. In the meantime, we must not follow the lead of Congress and bring progress to a standstill. Rather, we can put to effective use the collective treasure trove of innovation skills, broad clinical expertise, and superbly talented leadership that defines our PSA membership and positions us so well for the future.

I encourage commentary and debate on these ideas. Please write me with your thoughts and comments Joshua.Atkins@uphs.upenn.edu. Selected responses will be published on the PSA website: www.psanes.org. Please check-in with us as often as you can.

Glossary

PPACA: Patient Protection & Affordable Care Act: www.kff.org/healthreform/KIHRPI.cfm for informative discussion.

ACO: Accountable Care Organizations: See www.asahq.org/For-Members/Advocacy/Federal-Legislative-and-Regulatory-Activities/Accountable-Care-Organizations/What-are-ACOs.aspx

CCIIO: Center for Consumer Information and Insurance Exchanges: <http://cciio.cms.gov/programs/exchanges/index.html> - Responsible for rule making and health insurance exchange implementation under ACA

HAP: Hospital & Health System Association of Pennsylvania: www.haponline.org

HCAHPS: Healthcare Consumer Assessment of Healthcare Providers & Systems: See www.hcahpsonline.org

IPAB: Independent Payment Advisory Board: Appointed group created by ACA to contain Medicare costs through reimbursement cuts to providers; www.ama-assn.org/resources/doc/washington/ipab-summary.pdf

NQF: National Quality Forum: Independent organization focused on development of standards and quality metrics; www.qualityforum.org/Home.aspx

SCIP – Surgical Care Improvement Project: www.joint-commission.org/surgical_care_improvement_project/

Physician Assistant Legislation

A Commentary on the Future of Medicine

by Joseph Answine, M.D., ASA Assistant Secretary-Treasurer, PAMED Trustee

During the 2011-2012 session, the Pennsylvania legislature considered a bill that would remove the co-signature requirement for physician assistants (PAs). Currently, notes written by PAs in Pennsylvania have to be co-signed by their supervising physician. They are asking that this requirement be removed.

That bill stalled after the Pennsylvania Medical Society (PAMED) pulled its support for the bill. Those opposing the bill on the PAMED Board of Trustees argued that this would be an expansion of scope of practice of the PAs and would potentially be a detriment to patient safety.

The vote, however, was far from unanimous, and many physicians, including primary care and emergency doctors, were in favor of the removal of the co-signature requirement. Why? Many stated that the co-signature is a waste of clinical time and provides no benefit to patient safety. Furthermore, the current requirement is a significant discrepancy between the PAs and Certified Registered Nurse Practitioners (CRNPs). The Pennsylvania Society of Physician Assistants (PSPA) claims that this leads to an unfair disadvantage when PAs compete for jobs with the CRNPs.

The PSPA asked PAMED to reconsider its position with the hope that new legislation will be introduced in 2013. It was reconsidered by PAMED's executive committee with the eventual recommendation that the board support further legislation. There was a long discussion at the recent PAMED Board of Trustees.

Except for minor modifications, the board, with a vote of 22 for and 10 against, decided to accept the executive committee's recommendation and support any future bills introduced. The arguments were the same as with previous discussions.

How did I vote? I am currently writing the minority report. PAMED is an organization responsible for the betterment of physicians and patients in Pennsylvania. I fail to see how either is achieved with removing the co-signature requirement.

They (the physicians for this bill) argue that a physician's signature doesn't improve patient safety. It surely can't hurt it. When you have to put the pen to paper, you pay attention to what you are about to sign. Even if it's a quick review, at least the PA's assessment and plan has been reviewed.

Does it lead to a waste of a physician's clinical time? Reviewing a plan for a patient of yours is never a waste of time, and regardless of whether there is a co-signature or not, that patient is "yours."

Does it lead to less job opportunities for PAs? If it does, it is a sad statement for patient care in Pennsylvania. Furthermore, "two wrongs don't make a right," and losing significant supervision over CRNPs was not a win for our state.

But the battle was "uphill." One primary care physician on the board (an excellent one as a matter of fact) stated it took time away from his own patients. I, of course, in my usual smooth way, stated that they were all

his patients. Then, he said that some things such as sinusitis do not need his oversight. And, of course, I said: "What if the sinusitis was a sinus tumor?" He then stated that he would possibly miss that diagnosis as well. He is correct. However, I hope and assume that it is less likely.

What does a level of physician oversight bring to the table, in my opinion? First, there is a broader differential diagnosis developed from years of in-depth education. Second, there is a better understanding of whether there is a need for further workup and what is available to help secure the diagnosis. Third, the analysis and eventual decision as to the pharmacopeia instituted for treatment are more diverse. I was truly impressed with my argument. But alas, at the end of the day, I was one of the 10 in the minority.

PAs, CRNPs, midwives and CRNAs are physician extenders, not physician replacements, less we forget. We as physicians, again in my opinion, continue to be our own worst enemy.

Joseph F. Answine, MD, is Assistant Secretary Treasurer of the Pennsylvania Society of Anesthesiologists and serves on the Board of Trustees at the Pennsylvania Medical Society. He is a partner at Riverside Anesthesia Associates in Harrisburg, Pa.

Winds of Medical Change

by Paul Schaner, M.D., Sentinel Editor

Climate change happens. The only constant is change. What was initially forecast as an Arab spring is turning to an Arab winter. Clippers fly through Pennsylvania and across the country with an increasing frequency. Hurricane Sandy in New York, tornadic activity in the south, and droughts in the midwest are occurring. As Obamacare unfolds, I believe it will cause a medical winter.

The famous quote (“you will know what’s in it after you pass it”) was prophetic. However, the promulgation of an ever expanding regulation blizzard will be blinding indeed. The saying “The devil is in the details” is as true as ever, and we have a lot of details.

The regulations are the details that matter. Medical reimbursement is in the cross hairs. Obamacare was to permit everyone to keep their doctor and the health insurance. It is apparent that will not happen. Mid-level providers will increasingly be expected to provide care beyond their educational backgrounds. The number of physicians will decrease due to retirements, and the ability to attract the best and brightest to replace them will be difficult. A plethora of taxes imbedded in the legislation will have a significant impact on everyone.

Forecasting the impact of these changes requires a dedicated staff. The staffs in Harrisburg (PA Society of Anesthesiologists) and Washington (American Society of Anesthesiologists) work diligently to keep abreast of the evolving regulations and legislation that will impact practitioners and patients. Our lobbyists in Harrisburg are crucial in forecasting

potential problems with pending state legislation. Just as when inclement weather is in the offing, strike being preparation is the key to survival. The same is true in Washington, where our lobbyists are keeping track of the evolving storm of regulations.

While the lobbyists are required for survival, Z-PAC and ASAPAC are just as crucial. The fact of the matter is that money is required for political success. This fundamental does not go away. If the membership responded with 100 percent participation, the chance for successful outcomes significantly improves. Are you doing your fair share or is this left to others? A monthly contribution by credit card or payroll deduction is a painless way to make a significant impact. Please become pain free this month and bolster

our efforts for safe anesthesia and superior medical care in the Commonwealth and across the country.

It is incumbent upon every member to become politically active. The impact on your patients and family will be significant. The time to prepare is now. Meeting and getting to know your elected representatives and senators before you need them is a simple step that will pay off in the coming days. A letter or phone call in a time of crisis has more impact when the writer or caller is a constituent and known to the legislator.

These small steps are easily done but most are reluctant to do them. Overcome this reluctance. It is essential. Please help maintain future quality safe anesthesia and medical care.



PSA Continues Fight for Physician Supervision

by Andrew Goodman, MBA, Milliron Associates, PSA Legislative Counsel

The point of this article is patient protection and the legislative need to ensure it. For many years, anesthesiologists on behalf of their patients have asked the general assembly to put into statute what already exists in enforced regulation.

Current Pennsylvania Hospital Regulations (123.5) stipulate that “Anesthesia care shall be provided by a qualified physician, anesthesiologist, resident physician in training, dentist anesthetist, qualified nurse anesthetist **under the supervision** of the operating physician or anesthesiologist, or supervised nurse trainees enrolled in a course approved by the American Association of Nurse Anesthetists.”

The Society has straightforward legislative goal. Our primary goal is to codify in statute what already exists in enforced regulation. The issue is really that simple. Our advocacy efforts will center on including this language in legislation currently before the General Assembly that deals with hospital regulations and hospital accreditation guidelines.

Last year and moving into this session, PSA has advocated legislating our current health care facilities regulation into statute. And, over the course of the same time period, the PSA has been negotiating with the Department of Health, Hospital Association and other stakeholders to include our language. However, opposing stakeholders are doing their best



to change that today and will be working tomorrow to do the same.

Our firm, Milliron Associates, is continually meeting with the chairmen and members of the health committees within the Senate and House. Furthermore, we are working and educating key members of both chambers, including leadership.

I want to be very clear, if we are included, we will support and advocate on behalf of the legislation. If our language is not included, we will continue to attempt to amend the bill but will oppose it until it is amended to our liking.

Either way, the PSA, the Pennsylvania Medical Society and other specialties have a long and difficult road ahead. We are up for

it, but we will need your help. Over the next few days and weeks, I will have email updates and calls to action. Please follow them or contact us directly at (717) 232-5322 if you have questions.

It will be critical for you to advocate with both your House and Senate member. We will work to keep you abreast of this rapidly evolving legislative picture. Success hinges upon you making calls and appointments to personally reiterate our straightforward message to legislators: Act to enforce current regulations – safe anesthesia is care supervised by physicians!

Scope of Practice Issues Highlight Specialty Leadership Cabinet Meeting

by Joseph Galassi, M.D., PSA's Representative to the Specialty Leadership Cabinet

The Pennsylvania Medical Society's Specialty Leadership Cabinet met in February 2013 to discuss a number of issues that may impact the specialty of anesthesiology.

Controlled Substances Database

Many in attendance supported the controlled substance database legislation that is pending before the state house. Michael Ashburn, M.D., Director of Pain Medicine at the University of Pennsylvania and a PSA board member, has worked tirelessly on this issue for the past several years. I requested the support from the SLC to endorse this legislation and it was very well received (author's note: It is expected that PAMED will take the lead on this legislation and PSA will play a supportive role; many thanks to Michael for his work on this issue).

Scope of Practice Topics

PSA also asked for the SLC's support on scope of practice for CRNAs as it relates to providing chronic pain medicine care. In light of the recent CMS payment changes that allow CRNAs to bill for chronic pain medicine services despite the vehement opposition by ASA, PSA has written to the State Board of Medicine (SBOM) on this issue. Dr. Galassi updated SLC members on this topic and asked for similar letters to be written to the SBOM.

This was followed by discussion of scope of practice by other specialty groups. Audiologists want to be allowed to perform

and interpret intraoperative neurophysiological monitoring. Only one university in the state gives them any training in this area. The PA Academy of Neurology is opposed to this expansion of the audiologists' scope. The PA Optometric Association wants to perform laser surgery. The PA Academy of Ophthalmology vehemently oppose this expansion of their scope. Finally, the State Dental Board recently issued a statement that dentists in their scope of practice may perform dermal fillers/botox injections and the like in the facial area. Those physicians performing these types of treatments are opposed to this expansion.

Workers Compensation

One issue that may affect reimbursement for all physicians is the possibility that the state legislature may take up worker's compensation reform. The Pennsylvania Orthopaedic Society is particularly attuned to this topic and has contracted with an actuarial company to help it in its efforts (author's note: PSA will stay on top of this topic as well.)

Changes to PAMED's Governance Structures

SLC attendees heard a review of the ongoing PAMED efforts to streamline its governance structures and processes. A task force was charged to put forth recommendations to the PAMED Board of Trustees and the House of Delegates (HOD) on this matter. It was determined that more time

will be needed to accomplish this goal, and, while the HOD wanted an interim meeting this spring to set the ball in motion, this will not be feasible. Suffice it to say that a smaller group of physicians, potentially composed of representatives from the various specialties as well as geographical areas from the state, may be what gets recommended to replace the HOD.

'Pill for Ills' Campaign

PAMED's "Pill for Ills Not Thrills" campaign was also discussed. PAMED rolled this out at the HOD in October 2012 and it has had significant impact in the lay press. Leading newspapers in Pittsburgh and Philadelphia, as well as a number of the smaller papers around the state have written op-eds in favor of this matter.

The next scheduled meeting of the PAMED SLC will be Tuesday, May 21, 2013.

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Pennsylvania MEDICAL SOCIETY

What CMS's Pain Medicine Policy for CRNAs Means for PA Anesthesiologists

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

Pain medicine is a recognized medical sub-specialty, and many of its practitioners are anesthesiologists. Is it, should it be, and/or will it become an equally accepted part of the scope of practice of nurse anesthetists?

The question is more relevant now than it has been because the Centers for Medicare and Medicaid Services (CMS) has authorized Medicare payment, effective January 1, 2013, for chronic pain management services performed by nurse anesthetists, provided they are legally authorized to perform that service by their state of licensure.

This article addresses two questions:

- How and why did CMS act?
- What is and will be the impact of that decision in Pennsylvania?

CMS's Action

Since 1986, Medicare has paid nurse anesthetists for "anesthesia services and related care." CMS has now redefined that term as "medical and surgical services that are related to anesthesia and that a CRNA is legally authorized to perform by the state in which the services are furnished." Although that redefinition does not mention "pain management" and chronic pain management is not "related to anesthesia" in any meaningful way, that was the explicit context in which the issue arose.

Explaining its action, CMS noted that in 1986 nurse anesthetists rarely practiced outside the surgical setting and perioperative timeframe. Since then, nurse anesthetists in some states "have

moved into other practice settings," most particularly "chronic pain management services" unrelated to surgery. The health care community, CMS stated, "continues to debate whether CRNAs are qualified to provide chronic pain management," with some arguing a lack of sufficient education and skills and others arguing the converse. CMS decided not to decide, or more accurately, to let states decide:

"We have concluded that chronic pain management is an evolving field, and we recognize that certain states have determined that the scope of practice for a CRNA should include chronic pain management in order to meet health care needs of their residents and ensure their health and safety."

Finally, CMS emphasized that even in states that allow nurse anesthetists to practice pain medicine, an individual practitioner cannot do so without having the necessary training to do so competently.

The Pennsylvania Impact of the CMS Action

As to "the impact of that decision in Pennsylvania," the simple answer is "nothing, at least now."

First, the CMS revision is a payment rule, not a scope of practice rule. No more than insurers generally, CMS does not establish who can do what, only what it will pay for. The CMS action does not allow a nurse anesthetist, in Pennsylvania or anywhere else, to do anything s/he could not previously do. It simply recognizes that some states appear to allow nurse anesthetists

to practice pain medicine and in those states CMS will reimburse the anesthetist for doing so.

Second, Pennsylvania law does not authorize nurse anesthetists to engage in the independent practice of treating chronic pain. That will remain the case unless and until the legislature establishes a new and broadened scope of practice for nurse anesthetists. This issue takes a little more explanation, which follows.

Managing chronic pain is, of course, the practice of medicine. Its practitioners have usually completed "post-residency," a one-year multidisciplinary pain fellowship program. It involves diagnosis of the cause of pain; selection of the proper procedures, medication, or other modality to diagnose and address the pain; and performing any procedures deemed appropriate. Pain medicine views pain as a disease in itself, quite similar to the medical diagnosis and therapy of other diseases by other specialties. Pain medicine procedures themselves are far from routine, requiring far more precise placement, often with fluoroscopic, CT, or ultrasound guidance. The medications used, in particular steroids and neurolytic agents, are very different than those used in surgical anesthesia care.

Nurse anesthetists, in contrast, are registered nurses who are authorized by a Board of Nursing regulation to "administer anesthesia" in conjunction with a physician. They cannot diagnose medical conditions or order treatment. As these limitations imply, nurse anesthetists cannot act independently, not even to the

limited extent that nurse practitioners, nurse midwives, or physician assistants can. Nurse anesthetists have no more authority to independently diagnose the cause of and treat chronic pain than to perform surgery or diagnose heart disease.

The Future

Pain medicine as a specialty will likely prosper in future years and anesthesia-trained practitioners will be at the forefront. But the current cost-driven effort to replace physicians with mid-level professionals of all kinds will likely continue.

That suggests that the efforts of nurse anesthetists to treat chronic pain will increase, bringing with it efforts to change scope of practice laws, like Pennsylvania's, that now do not allow it. The American Association of Nurse Anesthetists (AANA) funded a recently published "case study report" of four pain patients, prepared by the Lewin Group, asserting that CRNAs provided these patients with "high quality care at a lower cost in their community." The Report is entirely anecdotal, miniscule in scope, non-peer-reviewed, and withholds the identifying information (as to patient and even the state where the patient lived) that would allow meaningful review.

Nevertheless, it shows the direction the AANA wants to proceed. While we are unaware of any analogous efforts or activities now underway within Pennsylvania, future efforts to promote the utilization of nurse anesthetists in chronic pain management in the Commonwealth and to modify the



current regulatory scheme so as to allow it are likely.

The role of mid-level practitioners should follow from a fair-minded understanding of the knowledge and skills needed to perform the tasks of chronic pain medicine competently and a finding that the mid-level does, or does not, have those competencies. If diagnosing and treating pain as a disease requires an understanding of anatomy, physiology and other matters that physicians acquire in medical school, residency, and fellowship training, nurse anesthetists and any others wanting to provide that care must show they have received comparable training and experience in their own educational pathways.

EDITOR'S NOTE: *PSA President Joshua Atkins, M.D., PhD, recently wrote a letter to the State Board of Medicine echoing many of these points.*

Mr. Hoffman is outside counsel to PSA.

Residents' Corner

Thoughts From Vegas Conference and Searching for the Perfect Job

by Stanislav Kelner, M.D., PSA Resident Component President

On behalf of the resident component, I would like to wish you a belated Happy New Year. Members of the resident component have been hard at work over the recent months compiling information on the practices across our state. We hope this information will be available on the PSA website in April and can assist you with your job search.

For this issue, I wanted to tell you about my experience at the Practice Management Conference in Las Vegas. Namely, I had the privilege of attending lectures in preparation for my quickly approaching graduation and entry into the world of private practice. Valuable topics included fee for service, the change over to the

ICD-10 billing system, penalties for false billing, hospital bylaws, and issues of billing compliance.

However, timing on the rest of the lectures was not optimal. Along with most other pgy-4s, I have been thoroughly exposed to both contract negotiation and realities of today's market. In that sense, these lectures would have served far better earlier in my residency.

Subjectively speaking, today's market is what you make of it. A graduating resident who puts substantial time and effort into finding their perfect job, is very likely to succeed in finding the right job.

Is it the same market of eight or 10 years ago? No it is not. Are there practices out there that want

to take advantage of wide-eyed residents? Absolutely and it can be very shameless. What was not said at this conference was that, at times, it is simply a gut feeling at yet another interview that tells you if you will fit in with that group. We hope that our training and involvement has taught us enough to avoid all those many pit falls.

I am grateful to the governing body of the PSA for the opportunity to attend this meeting in fabulous Las Vegas. It is an experience that will prove beneficial in both my practice and societal involvement.

Register today for PSA's Ultrasound Guided Regional Anesthesiology Best Practices Workshop

This workshop is hosted by the Department of Anesthesiology, Drexel College of Medicine.

Date and Location
Saturday, April 27, 2013

Drexel College of Medicine,
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www.psanes.org

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April 26-28, Boston

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Lifebox Pulse Oximetry Project

by Berend Mets, M.D., PhD

The Lifebox Project seeks to place a pulse oximeter in the estimated 77,000 operating rooms around the world that do not have this lifesaving technology. This 77,000 “oximeter gap” is based on computations of the responses to surveys sent to anesthesia providers in 72 countries around the world, and published in a now landmark article in the *Lancet* (Funk et al, 2010).

The idea for addressing this problem flowed from members of the Safety Committee of the World Federation of Societies of Anesthesia (WFSA) at the World Congress, held in Paris, France, in 2004. The ensuing Global Oximetry Project resulted in the commissioning of the Lifebox Oximeter Package. This is an oximeter built to WHO specifications that has a 12-hour rechargeable battery, with a replaceable probe and is sent with a print and CD multilingual education package. Lifebox can be delivered anywhere in the world at a total cost of \$250 by donation. Over the last two years, more than 4,000 Lifeboxes have been placed in more than 70 countries, narrowing the gap to 73,000.

Recently, the American Society of Anesthesiologists has endorsed the support of the WFSA, Lifebox Project. More specifically, the above mentioned article determined that there is a Pulse Oximeter Gap in Central Latin America of 1,648 oximeters. The Global Humanitarian Outreach Committee of the ASA has determined that we will focus on Central America in our efforts to



“Make it Zero” in the countries adjacent to the U.S.

Lifebox has now become a registered charity and its stated strategy is to first provide an actual pulse oximeter needs assessment in a particular country. The next step is to seek the necessary funding/donations for Lifeboxes to that country, to address the actual pulse oximeter gap.

Once these Lifebox donations have been secured, the requisite number of Lifeboxes is then delivered to the country. Usually this Lifebox delivery is done to coincide with an annual meeting of the particular country’s Society of Anesthesiologists. At that time, trainees from across the country are trained in the use of this oximeter at the national meeting. These trainees then return with the oximeters to their place of work and so are able to distribute the oximeters around the country to ORs that have none.

Subsequently, using a provided logbook, a national audit of donated Lifebox use is planned. We have identified the potential to narrow the Pulse Oximetry Gap in Guatemala, where there is a need for 140 pulse oximeters (80 ORs and 60 PACU beds). You could help this effort in Guatemala by donating \$250 through the following site, www.lifebox.org/donations/.

Other Central American countries to consider are Belize, Nicaragua, Costa Rica and Panama as well as Mexico, Colombia and Venezuela. Please consider helping in this effort. The administration of a safe anesthetic in the U.S. would be unthinkable without a pulse oximeter. You can help make this a reality in Guatemala and assure the potential for safer surgery in that country.



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April 27, 2013	PSA's Ultrasound Guided Regional Anesthesiology Workshop
April 29-May 1, 2013	ASA Legislative Conference, Washington, D.C.
September 30, 2013	PSA Board Meeting, Hilton Harrisburg, 8:30 a.m.
September 30, 2013	PSA Legislative Reception, Hilton Harrisburg
October 12, 2013	PSA Annual Business Meeting, San Francisco, location TBA

2013 Upcoming PSA Events

APRIL

SUN	MON	TUE	WED	THU	FRI	SAT
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	1			

SEPTEMBER

SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

OCTOBER

SUN	MON	TUE	WED	THU	FRI	SAT
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		