Sentinel
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Society of Anesthesiologists
Newsletter

Summer 2012

PRESIDENT'S MESSAGE

Strength in Numbers: Why You Must Join the PSA and ASA

By Margaret M. Tarpey, M.D., President

I have recently been asked why membership in ASA is required to be a member of PSA. That is a reasonable question, and I would like to devote some time to my answers.

ASA is the society that represents anesthesiologists nationally. This occurs at several levels:

At a governance level, the ASA House of Delegates is composed of representatives from each state based on the number of ASA members from that state. Additionally, there is a director from each state, with an alternate, that forms the board of directors. These two bodies are where much of the policies, guidelines, and practice parameters of the society are vetted. Without active membership in both state and national societies, Pennsylvania anesthesiologists cannot be fully represented within the House of Delegates.

On a policy or practice level, national committees are responsible for elaboration and

development of the standards and guidelines that direct the high quality of practice for which our specialty has become known. One must be a member of ASA to be considered for membership on a committee. Again, without active participation from Pennsylvania members, our region will not be adequately represented on the committees that form a vital part of the national organization.

As advocates for the practice of anesthesiology, the national organization has been able to assist state component societies. Recently, ASA has been involved in efforts to overturn unfavorable policies in both California and Colorado. Without strong evidence of those states' members in national activities, what is the motivation for a national organization to provide such assistance?

ASA also serves as a national clearinghouse for state-related issues. As matters arise in one region, the ASA can provide information about other states that have dealt with similar topics. This is far more effective than trying to contact all other component societies individually.

The ASA speaks for anesthesiologists on a national basis. Society leaders have been instrumental in providing leadership on issues that affect anesthesiologists across the country, such as helping to organize, in concert with the FDA, the recent workshop on drug shortages.

The ASA is also important in advocating our positions to federal officials, both in the legislative and executive branches. Most state

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The History of Modern Anesthesia

By Robert B. Hoffman, Esq., and Donald E. Martin, M.D.

Introduction

A recurrent issue in health care policy, particularly in efforts to control costs while maintaining quality, is the extent to which non-physician professionals should perform, independently or under supervision, medical tasks that are now the general responsibility of physicians. Doing so often implicates the profession's scope of practice, the provision found in most state professional licensing statutes that determines the range of services a health care professional can legally perform. One such issue involves whether to expand the scope of practice of various categories of advanced practice nurses, including nurse practitioners and certified registered nurse anesthetists (CRNAs), to sanction more independent practice.

As anesthesiologists, CRNAs, hospital administrators, and health policy experts debate and consider scope-of-practice and supervision issues for non-physician anesthetists, those supporting a broad scope of practice often point out that nurses, not anesthesiologists, were the first modern anesthesia providers. A recent resolution in the Pennsylvania House of Representatives, designating January 22-28, 2012, as "Nurse Anesthetists Week," began with that point. A press release/article by the New Jersey Health Care Quality Institute ("Nurses are an equal, if not superior choice, to administer anesthesia") believes it "important to understand the history of anesthesiology in America" and explains that "the very first professional that provided dedicated coverage to a patient under anesthesia was a nurse."

A president of the Pennsylvania Association of Nurse Anesthetists began testifying in 2007 before the Pennsylvania House of Representatives Professional Licensure Committee by telling the legislators that nurses had been "administering anesthesia in Pennsylvania since 1877 when the first anesthetic was delivered at St. Vincent's Hospital in Erie." Even Wikipedia leads off its "Nurse Anesthetist" entry with that history, citing to the American Association of Nurse Anesthetists as the source.

Most of these historical references are accurate, particularly as they compare the relative involvement of nurses vs. anesthesiologists per se in early anesthesia care. The question is, what is the significance of this history? Does it support the broad scope of practice claimed by nurse anesthetists in 21st century anesthesia? This article explores the history of the origin and development of surgical anesthesia in an effort to answer that question.

The Origin of Modern Surgical Anesthesia

Prior to the advent of effective anesthesia, elective surgery was uncommon. From 1821 to 1846, the annual reports of Massachusetts General Hospital recorded only 333 surgeries, barely more than one per month. Surgery was a last and desperate resort, and understandably so (http://neurosurgery.mgh.harvard.edu/history/beforeth.htm). As of 1846, opium and alcohol were the only agents generally regarded as having practical value in reducing surgical pain. An 1847 publication on New Elements of Operative Surgery listed opium, water of nightshade, hebane, lettuce, hypnosis, strapping, compression of nerve trunks and noise as anesthetics then in use.

That changed in 1846, when William T. G. Morton, a Boston dentist, used ether as he removed a tumor from a patient's jaw. Surgeons watched and saw that ether could anesthetize, and Morton became widely recognized as the founder of anesthesia. In fact, another dentist, Horace Wells, had demonstrated the use of nitrous oxide at about the same time, and Crawford Long, a Georgia surgeon, had used ether as early as 1842 but his doing so was not well known. Morton's use of ether was a substantial advance in anesthesia and surgery.

As of Morton's demonstration, the physicians most knowledgeable on the subject of anesthesia inevitably were surgeons; there were no physicians specially trained to provide anesthesia. The surgeons, of necessity, relied on their operating room nurses to administer the ether under their direction while they operated. It was undoubtedly Morton and his fellow surgeons who gave the orders, who decided how much ether to use, and who were the proverbial captain of the anesthesia ship.

So it was that nurses became the first professional group to administer ether, then the anesthetic

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Fifteen Years of Action

by the

Pennsylvania Society of Anesthesiologists

1995 to 2010

Information Compiled By: Robert F. Early, Jr., M.D.

Membership

Total: 1,676 average, ranging from 1,467 to 1,802.
Active: 1,194 average, ranging from 1,011 to 1,265.

PSA's goals include representing the interests of anesthesiologists before the Pennsylvania legislature and executive agencies. The PSA Board, and its legislative and legal counsel, constantly monitor proposed legislation and other actions to determine whether PSA should take a position and what that should be. Over the past 15 years, PSA has acted aggressively and successfully on a host of issues important to anesthesiologists and to their patients. The discussion below highlights several of the most important, and persistent, of those issues.

Medicare Payment Issues

1995-2001

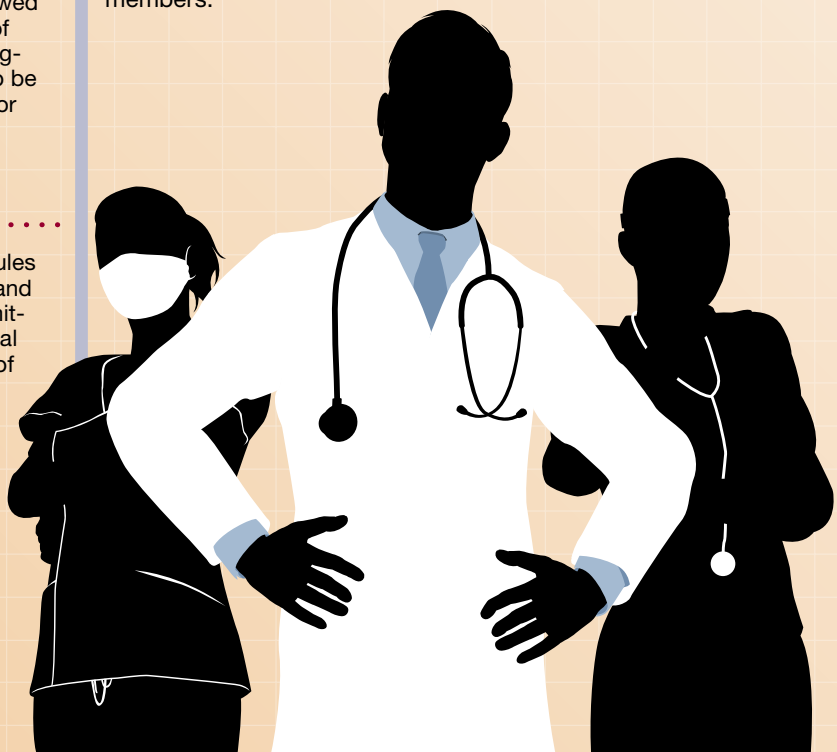
Medicare considers reducing or eliminating payments for certain MAC services. Marc Hahn, DO, PSA's representative to the Pennsylvania Carrier Advisory Committee, was especially helpful in drafting a compromise local medical review policy that allowed continued payment for anesthesiologist services for a range of diagnostic and therapeutic procedures, and for a range of diagnoses. This compromise policy permitted anesthesiologists to be reimbursed for a wider range of services providing moderate or deep sedation. The final policy was implemented in 2001.

1998-2005

PSA helps to better define and clarify Medicare compliance rules for anesthesia services as federal efforts to address medical and billing fraud and abuse continue. PSA Carrier Advisory Committee representatives meet with Dr. Andrew Bloschichak, Medical Director for Highmark Medicare Services, leading to a series of "FAQs" published by both Highmark Medicare and PSA in 2001, 2006, and 2010. These FAQs outlined appropriate billing practices under "medical direction" rules, as well as the conditions under which anesthesiologists providing medical direction could perform simultaneous services. The clarifications allow PSA members to practice more effectively while maintaining compliance with billing requirements.

1997

Office of Inspector General announces plans to audit anesthesia billing practices for compliance infractions. PSA informs members.



CRNA Scope of Practice

On a regular basis since at least 1995, CRNAs have tried to obtain the right to practice essentially independently and without "supervision" from anesthesiologists. PSA has successfully opposed those efforts and protected the public health from actions that would have diminished patient safety. Without PSA's efforts, it is likely that CRNAs would have succeeded. The details of the CRNAs' efforts and PSA's actions follow.

1995-1997

Proactive attempt by PSA to have Board of Medicine promulgate a state regulation requiring physician supervision of CRNA's. This effort ultimately fails when one Board of Medicine member insists on supervision by an anesthesiologist ONLY, making the regulation politically unfavorable.

1999

House Bill 50 is introduced, which would provide statutory recognition for CRNAs, as category of Advance Practice Registered Nurse ("APRN"). Bill would have allowed CRNAs to administer anesthetics pursuant to Nursing Board regulations and contained no reference to physician supervision or direction. PSA vigorously opposes and develops multi prong approach, with guidance from PSA legislative counsel, John Milliron, on how to mobilize opposition. Drs. John BianRosa and Carol Rose testify for PSA at House Committee hearing. PSA efforts succeed. Bill is referred to the House Professional Licensure Committee and never leaves.

2001-2002

House Bill 823 is introduced, which would amend the Health Facilities Act to require supervision of CRNAs by a surgeon or anesthesiologist who was physically present in the health care facility (presence would not be required in an ASF). Bill passes House unanimously, but never gets out of committee in Senate.

2005

PANA approaches PSA to establish liaison. PSA strongly supports this concept as a way to further patient safety. The effort fails when PSA refuses to support PANA's efforts to obtain independent practice for CRNAs, leading PSA to conclude that an expanded relationship with PANA "would be unfruitful at best."

SB 452 is introduced. Bill was comparable to Senate Bill 580 (from 2003) would provide statutory recognition for CRNAs and authorize them to practice "in cooperation" with a physician, dentist, or podiatrist. PSA opposes. Bill is referred to House Consumer Protection and Professional Licensure and no further action taken.

2007

HB 700 is introduced. The Bill is Gov. Rendell's "Prescription for PA" and proposes a broadening of the scope of practice for CRNAs, CRNPs, clinical nurse specialists, physician assistants, nurse midwives and independent dental hygienist practitioners. PSA vigorously opposes as to CRNAs. Drs. Erin Sullivan and Joseph Answine testify before the House Insurance Committee. PSA efforts succeed. All groups other than CRNAs obtain broader scope of practice. No change made for CRNAs.

2009-2010

HB 1866 is introduced. Bill is similar to earlier CRNA efforts to obtain statutory recognition and near-independent scope of practice. PSA vigorously opposes. Drs. Carol Rose and Joseph Answine testify before the House Professional Licensure Committee. PSA, with guidance of legislative counsel John Milliron, develops substantial grass roots effort to educate legislators. Efforts succeed: The Bill is referred to Committee and never leaves.

1997-1998

Child dies in Hazelton dental office while receiving anesthesia. Some legislators announce intention to introduce legislation to expand CRNA scope of practice and Pennsylvania Association of Nurse Anesthetists ("PANA") begins initiative to be allowed independent practice; PSA plans to sponsor a bill that would declare that providing anesthesia is "the practice of medicine" and that non-physicians can administer anesthesia only under "medical direction."

1999

The Department of Health proposes revised regulations governing the operations of Ambulatory Surgery Centers, including the provision of anesthesia there. PSA monitors and submits comments on importance of physician supervision of CRNAs in that setting as well as in hospitals.

Board of Medicine begins the process of promulgating regulations regarding physician delegation of medical services. PSA supports the Board's efforts. The Board finalizes the regulations in 2004.

2003-2004

Senate Bill 580 is introduced, which would authorize CRNAs to provide anesthesia care "in cooperation with a physician, dentist or podiatrist" and under "overall direction" of the chief of anesthesia services. PSA opposes. Bill is referred to the House Consumer Protection And Professional Licensure and no further action is taken.

2006

HB 2883 is introduced. HB 2883 would require insurers to make equal payments to CRNA's and physicians for anesthesia services. PSA opposes. The Bill is referred to the House Insurance Committee and dies there, after opposition from many medical and business groups.

2008

PSA and PANA make effort to jointly sponsor legislation providing CRNAs with statutory recognition and providing for CRNAs to practice under physician supervision. Effort appears on verge of success when CRNAs reject concept of "physician supervision." Joint effort collapses.

2012 and Beyond

CRNAs will undoubtedly continue efforts to obtain statutory recognition and right to practice without physician supervision. PSA will remain in forefront to assure that CRNA's scope of practice includes appropriate safeguards.

Worker's Compensation Insurance Reimbursement

1999 Amendments to Pennsylvania's Workers Compensation Act tied physician reimbursement to Medicare, a benchmark that for several reasons substantially and uniquely disadvantages anesthesiologists. A provision proposed by PSA and enacted with those amendments allowed the Insurance Commissioner to revise the reimbursements for a specialty when evidence showed the rates were uniquely unreasonable it. PSA, after years of effort by its legal and legislative counsel, convinced the Insurance Commissioner in 2004 to increase reimbursement to anesthesiologists by 63.2%, then and every following year (unless the law changes). The impact on anesthesia practices was and remains substantial and immediate. It increased the reimbursement per unit in 2004 from the low $20's (a low of $21.84 (Region 4) and a high of $24.51 (Region 1) to from $35.63 to $40/unit. The per unit reimbursement has changed annually since based on changes in the Statewide average weekly wage; in 2011, per unit reimbursement ranged from $44.35 to $49.78. But each year the rates are 63.2% greater than they would be but for PSA's efforts.

Here are some details on how it happened:

Prior to 1995

PSA requests the Insurance Commissioner to revise rates but the Commissioner takes no action.

1995

First hearing is held by the Insurance Commission in response to PSA petition.

1998-2003

PSA hires an outside lawyer, Bob Hoffman, to join the legal team with an eye to filing litigation. PSA, through its new counsel, files a revised Petition with the Insurance Commissioner. Efforts are made to accumulate claims payment data from anesthesiologists concerning Workers Compensation reimbursements to them and to other specialties. Ultimately, PSA submits a wealth of data to the Insurance Commissioner. Progress remains slow and Insurance Department resistant. PSA contemplates a lawsuit to require the Commissioner to rule on the Petition. Finally:

2004

VICTORY!!! After 10 years of hard work; the Insurance Commissioner agrees that the Medicare-based reimbursement uniquely harms anesthesiologists. Relying on PSA-submitted data on what private insurers are paying/unit, the Commissioner decides Workers Compensation reimbursement will be increased by 63.2% in all parts of Pennsylvania. The Commissioner drafts and promulgates a new regulation, 31 Pa. Code § 167.2, and legislative counsel, John Milliron, joins the effort to shepherd it through the legislative review process. The rate increase takes effect as of December 3, 2004.

2005

After the victory, PSA takes a member survey to ensure that all insurers are paying and all anesthesia practices are receiving the newly required increased reimbursements.

Anesthesiologist Assistants

Anesthesiologist Assistants are a type of non-physician anesthesia provider recognized in some states but not in Pennsylvania. The PSA Board has considered the desirability of having AAs work in Pennsylvania. A quick summary follows.

1998

PSA Board begins investigating options for practice opportunities for AA's in Pennsylvania.

2000-2010

Discussions continue, outreach made to potential academic sponsors of AA programs, but no legislation introduced. Obstacles include (1) CRNA supervision/scope of practice legislative battles and (2) the desirability of establishing AA training program in Pennsylvania and the difficulty in obtaining a commitment from any schools to do so.

Communication/Education

1995

PSA forms a Committee to investigate how to communicate more effectively with PSA members.

1999

PSA begins regional representation for PSA members (improve grassroots effort).

2003

CME added to PSA website.

2005

New PSA newsletter format introduced.

2007-2008

PSA undertakes branding initiative – "Physicians Protecting Patients" –to enhance public image with message development, regionalized efforts and web optimization.

1997

PSA website moves to the Pennsylvania Medical Society server.

2002

PSA takes steps to inform members about the implications of the then newly-enacted Mcare Act.

2004

PSA participates in joint statement with CRNA's , at both state and national level, regarding the need for trained anesthetist involvement in Propofol sedation.

2007

PSA website enhancements made, including dues payment, member services, PSA activity updates, and patient information page.

2009-2010

PSA website is redesigned, providing new content for Anesthesiologists, Physicians, Patients, Legislators, and Media.

Additional Highlights

1995

First mention of "bundled" payments to hospitals for hospital-based physicians, from Blue Cross of Western PA.

1998

PSA joins PA Civil Justice Coalition, an organization of business, municipalities, medical and non-profits whose goal is broad-based tort reform.

2009

The Pennsylvania Pain Coalition is created, PSA is actively involved and several PSA Board members play leading roles.

1995

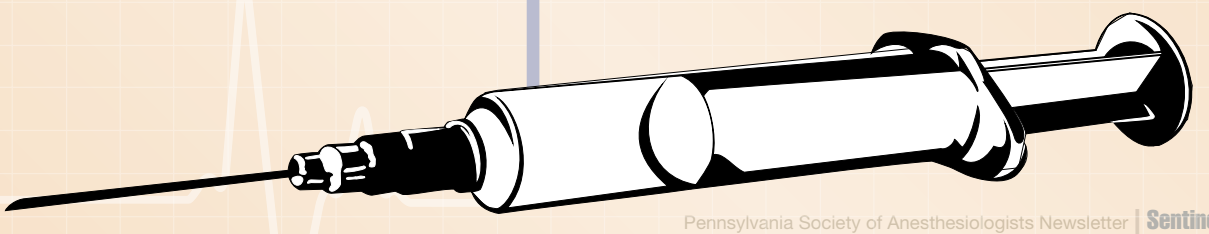
AMA and PA Medical Society "deunify" memberships.

1999

Regulations regarding anesthesia in Ambulatory Surgical Facilities are adopted by the Department of Health with PSA input and support.

2009

PSA works with the Patient Safety Authority to address issues and collect information pertinent to anesthesiology.



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of choice, in the United States, doing so under the surgeon's direction. By the late 1800s, nurse anesthesia had become a recognized nursing specialty, and training, almost entirely empirically in the operating room, began to be available. Ultimately, the process gave rise to the certified registered nurse anesthetist. At that time, a relatively untrained person could manage anesthesia without great misadventure because the primary choice of anesthetic agent in the U.S., ether, both supported respiration and was relatively well tolerated hemodynamically. The surgeon was close at hand and firmly in charge.

The rise of nurse anesthetists in the late 1800s coincided with broader changes in the nursing profession. Nurses were establishing themselves as part of the growing and increasingly professionalized health care industry. Nurses were performing similar functions, administering new medications in many settings.

For nearly another 100 years after Morton's ether demonstration, the common anesthetics were various inhaled gases – initially ether and nitrous oxide, then chloroform (late 1870s in Europe, early 1900s in United States), cyclopropane (beginning mid 1930s), and halothane (first used clinically in 1956).

With ether, reversing anesthesia generally meant terminating the inhalation and allowing the patient to awaken. However, unlike ether, these other agents depressed respiration and circulation, and a real understanding of their pharmacology was needed to administer them safely. These agents were first used in Europe, perhaps explaining the earlier involvement of physicians in anesthetic administration there.

In the early days of anesthesia, operative morbidity and mortality was substantial, reported in some sources as approaching 50 percent.

The first death from anesthesia, of a young girl under chloroform, was reported in 1848. She was the first of many to die of unexpected cardiac arrest under chloroform anesthesia, a result later understood to arise from an interaction between chloroform and catecholamines released during stress. Over the next several decades it became apparent that anesthesia, for all of its benefits, brought significant new risks to the operating room, including asphyxia, aspiration of gastric contents, a drop in blood pressure, and cardiac arrhythmias, in some cases resulting in death.

Even in that era, some thought medical personnel were the key to patient safety. In 1893, the British Medical Journal opined:

> Anaesthetics should be administered only by duly qualified medical men. There is no law upon the subject, but only those who are able to perform tracheotomy in the event of asphyxia ought ever to administer nitrous oxide gas. Ether and chloroform should only be administered by medical men experienced in the use of anaesthetics. If a death were to occur in a dentist's chair the magistrate might consider it culpable negligence on the part of the dentist if he had no medical assistant present at the operation. The only safe rule is always to have a second person present, and, when possible, that person should be a doctor, or, better still, a skilled [physician] anaesthetist.

And in 1901, it opined similarly:

> For years past the profession in general has been acutely aware that, for surgical anaesthesia, it is advantageous to have an administrator of such large experience as to make him more or less a specialist.

Origin of the Science of Anesthesia

The scientific basis for anesthetic practice took form during the 19th and early 20th centuries. In the late 18th and early 19th centuries, Joseph Priestley, who came to live in Northumberland County,

The Cost of Political Advocacy

by Robert Campbell, M.D.

The practice of medicine is a special calling that is rewarding in countless ways. The required skills are acquired over an extended period of intense training. It is really more of a decade-plus-long immersion experience. There is even an entire language of medicine which is at times intuitive and descriptive. At times it is inaccessible and confusing. Medicine is not for everyone. Practitioners are at times consumed by its demands.

I would like to challenge readers of this newsletter to take time to reflect upon our specialty from a more unfamiliar perspective. Our PSA membership is now more than 2,000 strong. We are

able to encourage 10-15 percent of our members to make Z-PAC and ASA-PAC contributions. This is perfectly consistent with other physician societies. This means 85-90 percent of our membership chooses to not contribute and to not be involved in the political process.

Why is this? As physicians we all go through a rigorous training process that in the end influences each of us in subtle and some not-so-subtle ways. Attorneys, teachers, businessmen, accountants, police officers, and the list goes on are all groups of individuals who all go through career specific training that influences them as well. In the end, doctors in aggregate look at situations a certain way and make stereotypic assessments that are in some ways a result of this similar decade-plus-long training process. We spend a great deal of time mastering the required material necessary to become competent physicians. We are collectively much more focused on being good physicians than deciphering the political process.

I asked earlier if you would look at our specialty from an entirely different perspective. Consider how a politician in Harrisburg might view us. I assert that in our state capital, the practice of medicine in all its variations is simply one of many highly regulated industries. As physicians, we see the practice of medicine in terms of an amalgam of art and science. It is highly individualized. It is a high impact activity and has high risks. It is frighteningly complex, sometimes heroic, and often humbling. But from the point of view of regulators and politicians, they see the practice of medicine as one more highly regulated industry. We are much like the insurance industry, accounting profession, tort attorneys, municipal governments, banking industry, agricultural industry, oil exploration industry, food processing industry, etc.

As physicians, we collectively have a below average amount of political interest and knowledge. As a consequence, we have a below average collective political impact. I submit to you that unless we engage with regulatory and political leaders in a manner consistent with other highly regulated industries, the very practice of medicine with which we are familiar will be subject to unfavorable dramatic changes. As physicians we must be engaged in the political process. It is part of our duty to our patients. It is a requirement for anyone conducting operations within a highly regulated industry. We must recognize this simple fact.

The cost of political activism is easily measured. Take an hour to meet your state representatives. Donate to Z-PAC and ASA-PAC. If you have never done it before, give $100 to each PAC. If you have done it before, step up to $200 each per year. It costs less per year than a cell phone or cable television service, both highly regulated industries with strong political presences I might add. The cost of not participating is guaranteed to cost more.

Pennsylvania, in 1794, discovered oxygen and carbon dioxide. John Haldane pioneered oxygen therapy for respiratory disease and blood gas analysis in 1892. Scipione Riva-Rocci discovered the principles used in the blood pressure cuff in 1896, and in 1905 Nikolai Korotkov described the sounds produced as a cuff is deflated.

In 1897, John J. Abel, one of the first American pharmacologists, discovered and named epinephrine and characterized the sympathetic nervous system. Theodore Tuffier, Gaston Labat, and others described the relationship between the sympathetic nervous system and anesthesia, and the use of ephedrine to treat anesthetic-induced hypotension, between 1900 and 1915. Finally, Moritz Schiff described the origin of pain perception in the nervous system, and the ability to block pain transmission with injection of cocaine in the early 20th century.

These discoveries provided the scientific basis on which the medical practice of anesthesiology was founded. Throughout the 20th and now the 21st centuries, physiologists, pharmacologists, and anesthesiologists have expanded that understanding to produce 21st century anesthesia.

Development of the Medical Specialty of Anesthesia

The use of newer and more complex anesthetics and the adverse consequences of their use, led physicians to acquire special expertise in not only anesthetic administration—keeping the patient comfortable during

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HISTORY OF ANESTHESIA

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surgery—but also in the medical management of surgical patients—keeping patients safe. At the same time, surgical procedures became longer and much more complex. As they did, specialized medical management was needed to allow patients to tolerate these more invasive procedures and to allow surgery to be performed on greater numbers of sicker patients. Surgeons could no longer provide meaningful supervision to non-physician anesthetists while they were operating, so other physicians with expertise in anesthesia began to either administer anesthetics themselves or to supervise the non-physicians. Those trends led ultimately to the physician anesthesiologist and the concept of the anesthesia care team, a hierarchical pairing of anesthesiologists and CRNAs. These changes did not take root in an instant, but over a course of decades, from the early 1900s to the 1940s.

In 1905, nine physicians who were practicing anesthesia as a medical specialty at Long Island College Hospital formed what is considered the first physician anesthesia society, the Long Island Society of Anesthetists. By 1911, the group broadened its geographical scope and name to become the New York State Society of Anesthetists. But formal recognition came slowly. In 1912, the New York Society petitioned the American Medical Association to create a Section on Anesthesia. The AMA said "no." In 1936, the American Society of Anesthetists (ASA) was formed, its name later changed to the American Society of Anesthesiologists. In 1941, the American Board of Medical Specialties recognized anesthesia as a new medical specialty, with a board certifying its residency programs and their graduates.

More recently, the American Society of Anesthesiologists formed three non-profit foundations dedicated to the development of anesthesia practice the Anesthesia Patient Safety Foundation in 1985, the Foundation for Anesthesia Education and Research in 1986, and the Anesthesia Quality Initiative in 2010. Each plays a major role in improving the quality of and safety of the patient care delivered by physician anesthesiologists.

The first anesthesia training program, a precursor to present anesthesia residency programs, established by Dr. Ralph Waters at the University of Wisconsin, began in 1927. The specialty and residency programs grew from there, but not all at once. For example, the University of Pennsylvania Medical School appointed its first anesthesiologist in 1938. The Medical School's website, **http://www.uphs.upenn.edu/dripps/about/history.html**, describes how that occurred:

> Two 1918 graduates of the Medical School…recognized the inadequacies of anesthesia care and a need for direct physician involvement. I. S. Ravdin, a surgeon, and Carl F. Schmidt, a pharmacologist, recruited [Robert Dunning] Dripps, a 1936 graduate of the Medical School who had been doing postgraduate work in the Pharmacology Department, and sent him to the University of Wisconsin to work with Ralph Waters, who had founded the first independent anesthesia department in a medical school…That Dripps spent only six months as a resident is as much a reflection of the knowledge base for the specialty at that time as to his brilliance. In 1943, Dripps became Chair of Anesthesia at [the University of Pennsylvania]….Dripps also started the residency program at Penn.

Massachusetts General Hospital, where Morton performed his surgery, did not establish an academic program in anesthesia until 1936, after its Chief of Surgery sent a young surgeon, Henry K. Beecher, to Copenhagen to work in the laboratory of the Nobel Prize winner August Krogh (**http://www2.massgeneral.org/anesthesia/index.aspx?page=about_us&subpage=history**).

Also important to this history was the 1954 publication in the Annuals of Surgery, 140:2, July 1954, of a study by Beecher and Todd entitled Deaths Associated With Anesthesia and Surgery. The paper discussed outcome data from 600,000 surgical patients over five years, from 1948 to 1952, at 10 university hospitals. The results were shocking: an overall anesthesia-related mortality rate of 6.40/10,000 (384 deaths, a ratio of one death to 1,560 patients). Nearly one-fourth of all surgical deaths attributed to causes other than patients' own ailments were from anesthesia. Finally, men had a higher anesthesia mortality rate than women, presumably because they delayed surgery and were therefore sicker patients.

Later that same month, the report went mainstream. Time Magazine published an article, "Medicine: Pain & Patience-Killer" (July 26, 1954), that reported these findings and added context:

> Anesthesia has advanced far beyond the ether mask and morphine stage of 20 years ago. Today, during critical operations, e.g., inside the heart, as many as eight different painkillers may be administered to ease the patient's lot and the surgeon's task. Even in minor surgery, drugs are used lavishly to prevent discomfort. But even the best of the new techniques carry their own hazard. Last week,

> two top Boston anesthesia experts, Henry K. Beecher and Donald Todd, laid down evidence that modern anesthesia is killing not only pain *but is still killing a shockingly high percentage of patients.*
>
> (emphasis added).

The Transition into the 20th Century

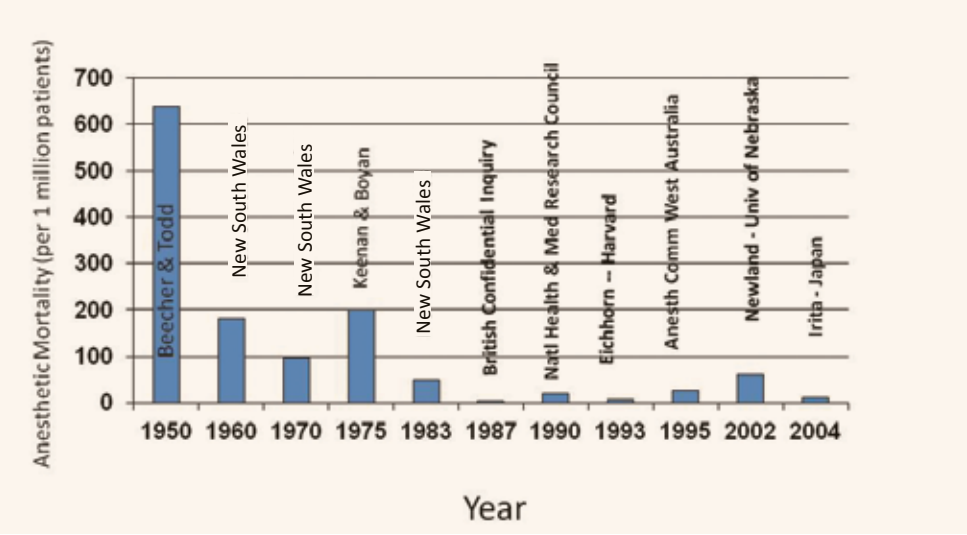
Anesthesia care began to change in meaningful ways, beginning in the 1930s and 1940s. Scientific and medical interest grew in finding more effective and safer ways to provide anesthesia. The intravenously administered anesthetic induction agent sodium pentothal was introduced in 1934 by Dr. John Lundy, an anesthesiologist at the Mayo Clinic. Despite dangers with its administration in some patients, it remained the most common anesthetic induction agent until the introduction of propofol in 1977 by Dr. Brian Kay. Rubber endotracheal tubes were introduced after World War I, and muscle relaxants in the late 1940s, both helping to establish and maintain a patent airway. As with intravenous induction agents, the use of muscle relaxants was first associated with an almost six-fold increase in anesthetic mortality, as reported by Beecher and Todd in 1954. The adoption of techniques for monitoring and managing neuromuscular blockade, described by Drs. Churchill-Davidson and Richardson in 1952, greatly improved patient safety.

The ability of anesthesiologists to monitor the patient's condition, and the resulting need to be able to respond to what that monitoring revealed, changed over time as well. Until the 1950s, patient monitoring consisted primarily of checking a patient's pulse and blood pressure by hand and watching the patient's respirations and pupils, eye movements, movement, and sweating. Important advances in patient monitoring include the EKG, introduced into clinical anesthesia practice between the 1950s and 1970s; electronic arterial pressure monitoring in the 1970s; and pulse oximetry and end tidal CO2 in the 1980s. More recently, specially processed EEG measurements allowed better quantification of the depth of anesthesia.

Contributing to the trend toward physician anesthetists, surgeons continued to operate on patients who had more serious health issues, raising more complications and greater risks with anesthesia. New types of surgery — open heart and transplantation—brought even sicker patients to the operating room. Compared to the single agent ether in the 1840s, anesthesiologists currently use a wide array of drugs, such as the following: 1.) benzodiazepines or other drugs as pre-surgical sedatives; 2.) a narcotic such as Fentanyl and a hypnotic such as Propofol for anesthesia induction; 3.) a neuromuscular blocker for intubation in general anesthesia; 4.) a combination of drugs for maintenance and yet others to facilitate emergence. Other drugs are administered during anesthesia to treat side effects of general anesthetics or patient-specific conditions such as low blood pressure or arrhythmias. At the same time, medical procedures, such as spinal, epidural, and regional anesthetic administration; placement of arterial, central venous pressure, and pulmonary artery pressure catheters; and fiberoptic bronchoscopy became more frequently performed on patients in the operating room.

The anesthetic mortality reported in 11 studies over the last 60 years is shown in the table:

Overall Anesthetic Mortality



As the table shows, anesthetic mortality has decreased from approximately 640 per million anesthetics, reported by Beecher and Todd in 1954, to approximately 60 per million, reported by Newland in 2002 (Newland MC, Ellis SJ, Lydiatt CA, Peters R, Tinker JH, Romberger DJ, Ullrich FA, Anderson JR: Anesthetic-Related Cardiac Arrest and Its Mortality, Anesthesiology 2002; 97:108-115) and 10 per million reported by Irita (Irita K, Kawashima y, Iwao Y, Seo N, Tsuzaki K, Morita K, Obara H: Annual mortality and morbidity in operating rooms during 2002 and summary of morbidity and mortality between 1999 and 2002 in Japan, a brief review, Masui 53:320, 2004) in 2004. The greatest portion of this decrease occurred between 1950 and 1990, a period marked by an increased presence of physician anesthesiologists, improvements in technology and techniques resulting from medical research, as well as concerted patient safety programs of the ASA and the Anesthesia Patient Safety Foundation.

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HISTORY OF ANESTHESIA

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Recap and Conclusions

Returning to the question with which we began this discussion, the most relevant facts in 2012 are not who provided anesthesia care 150 years ago or for how long. If those were the relevant inquiries, barbers would be surgeons now as they once were. Instead, there are two centrally relevant questions. First, has the body of knowledge and skills necessary to care for patients changed? Second, has the practitioner's education and training kept pace with those changes? When surgery progressed beyond bleeding patients to other forms of treatment, the barbers' skills did not expand to keep pace, and their scope of practice reverted to its traditional role of cutting hair.

The history of modern anesthesia over the past 160 years begins with nurses assisting surgeons in the use of ether and then other gases. Anesthetics became increasingly more complex, from approximately the 1920s on. Surgical patients became sicker. Anesthesia outcomes initially worsened. These trends led to specially trained physicians—anesthesiologists—assuming responsibility for providing and directing anesthesia care, as well as performing the increasingly complex medical procedures associated with the perioperative care of surgical patients.

Indisputably, the nature of anesthetic practice as well as of surgery, have changed tremendously in the last two centuries, bringing with them dramatic changes in the necessary body of knowledge and skills. Medical training and medical research have transformed surgery and anesthesia into complex and inseparable medical disciplines. The answer to the first question – has the body of knowledge and skills necessary to care for patients changed – is a clear-cut "yes."

Nurse anesthetists have continued to administer anesthetic medications and monitor many patients during surgery. Other nurses perform somewhat analogous monitoring tasks in intensive care units and procedure rooms. But a nurse anesthetist's functions of administering medication on physician order, although it resembles what nurses routinely do, takes place in a very different and far riskier setting than its non-surgical counterpart. Treating it as akin to the bedside administration of medication in a medical-surgical ward, as some do, ignores these substantial differences. Moreover, actually administering medication is only a small part of the necessary functions included within the practice of anesthesia. There should be little doubt that ordering the panoply of medications used in providing anesthesia care and responding to developments arising in surgery lie far outside the normal scope of nursing practice.

But more fundamentally, anesthesia care has evolved to the point of requiring medical decision-making regarding the management of the patient's surgery as well as the patient's co-existing medical diseases. Further, it requires those judgments be made in circumstances in which an error can have immediate and profound consequences. In this respect, medical decision-making requires having acquired both a substantial knowledge base of bodily systems, processes, and diseases, as well as the basic science underlying them, and extensive practical training in the application of that knowledge to the problem presented. Anesthesiologists acquire that knowledge base and the mode of analysis that leads to its proper application initially in medical school and then put it into practice during residency. The need for medical decision-making is, we believe, the central change in anesthesia care from the beginning of the modern era to the present.

ABOUT THE AUTHORS

Mr. Hoffman is an attorney with Eckert Seamans Cherin and Mellott, LLC, and serves as outside legal counsel to the PSA. Dr. Martin is Professor of Anesthesiology at the Milton S. Hershey Medical Center, former president of the Pennsylvania Society of Anesthesiologists, and long time delegate and District 6 Director to the PSA.

Residents from Pennsylvania pose for a picture at the ASA's annual legislative conference in Washington, D.C.

The ASA Legislative Conference 2012: A Resident's Impressions

By Soorena Khojasteh, M.D.

I had the opportunity to attend the ASA Legislative Conference in Washington, D.C., which was held from April 30 to May 2. I had asked Dr. Richard Month, PSA's resident component adviser, if I could attend this year's legislative conference with the abstract goal of "getting involved."

But what did "involved" actually mean? Having never received any formal training in health care finance and policy, I was admittedly hesitant and slightly intimidated as I walked into the lobby of the J.W. Marriott Hotel. Instead, like many physicians, I have experienced some of the many frustrations attributed to our health care system and wanted to learn how it can be improved.

My concerns regarding my lack of formal training in health care finance quickly were alleviated. The legislative conference staff did a great job of making everyone feel welcome and addressed any questions with regards to the busy schedule of speakers. On Day 1, I had an opportunity to hear anesthesiologists from South Carolina, Nevada, and Wisconsin describe their interactions with their local and statewide legislatures. One such story seemed worth mentioning. Nurse anesthetists in South Carolina were advocating not only for performing but also interpreting transesophageal echocardiography. Hearing how the South Carolina Society of Anesthesiologists was able to mobilize and advocate with its legislature to ensure that TEE and its interpretation remains under the practice of medicine and not nursing made me realize the importance of legislative advocacy.

If Day 1 was meant to motivate conference participants, Day 2 was meant to educate the conference participants on the ASA's major issues. Some of most interesting included the following:

- Dr. Andy Harris, an anesthesiologist and member of the United States House of Representative from Maryland, spoke regarding Federal Health Care Policy as well as ways of getting involved in politics as a physician. Specifically, he shared his insight on including anesthesiologists in the rural pass-through arrangement, which currently allows rural hospitals having difficulty retaining anesthesia providers to compensate anesthesia assistants and nurse anesthetists through Medicare Part A.
- Next, Dr. Marc Leib, chair of the ASA Committee on Economics, discussed anesthesia payments under Medicare and also expanded on another major issue re-

garding ensuring fair payment from Medicare. Specifically, Dr. Leib noted while Medicare pays most medical professions approximately 60-70 percent of what private insurance plans pay, anesthesiologists caring for Medicare patients unfairly earn only 33 percent of what private insurance pays.

- Another lecture included Captain Valerie Jensen, R.Ph., from the FDA, speaking about the increasing problem of drug shortages.
- Other interesting speakers included Ilya Shapiro, J.D., from the Cato Institute, speaking about the constitutionality of the Affordable Care Act as well as Dr. Tevi Troy, a special adviser for Mitt Romney, speaking about the pitfalls of trying to attain meaningful health care reform.

That evening, Dr. Pat Vlahos organized a wonderful dinner for the Pennsylvania Society of Anesthesiologists.

The last day of the conference was an absolutely beautiful day in our nation's capital. One could not help but be in awe of the Capitol building as we walked down Pennsylvania Avenue to meet our congressional representatives. Our first stop was Senator Pat Toomey's office. We met with Tessie Abraham, legislative counsel to Senator Toomey. As our PSA board members proficiently advocated our positions on the afore mentioned issues, it again became apparent how important participating in the legislative process is as our representatives rely heavily on our input when forming their positions on complex issues that may go beyond their formal education. I also was happy to see that when the discussion turned to the Health Care Truth and Transparency Act, which calls for all health care personnel to clearly identify themselves and their credentials, residents were able to participate, providing multiple examples of patients being confused in the hospital by so many health care providers.

We next visited Senator Bob Casey's office. There, we were able to meet with Deirdre Fruh, legislative assistant to Senator Casey. In addition to thanking her for all the work Senator Casey has done with regards to trying to hold pharmaceutical companies more accountable for reporting future drug shortages, we also had a productive conversation regarding the Health Care Truth and Transparency Act.

All in all, the ASA Legislative Conference was a tremendous experience. No matter your political leaning, I believe that any resident interested in politics or health care policy will find this to be an incredibly beneficial experience. As Dr. Donald Berwick, the former administrator for the Centers of Medicare and Medicaid Services, said during his lecture at the conference, "as physicians, it is not enough to say no, but we must be part of the solution." I think experiences like the ASA Legislative Conference start us in the right direction.

ABOUT THE AUTHOR

Dr. Khojasteh is a resident at the University of Pennsylvania's Department of Anesthesiology and Critical Care.

PSA Enjoys Successful Job Fair

By Stanislav Kelner, M.D., PSA Resident Component President-Elect

As the president-elect of the PSA Resident Component, I would like to thank you all for your support in the May 12 Resident Job Fair and Panel Discussion. This was a first of its kind event, involving groups and residents from across the state. It took place at the Geary Auditorium at Hahnemann University Hospital.

Our speakers for the panel were Drs. Meg Tarpey (University of Pittsburgh), Phil Sasso (Abington Memorial Hospital), and Gordon Morewood (Hahnemann University Hospital). The three-person panel began by speaking to anesthesia residents on the various aspects of working in academic, private, and hospital-based practice. Issues addressed included malpractice coverage, CRNA supervision and ratios, benefits, and salaries. Each of the speakers brought their own personal and unique experiences to the discussion. In the words of several residents, this was the first time many of them heard about topics

of tail coverage, resources to find salary statistics, retirement benefit discrepancies, group acquisitions and mergers, and hiring practices.

The discussion was followed by a fantastic table of appetizers and refreshments, sponsored by the PSA board. Academic and private practices, along with hiring firms, set up tables to discuss employment with residents and fellows. Contacts were made and information exchanged.

In particular, the PSA Resident Component would like to thank the panel speakers for sharing their great insight: Dr. Mike Green, interim-chair of Hahnemann's department of anesthesiology, for facilitating the event; Dr. Josh Atkins, for his support and help with the organization of the fair; and Dr. Rich Month, for being an invaluable liaison between the PSA and its resident component.

Left: The PSA held its first residents job fair this May in Philadelphia. Participating in a three-person panel discussion were, from left to right, Drs. Meg Tarpey (University of Pittsburgh), Phil Sasso (Abington Memorial Hospital), and Gordon Morewood (Hahnemann University Hospital).

Persistence Pays: It's Up to You to Continue Fight for Patient Safety

By Andy Goodman, MBA, PSA Legislative Counsel

Persistence is key. I know you have heard that phrase for years, and so has your political competition. Our persistence has worked so far, but will you continue to be persistent? Whether you have been politically engaged for a year or decade, no amount of time or effort is wasted if it is used to maintain or improve your patients' safety. Diminished persistence will be noticed by everyone. Your political involvement, relationships, fundraising and advocacy make the difference in patients' lives. You know it, so it is up to you to keep and reinforce the momentum. Over the past few years, your Society's board of directors has asked the PSA membership about its concerns regarding the delivery of anesthesia. The message was clear and echoed statewide to your executive team and its government relations advisers: maintain and strengthen the requirement that physicians have the ultimate responsibility for the delivery of anesthesia. You know how critical physician control of anesthesia care is to your patients' lives. We listened to you and we are moving forward. Your Society and its government relations team are working on behalf of patients and physicians across the state. The message is resonating. However, your persistence is key. Be prepared for some important upcoming legislative news. Furthermore, be prepared to reengage this summer.

The schedule for the remainder of the 2011-12 legislative session is moving by quickly. The House, Senate and Governor will likely have the Commonwealth's budget signed before the June 30 deadline. All indications are, at this point, that the Republican controlled General Assembly and Governor's office are nearing an agreement. Details of the agreement have not been made public, but we do not expect a major shift in policy from last year's budget, meaning we will once again "live within our means." Nonetheless, after the budget is signed the General Assembly will adjourn to return "back home" for its summer recess. The House and Senate will come back to Harrisburg in late September and October for limited voting. The Chambers have not officially announced that there will be no voting after the November General election, but that has been the practice for the past few years. The bottom line, limited voting days remain in 2012.

PRESIDENT'S MESSAGE

continued from page 1

components would not have the resources to have their own national advocacy staff.

The ASA provides the premier opportunities for life-long learning by anesthesiologists. The annual meeting is recognized for bringing together not just national, but international experts in the latest basic, clinical, and translational research that affects our specialty. Additionally, the journal Anesthesiology provides a monthly opportunity to learn about cutting-edge advances in the field. This emphasis on scientific advancement by members of our specialty has brought about the remarkable increase in the safety of anesthetic management and distinguishes us from other providers.

Does that mean that all members agree with all the actions of the national society? Of course not! However, you cannot implement change if you stand on the sideline – you have to get into the game! Get involved at the local level by becoming active in a PSA committee. Volunteer to become a member of an ASA committee. Bring your insight, expertise, and passion to your fellow anesthesiologists.

In summary, there is strength in numbers. The component societies that make up the ASA are the core of that power. However, in coming together at a national level, the interaction and cooperation of members from across the country amplify the influence of individual societies' and make us stronger advocates for our practices and our patients.

Serotonin Syndrome: An Interesting Case in an Interesting Place (A Case Report)

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

The patient was a 46-year-old white female, 62 kg, who was an active runner. She had a history of depression on Zoloft (sertraline) as well as allergic sinusitis on Allegra (fexofenadine). She was scheduled for an outpatient right open carpal tunnel release in a very small surgical center a few miles from the nearest acute care hospital. The anesthetic planned was sedation/monitored anesthesia care.

She received midazolam, two milligrams (mg) intravenously, five minutes prior to the procedure and fentanyl 50 micrograms IV on arrival to the operating room. She was then given 70 mg propofol IV 1.5 minutes prior to a local anesthetic field block (10 milliliters total of 0.25 percent Bupivacaine). She was sedated but cooperative prior to the administration of the propofol. Her initial vital signs were 132/71, 64, 16, 98 percent, 36.6. The tourniquet was up at 250 mmHg for six minutes and the total procedure time was 11 minutes. Her blood oxygen saturation level (O2SAT) on oxygen by nasal cannula (four liters/minute) five minutes into the procedure was noted to fall to 78 percent (her respiratory rate at the time was six to eight breaths per minute).

I asked the patient to take a deep breath with no response. While the surgeon was performing the carpal tunnel release, a mask with oxygen via the anesthesia machine was administered with assisted ventilation leading to an increase in O2SAT to 94 percent. However, the patient was still not responding appropriately. No other anesthetics or sedatives were given during the procedure. At procedure end, the patient was completely undraped and she was noted to continue to be unresponsive with what appeared to be mild rigidity. Her O2SAT was 88 percent with the mask oxygen and she was now spontaneously breathing at a rate of 22 breaths per minute. Her final set of vital signs in the operating room were 143/84, 88, 22, 90%, temperature not taken.

There was no change after five minutes in the post anesthesia care unit, therefore, she was given 0.3 mg flumazenil IV. Within two minutes after administration, she began to vocalize incoherently, she brought her arms to her chest and her knees to her chest, there was obvious sweating, and her heart rate rose to 134 with a sinus rhythm noted. Her other vital signs were 164/94, 30, 86 percent, 36.9. An ambulance was called for transfer to the local hospital emergency department (ED). The patient was given a total of four mg of midazolam IV just prior to transfer due to the continued posturing. The vocalizing decreased, but she obviously became even more unresponsive and the knee to chest posturing continued.

In the ED, her symptoms were unchanged, and her vital signs were 166/89, 112, 22, 91 percent (with oxygen by mask), 37.4. The toxicologist present in the ED at the time recognized the posturing and, after a brief history by me (including her chronic medications and timeline of symptoms), suggested that a diagnosis of serotonin syndrome should be considered. The toxicology service was officially consulted, and the patient was given diazepam IV in multiple doses of five mg until the symptoms subsided. She eventually required endotracheal intubation and mechanical ventilation. The O2SAT remained 90 to 92 percent on 100 percent O2 via the ventilator, and a CT of the chest suggested left sided aspiration pneumonitis.

She was transferred to the medical intensive care unit, and lorazepam IV was administered PRN for symptom control. At 24 hours post initial presentation, her symptoms persisted with withdrawal of the benzodiazepines. She was re-sedated and mechanical ventilation continued. At 48 hours post initial presentation (after withdrawal of the sedatives), the symptoms had subsided and the patient was responsive and following commands. She was extubated and O2SAT values improved with all oxygen support weaned off over the next 12 hours. Over 20 mg of lorazepam, 6 mg of midazolam and 50 mg of Valium (all IV) were administered during her surgical center/hospital stay.

The patient was discharged home at about 72 hours post initial presentation. Her CPK values reached 20,000 units/liter during the hospitalization from the muscle rigidity, but there was no obvious myoglobinuria (a brisk diuresis was instituted nonetheless). She experienced extreme fatigue and muscle aches for many days after discharge. The generalized fatigue lasted for up to two to three months as per phone call follow ups. She began walking and then jogging slowly after about three to four months. As of our last communication, she did not re-start the sertraline.

Serotonin syndrome may be a frequent diagnosis for a toxicologist, but it is not, by a long shot, for an anesthesiologist. There was only one case report that I found

in the literature describing post operative serotonin syndrome discovered in a post cardiac surgical patient (J Anaesthesiol Clin Pharmacol. 2011 Apr-Jun; 27(2): 233–235). Cases could range from mild agitation to life threatening symptoms such as muscle rigidity, posturing, extreme agitation, unconsciousness, fevers and hemodynamic instability.

The mild cases, which actually may be much more common than we realize, may be written off as a form of post anesthesia "emergence delirium." What is serotonin syndrome? It occurs when there is too much serotonin present within the brain, and it usually occurs when two drugs that cause or maintain the release of serotonin are taken together. It usually occurs when one medication is added acutely in a patient taking another on a chronic basis.

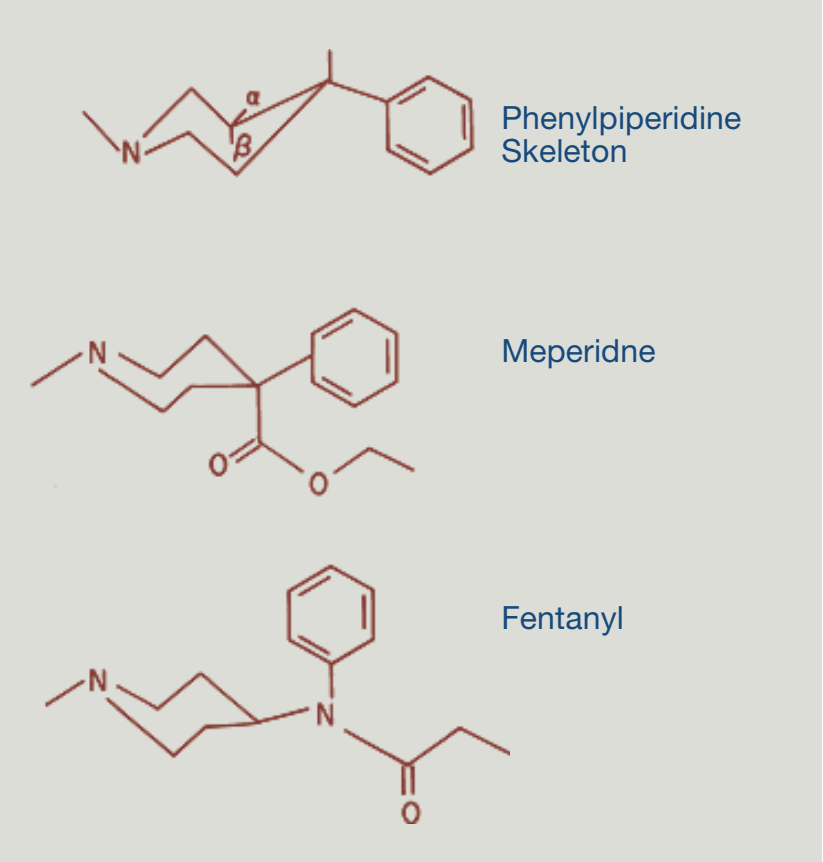
How common?

How common are serotonin level altering drugs? The most commonly prescribed class of antidepressants is the serotonin reuptake inhibitors (SSRIs). These include Celexa (citalopram), Lexapro (escitalopram), Paxil (paroxetine), Prozac (fluoxetine), and Zoloft (sertraline). These are followed closely by the serotonin and norepinephrine reuptake inhibitors (SNRIs) which include Cymbalta (duloxetine), Effexor (venlafaxine), and Pristiq (desvenlafaxine). So the answer is extremely common. Now throw in migraine treatments, other forms of antidepressants, anti-emetics, smoking cessation drugs, cough suppressants and pain medications.

We as medical practitioners know the tragic case of Libby Zion. She was a young girl chronically taking Nardil (phenelzine) who then received Demerol (meperidine), leading to her untimely death from serotonin syndrome.

So meperidine causes an elevation of serotonin. My patient

How Do We Treat



did not receive meperidine. However, she did receive a drug with a similar structure, fentanyl. Both have a phenylpiperidine backbone. Yes, fentanyl is a known triggering agent. Not known by me, however, as well as not known by most anesthesiologists.

How do we treat?

How do we treat serotonin syndrome when it occurs? Treatment includes benzodiazepines such as midazolam, diazepam and lorazepam to decrease agitation, the myoclonus, and muscle rigidity; cyproheptadine by mouth, which blocks serotonin production; IV fluids and withdrawal of the medications that caused the syndrome. In life-threatening cases, as with mine, muscle paralysis, endotracheal intubation and mechanical ventilation may be required to avoid worsening agitation and further muscle damage.

Should we not administer fentanyl, which is the most commonly used narcotic by anesthesia providers, when faced with providing care for patients on an SSRI or SNRI, which seem to make up the majority of our patient population? Do we ask that patients hold their antidepressants prior to surgery (that would be risky and very difficult to do with so many patients taking these chronic medications)? These are a couple ways to decrease the likelihood of the occurrence of serotonin syndrome. The other is to know the existence of this potentially fatal syndrome, regardless of its likely rare presentation in at least its most severe form, and treat it accordingly. Remember, you may be far from an emergency department, toxicology team and intensive care unit when it occurs.

Here's How You Can Make A Difference

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

We the people are in control of the government. This control is exercised by your vote. The primaries are past and hopefully you voted to determine who is on the ballot. If your candidate was not successful, choose from those who were and shape our country's future.

Start locally because it is the basis for all political activity. This is a great time to start your political activity. Relationships formed with candidates while in the battle for election or re-election will pay dividends in the future. You will have helped elect candidates who share your views and ideals.

It is a great time for teaching your children the importance of civic activity. Offer your help to work at campaign headquarters, put up signs, knock on doors, put signs in your yard, have a coffee klatch and invite friends to meet the candidate(s), organize a fundraiser, go to a fundraiser. Your involvement(s) (is) are essential activities any candidate needs.

Identify yourself as a physician who is an anesthesiologist. Inform the candidate you feel they will be an excellent choice for the office and that you share many common values. If they require any input on medical issues, say you are always available to them.

C andidate campaign contacts are critical.
I nvolvement in the election process is essential.
T ime donated is always noticed.
I ndividual contributions are always needed.
Z -PAC
E ncourage your friends to vote.
N etwork on Facebook.
S how up at the polls to represent your candidate on Election Day.
H old fundraisers for your candidate.
I nvite neighbors and friends to meet the candidate in your home.
P lease Vote!

CORRECTION

In the spring edition of the Sentinel, Congressman Patrick Meehan was incorrectly identified in the above picture.

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 2011 and posed for a picture with Rep. Patrick Meehan (second from right), who is a U.S. Congressman from Pennsylvania.

Reminder

In order to join Pennsylvania Society of Anesthesiologists, you must belong to the American Society of Anesthesiologists (ASA).

Welcome New Members

Active

Tiffany L. Bartsch, M.D.
Lee R. Bischof, D.O.
Laboni Choudhury, D.O.
Leanne M. Fike, M.D.
Kelly S. Gidusko, M.D.
Mark Gifeisman, M.D.
A. Joseph Layon, M.D.
Marievic G. Manrique, M.D.
Joseph M. Pellegrino, M.D.
Joel M. Pomerantz, M.D.
Andre M. Robinson, M.D.
Victor M. Romo, M.D.
Mahesh P. Sardesai, M.D.
M. Kyle Sila, M.D.
William Simmons, M.D.
Gregory G. Theodore, M.D.
John P. Weldon, M.D.

Resident

David H. Beausang, M.D.
Kamrouz Ghadimi, M.D.
Patrick J. Hackett, M.D.
Gerhardt Konig, M.D.
Yasdet Maldonado, M.D.
Anna L. Rabinowitz, M.D.

Retired

Thomas D. Mull, M.D.
Tomas H. Urbano, M.D.
Henry A. Villasis, M.D.

Read More Clinical Pieces

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:

Awareness Under Anesthesia (Patient Safety)
By Kristian Werneid, M.D., and Stephen R. Strelec, M.D.

Intraoperative recall and awareness is a rare, but psychologically significant and devastating phenomenon, with an incidence between 0.1-0.2 percent, translating to approximately 20,000-40,000 patients per year. Discovering methods for detection and avoidance is critical in prevention of long-term consequences, specifically post-traumatic stress disorder.

Read the full article at our Clinical Updates page at

www.psanes.org

Specialty Leaders Review Maintenance of Licensure Framework

By Joseph Galassi, Jr., M.D., PSA's Specialty Leadership Cabinet Representative

The Specialty Leadership Cabinet of the Pennsylvania Medical Society met May 15. Highlights of that meeting include:

In April 2010, the House of Delegates at the Federation of State Medical Boards (FSMB) adopted a Maintenance of Licensure (MOL) Framework and recommendations. Delegates also tasked the Maintenance of Licensure Implementation Group to develop a template for state medical boards' use in implementing MOL and to identify potential implementation challenges and solutions.

The intent of MOL is to require physicians to demonstrate active participation and commitment to a program of lifelong self-assessment and improvement. There are three components:

1. Component one requires licensees to complete accredited CME (Category 1 CME), a majority of which is practice relevant. The issue here is that the devil is in the details. What is the definition of majority? What is practice relevance?
2. Component two requires physicians to undergo knowledge or skill assessments germane to their professional practice. The goal of taking exams here is to enable physicians to assess their strengths and improve their weaknesses, not to ensure that the individual has a certain passing grade on the exams.
3. Component three expects physicians to continuously improve their performance in practice. The issue here is that physicians are to self assess their performance and participate in continuous improvements in their practice.

Overall, the physicians who would be most affected are those individuals who are not board certified and those who have time-unlimited certificates. Those physicians who have time-limited certificates and are undergoing the MOC (Maintenance of Certification) process will likely be considered having fulfilled the MOL process. However, until that is clarified, there is no guarantee physicians won't have to do both. PAMED wants to be at the table if and when the Pennsylvania Board of Medicine decides to take up this matter.

Capital BlueCross Quality Measures

There was an update on the ongoing quality measures project by Capital BlueCross, which is setting up quality measures with six specialties: Urology; obstetrics and gynecology; ear, nose and throat; gastrointestinal; general surgery; and orthopedics. The next step is to test them with pilot projects to see if these quality measures are good for widespread use.

Liability Protection for Emergency Health Care Providers Bill

House Bill 2299 was also discussed. This proposed law would change the burden of proof required in emergency medical care in liability actions from "Preponderance of Evidence" to "Clear and Convincing Evidence" of gross negligence. This bill would likely benefit anesthesiologists who practice in this setting, but the bill is not expected to move due to strong opposition from the trial lawyers.

MCare Update

The Governor's office has notified PAMED that it wants to phase out MCare. PAMED is working on a plan to soften the financial impact of the transition to 100 percent private malpractice insurance.

Ophthalmologists Scope of Practice Bill

The ophthalmologists asked for support for their bill that would put into statute that laser surgery is the practice of medicine and cannot be performed by optometrists. The bill is currently held up in committee in the Pennsylvania Senate.

Upcoming PSA Events

September 15, 2012: PSA Board meeting, 8:30 a.m., Bedford, PA

October 13, 2012: PSA Annual Luncheon at the ASA meeting, Washington, D.C.

PENNSYLVANIA
society of
ANESTHESIOLOGISTS

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