Sentinel

Pennsylvania
Society of Anesthesiologists
Newsletter

Summer 2016

PRESIDENT'S MESSAGE

Support Strong Physician Led Teams, Rather Than Fragmentation

by Andrew Herlich, M.D.

The national political landscape is ill-tempered at best. The ability to discuss politics and debate differences of opinion are no longer cordial and civil. Students of politics are no longer getting lessons in debate, moderation and compromise; they are getting lessons in arrogance, demagoguery and name calling. Many national candidates have turned to the tactics of middle school bullying.

Meanwhile, as they attempt to build walls higher, decide who appropriate future American citizens are, and how many troops to send to far-off lands, the American health care system is starting to show wrinkles and the "walls" of patient safety are being tested. The latest "wrinkle" is that the Hospital Association of Pennsylvania (HAP) has thrown its support behind a bill that would grant CRNPs independent practice with full prescription authority without physician oversight or collaboration. I can

only think that this is a misguided attempt to reduce costs and fragment the health care team without any consideration to patient safety. Warren Buffet's axiom of "price is what you pay, but value is what you get" is about to be turned upside down and inside out.

The CEO of Pinnacle Health and a HAP Board Member stated very clearly last fall at a Pennsylvania House of Representative hearing, that as CEO of a healthcare system, "…I lead the health care team." At best, that statement undermines patient safety. At the worst, it misleads the public into thinking that the CEO knows best and is responsible for determining the medical management for patients during their most vulnerable times.

There are rapidly increasing numbers of patient deaths from opioid abuse; does the Commonwealth need possibly more opioid prescriptions circulated and the complications of the opioids? We have enough problems with physician prescribed opioids already. How many more deaths will occur under the newest "wrinkle" of non-physician led teams?

As strong as the case is for physician led teams in all medical specialties, it is even stronger in the medical specialty of anesthesiology, where invasive medical procedures and medical decisions are needed to

continued on page 19

Summer 2016

Contents

Inside This Edition PAGE 3

Protect Safe VA Care PAGE 4

Legislative Update PAGE 5

Politics Meets Opioid Prescribing Practices PAGE 6

The Tortured Story of Criminal History PAGE 8

Guidelines for the Use of Opioids to Treat Chronic Non-Cancer Pain PAGE 10

ASA Legislative Conference PAGE 13

Recovery: Anesthesiologist vs. Perioperative Physician PAGE 14

Continuing Education PAGE 16

Welcome New Members PAGE 17

Z-PAC Contributor Update PAGE 18

PENNSYLVANIA society of ANESTHESIOLOGISTS

Sentinel
Pennsylvania Society of Anesthesiologists Newsletter

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

President
Andrew Herlich, M.D.

Association Director
Susie Wilson

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PSA Newsletter
777 East Park Drive,
P.O. Box 8820
Harrisburg, PA 17105-8820
717/558-7750 ext. 1596
www.psanes.org

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INSIDE This EDITION

Richard O'Flynn, M.D., Editor

Having just reviewed my editorial from the Winter 2016 edition, I see that the same issues are still present that I wrote about back then.

House Bill 1277 remains in Committee with no date scheduled for a vote.

As you should know, HB 1277 is simply the reincarnation of last session's HB 1603 which would put physician supervision of CRNAs into statute.

HB 1277 was overwhelmingly passed in the PA House of Representatives but never came out of Committee in the Senate. Charlie Gerow of Quantum Communications, our Legislative Counsel, reports on this bill and other legislative activity in his article. His take home action item is that now is the time for all anesthesiologists to call their Legislators and tell them that you support team-based physician-led anesthesia care. As a Past ASA President stated, "It's all about the patient".

On the Federal level, The VA Nursing Handbook change was published in the Federal Register on May 25.

That opens a 60-day window for submitting comments on this issue. Erin Sullivan, M.D., our District Director, describes the issue, the ASA action and what individual anesthesiologists need to do in order to protect our Veterans. As Dr. Sullivan writes, it is time for all anesthesiologists to step up and become involved. Realize that those pushing for these changes are well-motivated, well-funded and passionate about their goals. It is time for anesthesiologists to be the same. Our Veterans sacrificed a lot. They earned, and deserve high quality, safe anesthesia care.

An issue that seems to be causing much confusion is whether or not physicians and their staff caring for pediatric patients need to obtain Criminal History Clearances.

Robert Hoffman, the PSA counsel, describes in detail the history of the Child Protective Services Act of 1990 and the later revisions to the Act and how that changed the requirements and created the confusion

Donald Martin, M.D. reports on the Achieving Better Care by Monitoring All Prescriptions Act (ABC-MAP Act).

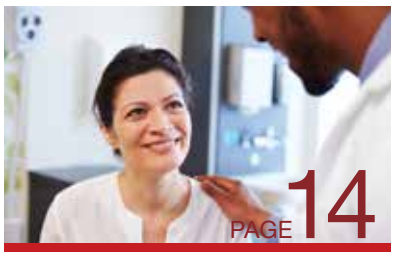
This Act, enacted in October, 2014 will provide Pennsylvania physicians with a database that is intended to reduce controlled substance abuse, diversion, and overdose. Physicians will be able to query the database regarding controlled substances obtained by their patients or attributed to their DEA number. There are also Pennsylvania Guidelines for the Use of Opioids in Treating Non-Cancer Pain.

Also with this edition of the Sentinel we are starting a new Continuing Education section.

The first article is about Operating Room Fires. We hope that you find this to be a valuable resource and welcome your feedback and suggestions for future articles. Submit letters to the editor to richoflynn@psanes.org.

PAGE 6

PAGE 8


PAGE 14

PROTECT SAFE VA CARE

VETS EARNED IT & DESERVE IT

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

On May 25, 2016, the Veteran's Administration published in the Federal Register the "Advanced Practice Registered Nurses" proposed rule, that authorizes four categories of Advanced Practice Registered Nurses (APRNs), including nurse anesthetists, to provide services "without clinical oversight of a physician". The comment period is open to the public for 60 days from the date of publication.

As advocates for safe, high quality, physician anesthesiologist-led care for our Veterans and preservation of the current anesthesia care team model where physician anesthesiologists and nurse anesthetists work together, the American Society of Anesthesiologists (ASA) strongly opposes and will continue to oppose the inclusion of nurse anesthetists in the "full practice authority" or nurse-only model of anesthesia care. The proposed APRN rule would remove physician anesthesiologists from the care of many Veterans, who will instead receive care from CRNAs acting independently

The proposed rule specifically mentions that there has been opposition to granting full practice authority for nurse anesthetists, as distinguished from other APRN categories, and requests feedback from stakeholders:

"Many external stakeholders expressed general support for VA's positions taken in this proposed rule, particularly with respect to full practice authority of APRNs in primary health care. However, we also received comments opposing full practice authority for CRNAs when providing anesthetics. To aid in VA's full consideration to this issue, VA encourages any comments regarding the proposed full practice authority. In this way, VA will be providing all affected State and local officials notice and an opportunity for appropriate participation in the proceedings."

You can read the Rule and related discussion in its entirety at https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-12338.pdf.

The publication of this proposed rule does not finalize the APRN proposed regulation/ Nursing Handbook. It represents the first part of the formal regulatory process whereby the VA will seek input from interested stakeholders prior to making a final decision. VA will review submitted comments and subsequently issue a final rule/ final regulation.

We must protect our Veterans. We cannot stand on the sidelines. As advocates for continued access to physician anesthesiologists and safe care for Veterans, ASA urges all ASA members, their friends and families to participate in the public comment period by submitting comments at www.SafeVACare.org and supporting the highest quality health care for Veterans by urging the exclusion of nurse anesthetists from the rule when the proposal is finalized.

As part of the 60-day comment period, VA is specifically asking: "To aid in VA's full consideration to this issue, VA encourages any comments regarding the proposed full practice authority" for CRNAs. With strong comment submissions by ASA members and Veterans' advocates, this is the opportunity to demand exclusion of anesthesia care from this rule and keep physician anesthesiologists involved in the anesthesia care of all of our Veterans.

Please submit comments online at www.SafeVACare.org. ASA has provided some sample language for comments, although personalization and stories are highly encouraged. Fill out your contact information and please remember to check the disclosure agreement box at the bottom. Once you have completed all steps, your comments will be delivered to the Federal Register.

To date, ASA has engaged over 90 Members of the U.S. House of

continued on page 19

Concerted Efforts are Continued to Gain Passage of HB 1277

by Charlie Gerow, Quantum Communications

HB 1277 – Physician Supervision of Anesthesia

The Pennsylvania Society of Anesthesia continues concerted efforts to gain passage of House Bill (HB) 1277.

HB 1277, currently in the House Professional Licensure Committee, was introduced early in 2015 by state Rep. Jim Christiana (R-Beaver). It will place into the Medical Practice Act a state Department of Health regulation that the administration of anesthesia by a CRNA must be supervised by a physician.

In early May, PSA President Andy Herlich, MD, wrote to Rep. Julie Harhart, chair of the House Professional Licensure Committee, requesting that HB 1277 be brought up for a vote as soon as possible. In his letter Dr. Herlich said "the overriding and compelling interest of the Pennsylvania General Assembly must be to protect patient safety."

"As PSA president, I speak for all of our 2,000 members, who remain firm in their support of this bill," he wrote. "Pennsylvanians expect and deserve the best care in any situation where hesitation, uncertainty or lack of training can have fatal consequences. Placing existing regulations into statute is a common-sense approach to giving our patients full assurances that, when seconds count, their lives will be in the best hands."

Dr. Herlich also sent individual letters to each member of the House Professional Licensure Committee, urging them to ask for an immediate committee vote and passage of the measure.

It is important that you call your legislator and ask for passage of HB 1277

Legislators need to hear from members of PSA right away stressing that this is a vital issue. Physician supervision protects patient safety by ensuring that the most highly trained medical professional is on hand, especially in the event of an emergency during surgery — when seconds count.

Now is the time for legislators to hear from each of us! If you are not certain who to contact, go to http://www.legis.state.pa.us/ to find your legislator's name and contact information. Please do it NOW!

Your voice will make a difference in this critical issue!

Other legislation

Of particular interest are **SB 717**, introduced by Sen. Pat Vance, and **HB 765**, introduced by Rep. Jesse Topper. These are companion bills in the Senate and House that would amend the Professional Nursing Law to remove the requirement that a "certified nurse practitioner" practice in collaboration with a physician.

An amendment, supported by the Hospital and Healthsystem Association, was added to SB 717 that allows nurse practitioners in the state to practice INDEPENDENTLY AFTER they have worked under a collaborative agreement with a physician for three years and 3,600 hours. *(SB 717 as amended passed the Senate Consumer Protection and Professional Licensure Committee on May 18 by a vote of 12 to 1. Sen. John Gordner, the Majority Whip, voted against the bill in committee. The bill is not currently scheduled for a full vote in the Senate.)*

SB 481 (introduced by Sen. Pat Vance) and **HB 764** (Rep. Brian Cutler) would amend the Professional Nursing Law to provide a definition of "certified registered nurse anesthetist." PSA says these bills do not clearly define what CRNAs can and cannot do. *(SB 481 is in Senate Consumer Protection and Professional Licensure Committee; HB 764 is in House Professional Licensure Committee.)*

Politics Meets Practice
Opioid Prescribing Practices and Prescription Drug Abuse

by Donald E. Martin, M.D., Pennsylvania Medical Society Specialty Leadership Cabinet Representative for Anesthesiology

History and Scope of the Problem

Opioids are one of the commonly prescribed classes of medications in the United States in 2016. It is estimated that 1 in 5 patients who come to a physician with non-cancer pain receives an opioid prescription. In 2012, health care providers wrote 259 million prescriptions for opioid pain medication, enough for every adult in the United States to have a bottle of pills. The number of opioid prescriptions written increased 7.3% from 2007 to 2012 nationwide.

Part of the reason for this increase in the last decade is the national emphasis on the treatment of pain and the desire for complete relief of pain, in all health care settings. The pain score has been described as the "fifth vital sign". Most measures of patient satisfaction, including Federally-approved measures used to determine value-based payments, include pain relief as one component.

The use of opioid pain medication, however, presents serious risks, including overdose and opioid use disorder. From 1999 to 2014, more than 165,000 persons died from overdoses related to opioid pain medication in the United States. Nearly 2,500 deaths were reported in Pennsylvania alone as a result of drug overdoses in 2014, and more people died from drug overdoses than in car accidents. Similarly, in the past decade, while the death rates for heart disease and cancer have decreased substantially, the death rate associated with opioid pain medication has increased markedly. Opioid-related overdose deaths have increased to almost the same degree as the sales of opioid pain medication.

The risk of prescription opioid and heroin dependence has received widespread national attention among physicians, patients, public advocacy groups, and the Federal and State governments. It is also a primary focus of action for the Pennsylvania Medical Society (PAMED) and the Specialty Leadership Council. There is no doubt that relief of pain is important. Now, however, that benefit must be balanced against the personal and societal risks of overdose, physical and emotional dependence, psychiatric disturbances, and lost productivity.

In September of 2014, the Pennsylvania Legislature passed the **"Achieving Better Care by Monitoring All Prescriptions"(ABC-MAP) Act**, establishing a statewide database to monitor all prescriptions for controlled substances. Michael Ashburn, M.D., Professor of Anesthesiology and Critical Care at the Hospital of the University of Pennsylvania and director of the Penn Pain Medicine Center, played a central role in the efforts to establish this database. Dispensers or pharmacies in the State will electronically submit information to the database regarding each controlled substance dispensed, and physicians will be able to query the database regarding controlled substances obtained by their patients or attributed to their DEA number. The database is projected to be operational in July of this year. It will then provide Pennsylvania physicians with an important resource for information to improve patient care and reduce controlled substance abuse, diversion, and overdose. Both PAMED and PSA supported the formation of this database.

Management Guidelines

In May of 2014, PAMED also joined forces with the Pennsylvania Department of Health (DOH) and the

Pennsylvania Department of Drug and Alcohol Programs (PaDDAP) to formulate **"Guidelines on the Use of Opioids to Treat Chronic Non-cancer Pain"** (found at https://www.pamedsoc.org/tools-you-can-use/topics/opioids/DownloadPAOpioidGuidelines). These guidelines are designed primarily for internists and family physicians, and include recommendations regarding pre-treatment evaluation, the impact of co-existing disease and other medications, as well as recommended opioid dose limits and discontinuation of opioid therapy. They also establish specific thresholds for consultation with pain management specialists.

More recently, the Federal Government has responded to the issues surrounding prescription opioids with public, patient, and physician educational programs. On March 15, 2016, the Centers for Disease Control and Prevention published **Opioid Prescribing Guidelines** in JAMA (Dowell D; Haegerich TM; Chou R: CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. JAMA 2016; 315(15) 1624-16454). These relatively specific CDC guidelines emphasize principles for preventing dependence, the use of immediate rather than extended release opioids, the maximum duration of therapy, the use of a state prescription drug monitoring program, and mitigation of overdose risk.

A summary of both of these sets of recommendations for physicians is included near the end of this edition of the Sentinel on page.

The anesthesiologist's role as pain management consultant will likely expand as a result of both of these sets of guidelines, and in the current high-risk environment. Anesthesiologists have much to offer using both systemic non-opioid pharmacologic therapy and minimally invasive procedures ranging from nerve blocks, to ablative therapy, to TENS and acupuncture.

Physician Resources

The Pennsylvania Medical Society has established an online **Opioid Abuse Resource Center** on their web site at: https://www.pamedsoc.org/tools-you-can-use/topics/opioids/OpioidResources. This resource center provides physicians with access to five sets of recommendations and guidelines established by various medical specialty and non-physician organizations, four individual online CME programs regarding different aspects of opioid prescribing, and a six-part CME series on the effective use of long-acting and extended release opioids (https://www.pamedsoc.org/learn-lead/topics/medications-pain-management-opioids).

Specific guidelines for anesthesiologists and pain medicine specialists have been developed by the American Society of Anesthesiologists:

Practice Guidelines for Chronic Pain Management. Anesthesiology 2010; 112:1–1
Found at: http://www.asahq.org/~/media/sites/asahq/files/public/resources/standards-guidelines/practice-guidelines-for-chronic-pain-management.pdf and the American Society of Regional Anesthesia and Pain Medicine (ASRA):

Management of Postoperative Pain: A Clinical Practice Guideline from the American Pain Society, the American Society of Regional Anesthesia and Pain Medicine, and the American Society of Anesthesiologists' Committee on Regional Anesthesia, Executive Committee, and Administrative Council. The Journal of Pain 2016; 17:131-15
Found at: http://www.jpain.org/issue/S1526-5900(16)X0002-8

THE TORTURED STORY OF CRIMINAL HISTORY CLEARANCES FOR PHYSICIANS AND THEIR STAFF

by Robert Hoffman, Eckert Seamans Cherin & Mellott

For just about a decade, Pennsylvania law has required most physicians and most of their employees to obtain Criminal History Clearances demonstrating that they had no convictions from among a list of about 15 specified crimes, ranging from homicide to sexual abuse of children. The requirement stemmed from the Child Protective Services Act (the "CPSA"), a law designed to prevent and investigate cases of child abuse. Then, all of a sudden, in the fall of 2015, physicians and their staff didn't need clearances. What happened is a case study on legislative drafting gone awry and the rules governing how statutes are to be interpreted.

The CPSA was enacted in 1990 and included the familiar requirement that physicians and others whose profession put them into contact with children report suspected cases of abuse to a Child Abuse hotline. There was then no "clearance requirement" for physicians and their staffs. That requirement was limited to child care workers, day care providers, and prospective foster and adoptive parents.

In 2006, the clearance requirement was extended to physicians and their employees. A new section, § 6344.2, was enacted, requiring the same background checks for "prospective employees applying to engage in occupations with *a significant likelihood of regular contact with children*," adding for good measure that those occupations included "social service workers, hospital personnel, mental health professionals, members of the clergy, counselors, librarians and *doctors*." Administrative and other support personnel were generally excluded. Things went along smoothly, more or less.

Then, in October, 2014, the Legislature broadened the background check rule so that it applied to volunteers — to "an adult applying for an unpaid position as a volunteer responsible for the welfare of a child or having direct contact with children." The "volunteer amendments" were no doubt motivated in some fashion by the Jerry Sandusky events. That requirement took effect at year's end 2014. For its own reason (and one that is unclear to this author), the Legislature put this provision into § 6344.2, where the language affecting physicians had been, and deleted the language that had been there. But that was okay, because the Legislature enacted a new section, § 6344(a)(5), containing language that was a bit different — "An individual 14 years of age or older applying for a paid position as an employee responsible for the welfare of a child or having direct contact with children" — but covered most of the same ground. "Direct contact with children" — a term that was already in the CPSA — means "the care, supervision, guidance or control of children or routine interaction with children." That term and definition would cover physicians (as well as the other previously-listed groups — social service workers, hospital personnel, mental health

professionals, members of the clergy, counselors, and librarians).

The "volunteer amendments" had unexpected consequences. To many volunteer agencies and volunteers, the provisions seemed overbroad, burdensome, and expensive (when adding up the costs to either the volunteers or the agency of obtaining criminal histories). Constituents complained. The Legislature acted. As the legislative sponsor, Rep. Katharine Watson, wrote in May, 2015, in what is called a "Sponsorship Memo" — telling other legislators about to-be-introduced legislation — "we cannot fix every complaint that members of the House have heard since the passage of the 2013-14 amendments, [but] I do believe that we can (and should) address the vast majority of them." The goal, Rep. Watson said on the House Floor, was to "narrow and make clearer the [volunteer] requirements, who is it that really needs to have a background check." Sure enough, the "fix legislation" — now known as Act 2015-15 — was introduced in early June and signed into law by Gov. Wolf on July 1, 2015, effective immediately. All well and good. Problem solved. Or so it seemed.

As it fixed the volunteer rules, the Legislature also decided to modify the rules as to which employed persons needed background checks. The intention was to "clarify" who is required to get background checks and under what conditions." The "employee provisions" passed as well.

In doing so, there was what I assume to be an unintended drafting glitch. The legislature amended § 6344(a)(5), which had contained the language covering physicians so that it no longer did so. The important part of the revision, with the new language in **bold** and deleted language shown with **~~strikethroughs~~**, is shown below. The revised Criminal Clearance Rules applied to (among others):

> (5) an individual 14 years of age or older **who is** applying for or holding a paid position as an employee **with a program, activity or service, as a person** responsible for the **~~welfare of a child~~ child's welfare** or having direct contact with children.

Shown without those editing notes, the revised Criminal Clearance Rules applied to:

> (5) an individual 14 years of age or older who is applying for or holding a paid position as an employee with a **program, activity or service,** as a person responsible for the child's welfare or having direct contact with children.

I've kept **"program, activity** or **service"** in **bold** for reasons that will become apparent.

What, you might ask, is the problem? Here it is. The language of the new provision, carefully and fairly read, doesn't apply, as the old provision did, to all employees (or applicants) who had "direct contact with children." Instead, it applied only to persons who did so and were affiliated with a "program, activity or service." Whether the phrase "program, activity or service" might possibly be stretched to include physicians — it couldn't if I were asked — was a moot point because the new Act specifically defined that phrase (as things like youth, recreational, or sports camps and programs that were sponsored by a school or a public or private organization.") In all likelihood, the provision meant to include employees in a "program, activity, or service" and at least some of the group covered by the previous language. There is no indication that the legislature intended to excise physicians and their office staffs. But that is what the enacted language did.

The state Department of Human Services, which operates the child abuse protection system, announced in the fall of 2015 that "a physician or other person employed by a medical practice or a hospital to deliver medical care or to provide administrative services related to the delivery of medical care would not need a child abuse clearance." The Pennsylvania Medical Society (PAMED), among others, unsuccessfully urged a broader interpretation.

Ultimately, this entire sad course of events speaks to several important legal issues.

First, drafting legislation so that it says precisely what you want and nothing else can be hard. It often requires a proliferation of words, clauses, sub-clauses, definitions, rules, exceptions, and cross references. The more complicated our society gets and the more laws already in existence that may interact, the more complicated the drafting process gets. It is even harder in the abstract, when nobody has thought of a set of circumstances in which the result is not as intended. Legislation is often mocked for its length – the federal Affordable Care Act is a prime example – but length is usually a byproduct of an attempt at precision and the complexity and scope of the subject being regulated. It is worth remembering that the second "Obamacare" case decided by the Supreme Court, King v. Burwell, in June, 2015, arose from the inartful and surely unintentional drafting of one

continued on page 12

Guidelines for the Use of Opioids to Treat Chronic Non-Cancer Pain

Pennsylvania Guidelines Pennsylvania Medical Society, Pennsylvania Department of Health (PaDOH), and Pennsylvania Department of Drug and Alcohol Programs (PaDDAP), May 21, 2014	**Centers for Disease Control and Prevention Guidelines** March 15, 2016
INITIATING THE USE OF OPIOIDS	
Before initiating opioid therapy, physician should complete initial patient evaluation, including thorough history, physical examination, and necessary laboratory testing. • Evaluation should include patient's psychiatric and substance abuse history. • Opioids should rarely be the sole treatment. • Patients with psychiatric co-morbidities may require specialty care. • Patients with obstructive sleep apnea (OSA) are at increased risk with chronic opioid therapy.	Non-pharmacologic therapy and non-opioid pharmacologic therapy are preferred for chronic pain. If opioids are used, they should be combined with non-pharmacologic therapy and non-opioid pharmacologic therapy, as appropriate.
When starting chronic opioid therapy, the physician should discuss the risks and potential benefits associated with treatment. Reasonable goals and expectations for treatment should be agreed upon. Physicians should proactively review the necessity of periodic compliance checks that may include urine or saliva drug testing and pill counts. Physicians may wish to document this discussion through the use of an opioid treatment agreement. • Initial treatment with opioids should be considered as a therapeutic trial to determine whether chronic opioid therapy is appropriate. Both clinicians and patients should understand that chronic opioid therapy will not be effective for all patients, either due to lack of efficacy or the development of unacceptable adverse events or drug-related behavior.	Physicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. They should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. • Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy. • When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.
OPIOID SELECTION, DOSAGE, DURATION	
Patient's opioid selection, initial dosing, and dose adjustments should be individualized according to the patient's health status, previous exposure to opioids, response to treatment (including attainment of established treatment goals), and predicted or observed adverse events. • Caution should be used in patients also taking benzodiazepines, as the use of benzodiazepines increases the risk of serious adverse events. • Caution should be used with the administration of methadone. Providers should be aware of the special pharmacokinetics of methadone and the need for careful dosing and monitoring. • Caution should be used with the administration of chronic opioids in women of childbearing age and in breastfeeding women. • When chronic opioid therapy is used for an elderly patient, clinicians should consider starting at a lower dose, titrating slowly, using a longer dosing interval, and monitoring more frequently. • Patients with co-existing psychiatric disorder(s) may be at increased risk of harm related to chronic opioid therapy. • It is not appropriate to refer patients receiving chronic opioid therapy to the emergency department to obtain prescriptions for opioids.	• When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/ long-acting (ER/LA) opioids. • Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.
• Total daily opioid doses above 100 mg / day of oral morphine or its equivalent is not associated with improved pain control, but is associated with a significant increase in risk of harm. Therefore, clinicians should carefully consider if doses above 100 mg / day of oral morphine or its equivalent are indicated.	When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/ day.

Pennsylvania Guidelines: https://www.pamedsoc.org/PAMED_Downloads/PAGuidelinesonOpioids.pdf
CDC Guidelines: Dowell D; Haegerich TM; Chou R: CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. JAMA 2016; 315(15) 1624-16454

Guidelines for the Use of Opioids to Treat Chronic Non-Cancer Pain (CONT.)

Pennsylvania Guidelines Pennsylvania Medical Society, Pennsylvania Department of Health (PaDOH), and Pennsylvania Department of Drug and Alcohol Programs (PaDDAP), May 21, 2014	**Centers for Disease Control and Prevention Guidelines** March 15, 2016
ASSESSING RISK, MONITORING, AND ADDRESSING HARM OF OPIOID USE	
• Clinicians should reassess patients on chronic opioid therapy periodically and as warranted by changing circumstances. Monitoring should include documentation of response to therapy, presence of adverse events, and adherence to prescribed therapies. • Clinicians should consider increasing the frequency of ongoing monitoring for patients at high risk for aberrant drug-related behavior. • In patients who have engaged in aberrant drug related behaviors, clinicians should carefully determine if the risks associated with chronic opioid therapy outweigh documented benefit. • Clinicians should discontinue chronic opioid therapy in patients who engage in repeated aberrant drug-related behaviors or drug abuse-diversion, experience no progress toward meeting therapeutic goals, or experience intolerable adverse effects.	When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.
When a dose of chronic opioid therapy is increased, the clinician is advised to provide counseling the patient on the risk of cognitive impairment that can adversely affect the patient's ability to drive or safely do other activities. The risk of cognitive impairment is increased when opioids are taken with other centrally acting sedatives, including alcohol and benzodiazepines.	Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present.
Clinicians should be aware of and understand current federal and state laws, regulatory guidelines, and policy statements that govern the use of chronic opioid therapy for chronic non-cancer pain.	Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.
	Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

Pennsylvania Guidelines: https://www.pamedsoc.org/PAMED_Downloads/PAGuidelinesonOpioids.pdf
CDC Guidelines: Dowell D; Haegerich TM; Chou R: CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016. JAMA 2016; 315(15) 1624-16454

THE TORTURED STORY

continued from page 9

subsection in that exceedingly complex and lengthy Act. That error almost derailed the Act. Chief Justice Roberts saved it on the basis that it was "implausible" given the goals and structure of the ACA, that Congress meant to adopt a construction that all agreed would destroy the Act.

Second, in the real world of enacting legislation, drafting mistakes happen and nobody realizes they have happened ... until someone, usually on the outside, looks at how the language applies to a situation at hand. That happens even though the actual bill drafting is usually done by employees of a dedicated agency, the Legislative Reference Bureau, who have substantial experience in how to do so. Here, nobody appears to have realized how adding the words "program, activity or service" (which had a very particular definition) would alter the meaning of the existing provision. In my view, that question was not a far-fetched hypothetical but one that should have been asked and answered. The answer was pretty straightforward: the new language will exclude from the criminal history requirement lots of people who were previously covered. But it appears that Q&A never took place.

Third, there are rules that guide courts and lawyers in interpreting statutes. Pennsylvania even has a Statutory Construction Act. I won't pretend that statutory construction is like baking a cake (i.e., just follow the directions); there are about 15 principles to choose from and judges exercise broad discretion as to which ones they decide govern the situation. The analogy to a differential diagnosis is a fair one; the construction rules guide the inquiry but do not control it.

But the primary rule, stated in the Statutory Construction Act and over and over again in Court opinions, is that when the words of a statute are unambiguous, you interpret them as they are, not how you think they were intended. Most likely, that is the rule the Department of Human Services lawyer applied in concluding that physicians and their staff no longer needed to get and pass criminal history checks. I can't fault that result.

Finally, it is, or at least should be, relatively easy for legislatures to rewrite what they miswrote. One reason courts feel a little freer to construe statutes in a particular way is that they know the legislature can, if it disagrees, fix the problem, often by what are referred to as "technical amendments." At least that is so in theory. The legislature could easily have fixed the Obamacare glitch that I referenced earlier but politics made that impossible; no Obamacare opponent would fix an unintentional error when the error could invalidate the Act. The more partisan a bill, the less likely there will be consensus to fix the glitches.

Yet another legislative fix is in the offing, currently as Senate Bill 1156, introduced in the Senate in March, 2016. In its current iteration, the Bill adds a new provision, aimed directly at "health care personnel." It would require background checks for:

> An individual 18 years of age or older who is applying for or holding a paid position as *health care personnel* and is a person responsible for the child's welfare or having direct contact with children.

The Bill even defines who are and are not "health care personnel", "health care providers" and employees of health care facilities are, and administrative and support personnel are not unless they had direct contact with children. "Health care providers" is itself a defined term, essentially comprising those health care personnel who are licensed, certified, or regulated by the Commonwealth

Reluctantly, my legal conclusion is that there is yet another drafting error in the proposed legislation as it stands as of this moment (late May, 2016). In particular, it is very unclear whether the revision extends the background check requirement to the many employees in physicians' offices who have patient contact but are not licensed, certified, or regulated by the state. Examples in this group are medical assistants and other similar employees who, unlike RNs or LPNs, are not licensed, certified, or regulated. I assume the Legislature wants that group to be subject to the screening and any omission of them is inadvertent. Hopefully, the ambiguity or gap will be fixed by additional language before the fix is signed into law, although as of this writing the full Senate and the House Children and Youth Committee have approved the fix, with the questionable language intact. Whether that language will be revised, and how the Department of Human Services will interpret the language if it is not, remain to be seen.

ASA Legislative Conference

by Richard O'Flynn, M.D.

The 2016 ASA Legislative Conference was held on May 16-18 at the Hyatt Regency Washington on Capitol Hill. The Conference is organized by the ASA Committee on Governmental Affairs, chaired by our District Director, Erin Sullivan, M.D. with the stated goal *"to prepare ASA members to engage effectively in the legislative, regulatory and political processes on behalf of the specialty"*.

PSA members joined with their ASA Colleagues to hear the latest information about the political issues affecting anesthesiology. They heard from policymakers on developments in healthcare legislation and how to effectively lobby and advocate for our specialty.

At the conclusion of the conference, attendees traveled to Capitol Hill for visits with their elected officials.

Meeting of constituents with Drew Kent, Chief of Staff of Congressman Charles Dent of Central Pennsylvania, who has supported the continuation of physicia led teams in the VA health system. Left to right: Robert Schoaps, MD (Penn State Hershey Resident); Bhaskar Deb, MD; Don Martin, MD; Drew Kent; Anita Gupta, MD; Andrew Herlich, MD; Joseph Galassi, MD

Visit of PSA Delegation with Christina Brown, Legislative Aide to Pennsylvania Senator Robert P. Casey, Jr.

PSA group in Representative Mike Doyle's office

Recovery: The Anesthesiologist versus the Perioperative Physician

by Joseph F. Answine, M.D.

Quality recovery from surgery means something different to different people. The surgeon sees a successful recovery as minimal or no complications after successfully completing a surgical procedure. The administrator sees it as a discharge on or before the expected discharge date, with no complications, no infections, no re-admissions, full payment due to successfully meeting quality measures, and a satisfied patient and family. Of course, the anesthesiologist sees it as stable ABCs (airway, breathing and circulation), controlled pain and no nausea. And, quite simply, the patient sees it as being as good as, or better than, before the procedure.

Although there is significant overlap in what is considered quality recovery, goals need to be unified in this new world of 'cooperation and collaboration' in medicine. If we as perioperative physicians see ourselves as breaking through the confines of the operating room and being in charge of the entire surgical process from identification of a surgical candidate to a completely rehabilitated ex-patient, we, as anesthesiologists, should be the unifiers.

As unifiers, to simply accept recovery as a modified aldrete score of nine or 10 as a discharge from the PACU, is quite narrow-minded. We should follow the patient's recovery days, weeks and months post-op because that is how long true recovery can take. This is how long we need to assess the extent of recovery in order to truly advance our initiative for broader responsibility and control; as well as to improve our specialty, and patients' safety and well being. Our parameters of observation must also expand. We need to continue to monitor the ABCs, gross movement, pain and nausea in addition to cognition, depression, anxiety, activities of daily living and overall satisfaction. It is without question, as more data emerges, that what we do as anesthesiologists has long-term and extensive impact on many aspects of a patient's life.

Newer assessment tools do just that. One is the recently developed Postop Quality Recovery Scale which follows all the "domains" listed above, and follows a patient for months post-op [1]. It is, according to the developers, only then that you truly know the extent of a patient's recovery. The scale follows the patient from prior to surgery to one to three months postoperatively using a simple questionnaire performed in person or by phone. There are six domains; physiologic, nociceptive (pain and nausea), cognitive, emotive (depression and anxiety), activities of daily living, and satisfaction. Deficits in any of these parameters can lead to poor long-term recovery. All but satisfaction is scored and compared to pre-operative values. The developers of this scale also believe that patient populations can be assessed as well as anesthesia techniques and surgical procedures in order to identify risk factors for poor recovery in one or all domains [2, 3, 4, 5]. By identifying areas of risk and the domains impacted, early intervention or a change in the perioperative plan can minimize the negative impact on an individual or population[6].

The data for an individual can be easily uploaded into a computer program or website as with Postop QRS and deficits can be identified triggering a necessary response and intervention. A provider's or institution's data can be tracked, collated and compared to regional and national data in order to assess variability. So much can be learned while improving on an individual's overall quality of recovery.

Obviously, this takes more manpower and man-hours to accomplish, however with the new found buy-in from institutions for enhanced recovery programs, this assessment as an extension of those programs can be legitimately argued as worth allocating institutional resources.

Utilization of this scale, or others to look at long-term, diverse recovery is not as relevant as the fact that now, as

continued on page 18

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Operating Room Fires

by Nicole Verdecchia M.D., resident at UPMC and
Kristin Ondecko Ligda, M.D., Assistant Professor, University of Pittsburgh Medical Center, UPMC Mercy Hospital

Incidence

Operating room fires, while rare, can have extremely devastating consequences, including burns, inhalation injuries, psychological trauma, and death. Approximately 550-650 surgical fires occur annually in the United States, which is similar to the rate of wrong site surgeries [1]. Electrocautery and lasers are the most common ignition sources, oxygen is the most common oxidizer source, and surgery on the head and neck is the most common site for fires [2].

Components

Three components are required to produce a fire, which is referred to as the fire triad: ignition source, oxidizer source, and fuel source [2-4]. Fuel sources include prepping agent such as chlorhexidine, drapes, towels, sponges, dressings, endotracheal tubes, PPE equipment, aerosols, blankets, etc. Ignition sources include electrocautery equipment, lasers, fiberoptic light sources, and sparks from surgical drills, and defibrillators, among other things. The oxidizer source is almost always oxygen [2-4].

Prevention

There are several things that can be done to prevent OR fires from occurring in the first place. First, fire safety education and protocols should be in place. Operating Room fire drills and simulation training can improve the response to fires by OR staff members [2-4]. Second, there should be preparation prior to the case if a high risk situation exists. The team should discuss specific roles if a fire should occur, and fire management equipment should always be available. Specific supplies that should always be available include several containers of sterile saline, an appropriate fire extinguisher, replacement endotracheal tubes, guides, facemasks, rigid laryngoscope blades, replacement breathing circuits, and replacement drapes and sponges [2, 3].

More importantly, there are specific methods to reduce the risk of OR fires that involve managing fuel, ignition sources, and oxidizers. Using saline to moisten all sponges and packing material, letting all alcohol based prep solutions dry prior to using ignition sources, and arranging drapes in a way to avoid oxygen accumulation are ways to reduce OR fire risk [3,4]. To manage the oxidizer source, the lowest supplemental oxygen concentration should be used that is clinically safe, especially when the ignition source is near the oxidizer source [3, 4]. To manage the ignition source, using lower voltages of electrocautery equipment is helpful, and using bipolar instead of monopolar current reduces risk [2-4].

There are even more stringent guidelines for high risk procedures in terms of managing fuel sources. During laser surgery near the airway, laser resistant endotracheal tubes are less likely to ignite or melt than conventional tubes when surgery is occurring near the airway [3]. The most

1. Which of the following are components required to start a fire?

A. Ignition source
B. Oxidizer source
C. Fuel source
D. All of the above

2. Which of the following tubes is not as effective as the other tubes in preventing fires during laser surgery?

A. Copper foil wrapped tube
B. Oral RAE tube
C. Aluminum foil wrapped tube
D. Stainless steel tubes

effective tubes for preventing fires during laser surgery include copper foil wrapped tubes, aluminum foil wrapped tubes, or stainless steel tubes. These laser resistant tubes should always be cuffed, and the cuffs should be filled with saline instead of air [3]. Methylene blue should also be added to the saline so that damage to the tube by a laser or ignition source can be immediately detected [3].

Management

If a fire does occur in the operating room, but not in the airway, there are specific steps that should be taken to manage the fire. First, recognizing that a fire is present is extremely important. The fire should be immediately extinguished. The procedure must be halted and the surgeon notified. Pouring saline on the source, removing drapes and any flammable material, turning off the oxygen source and disconnecting the circuit, and using fire extinguishers are methods used to extinguish fires. If the fire cannot be extinguished, evacuation should be considered. If evacuation occurs, the fire alarm should be activated, door closed to contain fire, and the gas supply to the room should be turned off. Finally, the patient will require post fire care, and ventilation will need to be reestablished [2-4].

If the fire is within the breathing circuit or in the airway, such as during laser laryngeal surgery or other ENT procedures, the first, and most important step is to remove the endotracheal tube from the patient, and turn off the flow of gases and oxygen simultaneously, and begin using bag-mask ventilation. Post-fire care is more involved in these cases. The endotracheal tube should be examined to assess the damage to the patient's airway. Rigid bronchoscopy might be needed to assess airway injury and for possible removal of foreign materials [2-4].

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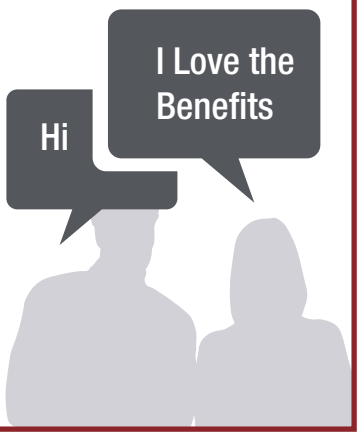
2. Rinder CS. Fire safety in the operating room. Curr Opin Aneaesthesiol. 2008 Dec; 21(6): 790-5.
3. American Society of Anesthesiologists: Practice Advisory for the Prevention and Management of Operating Room Fires. Anesthesiology 2008; 108:786-80
4. ECRI. "The patient is on fire!": a surgical fires primer. Health services. 1992; 21: 24-30.

If you would like to contribute to future Continuing Education articles in the Sentinel, please contact Kristin Ondecko Ligda, M.D. at kristin.ondecko@gmail.com.

Welcome New PSA Members

(Effective 2.18.2016 – 6.1.2016)

Rekha Galla, B.S., M.B.
Yohannes B. Getachew, M.D.
Denise M. Hall-Burton, M.D.
Heather K. Hayanga, M.D.
Stephen R. Strelec, M.D.
Kelsi E. Tagliati, M.D.
James H. Wright, M.D.



2015 Z-PAC Contributor Update – Correction

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

The 2015 Z-PAC Contributor list was published in the Spring edition of the Sentinel but was found to be incomplete. The following individuals were inadvertently left off the list. Thank you for your contributions:

David Beausang
James Cain
Tara Kennedy
Benjamin Kohl
Abraham Layon
David Metro
Richard Month
Andrew Newman
Marjorie Pierre
Sarah Clarke
Patricia Dalby
Michael Entrup
Marc Fisicaro
Shiv Goel
David Gratch
Jane Hoffman
Patrick Vlahos

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More information to come at a later date.

RECOVERY

continued from page 14

we move from intraoperative to perioperative care, anesthesiologists are expanding patient observation, and can intervene when necessary during a patient's true anesthesia recovery. This is just another way that we can assert our broader role in patient care.

References:

1. Development and feasibility of a scale to assess postoperative recovery: the post-operative quality recovery scale (Anesthesiology. 2010 Oct;113(4):892-905.)
2. Recovery after nasal surgery vs. tonsillectomy: discriminant validation of the Postoperative Quality of Recovery Scale (Acta Anaesthesiol Scand. 2014; 58(3):345-51)
3. The influence of propofol or desflurane on postoperative cognitive dysfunction in patients undergoing coronary artery bypass surgery. (Anaesthesia. 2011 Jun;66(6):455-64.)
4. Peripheral nerve blocks versus general anesthesia for total knee replacement in elderly patients on the postoperative quality of recovery (Clin Interv Aging. 2014 Feb 18;9:341-50.)
5. Knee surgery recovery: Post-operative Quality of Recovery Scale comparison of age and complexity of surgery. (Acta Anaesthesiol Scand. 2014 Jul;58(6):660-7.)
6. Assessment of early cognitive recovery after surgery using the Post-operative Quality of Recovery Scale (Acta Anaesthesiol Scand. 2014 Feb;58(2):185-91.)

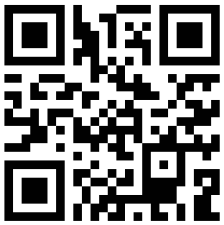
PROTECT SAFE VA CARE

continued from page 4

Representatives and U.S. Senate, prominent national Veteran organizations and other Veteran health stakeholders in raising concerns about the safety of eliminating physician involvement in anesthesia care provided to veterans by CRNAs. This unprecedented effort has led to VA's decision to closely examine the appropriateness of the nurse-only model of anesthesia care and to formally seek public input into the decision.

Thank you for your continued advocacy on behalf of the specialty and our nation's Veterans. Please take an active part in keeping physician-anesthesiologists as the leader of the anesthesia care team for our Veterans. Our Veterans have sacrificed so much for us. Now it's time for us to make sure that they continue to receive the high quality, safe anesthesia care that they have earned and deserve. Join me to Protect Safe VA Care. Submit your comments to the Federal Register now at www.SafeVACare.org.

Questions? Contact Amanda Ott with the ASA Advocacy Division at (202) 289-2222 or a.ott@asahq.org.



PRESIDENT'S MESSAGE

continued from page 1

manage critically ill patients from minute to minute. Twelve states have now mandated for nurse anesthesia without physician anesthesiologist supervision or direction. The contention was that access to care would dramatically increase. All but four hospitals in Pennsylvania have anesthesiologist on staff (Editor note: PA DOH regulations require physician supervision of all anesthesia care). In a very recent article in the Anesthesia and Analgesia Case Reports (May 2016; 6: 283-285,) the researchers found that in Medicare patients, there were no increases in access to anesthetic care when CRNAs were allowed to practice independently.

Although this is preliminary data and is limited to Medicare patients, the trend is not likely to be dramatically different in rural non-Medicare patients. Legislators of states without physician anesthesiologist oversight, so far, have probably guessed wrong and listened to effective lobbying and not actual data. It doesn't appear that access to physician anesthesiologists has changed in any meaningful way in any of the 12 states. In the Commonwealth of Pennsylvania, House Bill 1277 would put in statue the current DOH regulations which require physician supervision of anesthesia assuring the greatest patient safety. It implies that we, as perioperative physicians, have the most extensive training and will understand the nuances of complex medical conditions and work with nurse anesthetists to provide the very best care.

If one wants to practice in a similar manner as physicians, please get the education. Please don't pretend that 600 additional hours of education will make one a physician. Do the math, from the time of graduation from medical school through completion of an anesthesiology residency, the average resident completes greater than 2,500 hours of training PER YEAR (60 hours per week times 48 weeks). Now multiply that over four years, one gets approximately 10,000 hours of training that physicians complete after receiving their medical degree. How can one compare the advanced-practiced nurse to a fully-trained physician? No matter how one tries to equate the training, 10,000 does not equal 600!

After the 600 additional hours of training, assuming it doesn't include just getting the degree, will the advanced-practice nurse be willing to pay the same malpractice premiums and work the same hours? Will they be willing to practice in vastly underserved areas? The data so far in the Commonwealth of Pennsylvania shows that 97% of nurse practitioners don't practice in underserved or rural areas. Will they take the same amount of calls? Who will determine the value and quality? Not the administrators; not the CMMS, not JCAHO—only the patients will determine that quality and value to them as the receivers of care.

To take this "rant" home, HAP and the Citizens of the Commonwealth, do the right thing. Support strong physician-led teams, rather than fragmentation in all areas of medical practice. Don't think that less expensive care will improve value or safety!

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