

PENNSYLVANIA
society of
ANESTHESIOLOGISTS

SPRING 2019 *NEWSLETTER*

SENTINEL

Richard Month, M.D., F.A.S.A.
PSA PRESIDENT

President's Message

"You guys are just an advocacy organization. That just doesn't appeal to me."

I've had numerous conversations with both PSA members and non-members, and have heard the above sentence, in one form or another, more times than I care to count. As I truly began to think about what brought my fellow Anesthesiologists to think this way, I'm brought to the word advocacy, and the great Spaniard swordsman, Inigo Montoya: "You keep using that word. I do not think it means what you think it means."

In an effort to avoid burying the lede and to minimize suspense, yes, we are proudly an advocacy organization. But what does that mean? "Advocacy" comes from the Latin advocare, meaning "to summon, or call to one's aid;" and it is to this definition that we ascribe. We vigorously advocate for our patients, our members, and our profession.

We vigorously advocate for our patients, our members, and our profession.

First and foremost, we advocate for our patients. The mission of the PSA is "Advancing the Safest Patient Care Through Advocacy and Professional Development", and clearly this starts with the patient. We work to ensure that the highest-quality, best-trained Anesthesia and Pain Management care is available to all Pennsylvanians. We do this through patient and physician education programs, legislative advocacy to ensure availability of the newest procedures and protocols (such as the growth of opioid minimization strategies), and through strong connections with our residency programs, to ensure the future of patient care.

We also advocate for our members. A growing proportion of our work involves member-driven initiatives. Most notably, a member question about large anesthesia groups led to the formation of our Standing Committee on Anesthesia Practice, which is tasked with investigating the changing business of Anesthesia Practice to ensure the best possible outcomes for our membership. In this issue, this committee has an article from John Hogan, Esq., discussing the legal issues encountered with selling a practice to a large national company.

Finally, we advocate for our profession. Yes, this includes our advocacy on Scope of Practice, which seems to be the most visible avenue; however, we advocate for a number of other extraordinarily important issues as well. We are actively involved in the advocacy efforts around Surprise Balance Billing, working with a number of other specialties to ensure the best possible outcomes for both physicians and patients, and are also advising on the number of bills that are, and have been, trying to address the opioid crisis. We are actively involved in

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PENNSYLVANIA *society of* ANESTHESIOLOGISTS

SENTINEL *NEWSLETTER*

Association Director
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Editor
Richard P. O'Flynn, M.D., F.A.S.A.

President
Richard Month, M.D., F.A.S.A.

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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

EDITORIAL

Get involved in the political process

Richard O'Flynn, M.D., F.A.S.A.
EDITOR

This edition of the *Sentinel* has important articles about advocacy. As elected officials in Washington debate healthcare delivery from the Affordable Care Act to single payer Medicare for all, it behooves all physicians to become involved in the political process. While the political decisions will surely be ascribed as looking out for patients, rest assured that the cost will become the overriding concern and ultimately, the deciding factor. It will be up to physicians to be the watch dogs to make sure that the cost doesn't trump good patient care.

Also in this edition (page 23) is a reprint of the World Health Organization-World Federation of Societies of Anesthesiologists (WHO-WFSA) International Standards for a Safe Practice of Anesthesia. This standard was unanimously approved by the countries represented in the United Nations World Health Assembly. It clearly describes global standards for anesthesia care. The Anesthesia Patient Safety Foundation newsletter reprinted the standards attributed to the WHO-WFSA in its February 2019 issue.

Following the publication, the American Association of Nurse Anesthetists Board of Directors decided to pull their support and funding of the APSF unless the APSF retracted or modified the standards.

It is very disappointing that the AANA took this position. The APSF has long been the preeminent organization for safe anesthesia care. Politics has not influenced the APSF; safe anesthesia care has been the sole function. For the AANA to remove their support and funding simply based on a reprint of an internationally derived set of standards for anesthesia care leads one to believe that they are more interested in politics in the United States than in seeing safe anesthesia care.

Reprinted in the issue (page 23) is the letter from the APSF Board explaining this issue in detail. ■

President's Message *...continued from page 1*

making sure that, to the best of our abilities, decisions made in Harrisburg provide the best possible scenario for both physicians and patients.

If you've read this far, I likely don't need to convince you that PSA advocates on multiple levels. But what does this mean for your less-than-enthusiastic colleagues? In short, yes, we are an unapologetic advocacy organization, but our advocacy for patients, colleagues, and specialty is broad, and I can assure you that there is room for everyone. Now more than ever, in the rapidly-changing landscape of modern medicine, we need engaged membership to ensure that our patients continue to get the high-quality care they deserve. Help us as we advance the safest patient care! ■

Advocacy is Paramount to Our Field

Neal K. Shah, M.D.

Advocacy is paramount to the field of anesthesiology. There are a multitude of medical issues that have impacted the practice of anesthesia over the past few decades. Through advocacy, all physician anesthesiologists—including residents—can learn about the current issues affecting our specialty and can help shape our specialty's future. As anesthesiologists, we are often placed in positions of leadership to determine allocation of resources and improve efficiency through better systems processes. With the advent of the care team model, we work alongside nurse anesthetists and other anesthesia providers to ensure that the highest quality of care is delivered to patients while safeguarding the scope of practice. There are many decisions that are made at the local, state and national level regarding healthcare that affect our everyday work. This highlights the fact that advocacy is a crucial component of our work as anesthesiologists.

Each May, the American Society of Anesthesiologists (ASA) hosts a Legislative Conference in Washington, D.C. Leaders from across the nation gather to learn about the issues affecting our specialty and legislation that can impact our ability to provide the highest level of care. I attended this conference last May along with colleagues from across Pennsylvania to advocate on behalf of our patients and our specialty. We discussed the major issues at hand, which included drug shortages, the opioid epidemic and legislation in both the House and Senate that addressed the epidemic. Lastly, I heard from various speakers regarding the evolution of the anesthesia care team model and how to discuss the importance of strengthening relationships with other members of the anesthesia care team. This conference provides the opportunity to meet with local Congressman and Senators to discuss any issue affecting anesthesiology, thus shaping the conversation regarding our field in Washington, D.C. The representatives and their staff look to us as physicians to help them understand what various pieces of legislation mean to the practice of medicine and what other issues we face on a daily basis that they may not be aware of. It was exciting and invigorating to participate in the advocacy process directly and walk the halls of the Capitol Building to meeting with the individuals who have the ability to impact the future of anesthesiology through legislation.

The ASA Legislative Conference also provides residents an excellent platform to network with residents and faculty from across the nation. There are numerous social events scheduled in between sessions where you can mingle and share your ideas with colleagues. In addition to networking, there are other opportunities, such as the Leadership Spokesperson Training course, to develop skills in advocacy. It was eye opening to hear how often our colleagues from across the country are responsible for providing medical updates to the media after tragic events or are asked to weigh in on the complexity of a case. This short course provided skills to effectively communicate with the media or other representatives.

Overall, the ASA Legislative conference is an excellent opportunity to become more involved in the advocacy process and see the impact that ASAPAC and the Chicago/Washington, DC ASA staff has on enhancing the practice of anesthesiology by having meaningful discussions with our representatives. These conversations truly do make a difference in our practice and the quality of care we are able to provide to our patients. I highly encourage all residents to make an effort to attend this conference during their residency. It is an excellent opportunity to have your voice heard and to play a direct role in addressing current issues affecting anesthesiology. This year the Legislative Conference is from May 13-15, 2019. The Pennsylvania Society of Anesthesiology (PSA) encourages and supports all residency programs to send residents to attend this conference. If you have any questions about my experience or advocacy within anesthesiology in general, feel free to contact me at shahnk2@upmc.edu.

Book Review

Joseph A. Answine, M.D., F.A.S.A.

Joseph F. Answine, M.D. F.A.S.A.

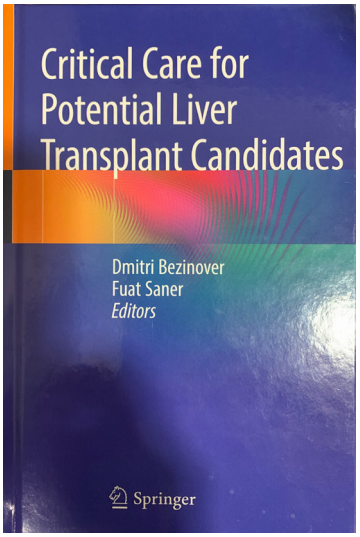
Critical Care for Potential Liver Transplant Candidates (Editors: Dmitri Bezinover and Fuat Saner)

The textbook, *Critical Care for Potential Liver Transplant Candidates,* is a new publication describing the pre-operative care for some of the sickest patients we may be confronted with: those with end stage liver disease (ESLD). The editors are from Germany (Dr. Saner) and Dr. Bezinover from the Department of Anesthesiology and Perioperative Medicine at Penn State Hershey.

This book will be a valuable resource for all medical professionals caring for patients with ESLD being considered for transplantation.

Below is a quote from Dr. Bezinover:

"Patients with ESLD presenting for transplantation are cared for by specialists in hepatology, critical care, surgery, and anesthesia and frequently require hospital admission and treatment in an intensive care unit (ICU). They bring with them many co-morbidities requiring careful pre-transplant evaluation and management including acute and chronic cardiovascular, pulmonary, and kidney disease, as well as coagulopathy. Many of these disorders have a significant impact on morbidity and mortality, and even selection for transplantation."



Written by experts in the fields of ESLD and transplantation from a variety of disciplines, the authors present up to date information on the evaluation and management of these co-morbidities providing unique insight and perspective. This book will be a valuable resource for all medical professionals caring for patients with ESLD being considered for transplantation.

With chapters authored by medical specialists from around the world, I contend that regardless of whether you are practicing within an institution performing liver transplantation or not, the contents of this book will provide value for anesthesiologists, surgeons, intensivists and primary care specialists. The first two chapters deal with the cardiac and pulmonary evaluation of critically ill patients to facilitate perioperative optimization. Other sections concentrate on the evaluation and management of acute kidney injury, coagulopathy and thrombosis, electrolyte abnormalities, acute gastrointestinal bleeding; wrapping up with the care of individuals with acute liver failure. The book is loaded with formulas, algorithms, graphs, cartoons and photos to aid in understanding the complexities of critical care medicine.

Although I am not sure when, or if, I will be in the OR again as an anesthesiologist for a liver transplant, the editors and authors dramatically improved my understanding of what is required to evaluate, treat and prepare a patient with ESLD for potential liver transplantation. ■

LEGISLATIVE UPDATE

Andy Goodman
MILLIRON & GOODMAN | GOVERNMENT RELATIONS, LLC

2019/2020 State Budget

In February Democratic Governor Tom Wolf delivered his fifth budget address to a Republican-led General Assembly. His proposed $34.1 billion spending plan is 4.3 percent higher than the enacted 2018-19 budget of $32.7 billion. However, the state is overspending that budget. Adding in those extra costs shows Wolf's 2019/20 budget proposal is about 2.8 percent higher than the $33.2 billion the state will need to close out the 2018/19 budget by June 30.

Governor Wolf's plan would boost funding for public schools, raise the minimum wage, and provide money for new voting machines and programs to improve skills training and the state's agricultural sector.

The budget plan would not increase the state's taxes on income and sales. However, the governor is reviving last year's proposal to impose a new tax on ambulatory surgical centers (ASCs) in Pennsylvania. A coalition led by the Pennsylvania Ambulatory Surgery Association of 17 state-based medical societies, including PAMED, opposed the proposal which would ultimately decrease patient access to quality, efficient, cost-effective, community-based healthcare and increase costs for patients and the healthcare system.

For the fifth time, Governor Wolf is asking lawmakers to impose a severance tax on drillers — although with a twist. He is not planning on using that money to balance the state's books, as he has in past years. Instead, the money would funnel through a separate account to finance an ambitious infrastructure improvement program.

Governor Wolf's proposal is just the start of the annual budget-making process that will be decided largely by the Republican-controlled legislature. His first three years in office were dominated by drawn-out partisan fights with the Republican-controlled Legislature over taxes and how to plug huge deficits. Ahead of his reelection campaign last summer, Wolf opted for a light on taxes approach and avoided an impasse. There is optimism this budget is heading in the same direction. The new fiscal year starts July 1.

Legislative Session Schedule

SENATE SESSION SCHEDULE

May 1, 6, 7, 8

June 3, 4, 5, 10, 11, 12, 17, 18, 19, 24, 25, 26, 27, 28

HOUSE SESSION SCHEDULE

May 1, 6, 7, 8, 13, 14, 15, 22, 23

June 3, 4, 5, 10, 11, 12, 17, 18, 19, 20, 24, 25, 26, 27, 28

Special Elections

With three open seats in the state House and three in the state Senate, it has been an unusually busy special election season in Pennsylvania.

In the state House, Democrat Bridget Malloy Kosierowski, a registered nurse, declared victory in the special election in the 114th District to fill the Lackawanna County seat left vacant after Democrat State Rep. Sid Michaels Kavulich passed away in October. Democrat Movita Johnson-Harrell, the former interim supervisor of Victim Services for Philadelphia's District Attorney's Office, won the highly contested special election for the 190th House District seat most recently held by Philadelphia Democrat Rep. Vanessa Lowery Brown.

Republicans hold the House majority with 109 seats and one vacancy. Democrats have 93 seats.

In the state Senate, Democrat Pam Iovino won the open state Senate seat in the 37th District. The Allegheny County seat was left vacant when Guy Reschenthaler, a Republican, resigned after being elected to Congress in November. Senator-elect Iovino served 23-years in the Navy, earning the rank of Captain, before retiring to assume the appointment

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by President George W. Bush as assistant secretary at the Department of Veterans Affairs.

Republicans hold the state Senate majority with 26 seats and two vacancies. With Iovino's win, Democrats now have 22 seats, their highest number since 2014. The win puts Democrats three seats away from flipping the state Senate. Iovino will face re-election in 2020, along with three other competitive districts currently held by Republicans in Erie, Dauphin, and Delaware counties. If Democrats win all those races, they would have 25 seats, with Democratic Lt. Gov. John Fetterman as the tie breaker.

The next round of special elections will coincide with the May 21 primary election. Pennsylvania voters will fill the open seats in the 33rd and 41st Senatorial Districts and 11th House District. The 33rd Senatorial District seat was most recently held by Franklin County Republican Senator Rich Alloway. Indiana County Republican Senator Don White held the 41st District seat. Both vacated their seats at the end of February. The 11th House District seat in Butler County was held by Republican Representative Brian Ellis who resigned from his seat in March.

Grassroots

Milliron Goodman continues to work closely with PSA's leadership and lawmakers on scope of practice legislation and regulations affecting your profession and the safety of your patients. With over 50 freshmen legislators this session we cannot stress enough the importance of getting to know your legislators and more importantly, making sure they know you. Your involvement in the legislative process is crucial for your profession and your patients. Please stay tuned for alerts from Milliron Goodman.

If you have any questions, please do not hesitate to contact our office. ■

Member Benefit!

Have a job you need to fill? Advertise on PSA's Job Bank!

This job bank is specifically for employment associated with anesthesiology.

Go to www.psanes.org/job-bank for details

Legal implications of grassroots lobbying

Telling your rescue stories

Charles I. Artz, Esq.
PSA GENERAL COUNSEL

Your PSA General Counsel usually writes articles summarizing relevant and important legal developments affecting Anesthesiologists. This article is different. For this edition, I am compelled to write about the legal implications of each and every PSA member's basic and essential participation in the political process.

The importance of PSA members' involvement in the political process has always existed, but the legal issues presently confronting PSA, as discussed at its recent Board of Directors' meeting, underscores the paramount nature of your involvement. Given the current climate, the word "urgent" is not an overstatement.

Stated simply, each PSA member's grassroots political involvement is imperative. It has never been more important than right now.

Why? Here are a few reasons:

1. *Department of Health CRNA Supervision Regulations.* The Department of Health is revising its Hospital Regulations. Part of those proposed regulations eliminate Anesthesiologist supervision over CRNAs. At the time this article went to press, DOH's plan was to allow each private hospital – and potentially one individual designated by each hospital's Board of Directors – to determine the level of CRNA supervision. DOH has completely eliminated Anesthesiologist supervision. DOH states that CRNAs's scope of practice and supervision is governed only by the State Board of Nursing regulations, which reference "cooperation" with the surgeon and no Anesthesiologist supervision.

2. *CRNA Titling Legislation*. CRNAs have introduced legislation that would amend the Nursing Law and give them the CRNA title that is presently absent from any law in Pennsylvania. PSA contends this is a step toward CRNAs practicing independently apart from Anesthesiologist supervision. It is similar to CRNPs and, to some lesser extent, Physician Assistants' efforts to practice medicine independently of physicians.

3. *Surprise Balance Billing Legislation.* Legislation will soon be introduced and considered during the 2019-2020 Legislative Session to eliminate so-called "surprise balance bills" from physicians who do not participate with commercial third party payors. The details of the legislation create onerous obligations on Anesthesiologists and other physicians and do not address the real problem – inadequate and narrow networks created by insurance companies.

4. *Physician Drug Monitoring Database Access Initiated by Anesthesiologists.* Some facilities in Pennsylvania are forcing Anesthesiologists to conduct the initial access to the PDMP for each patient. PSA does not believe this is legally required or mandated. The Department of Health has not solved the problem.

PSA has drafted legislation to once and for all solve the CRNA supervision issue. If that type of law were enacted through legislation, PSA would not have to worry about regulatory changes, such as the Department of Health's Hospital Regulations summarized above.

PSA has assembled superior physician leadership,

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Telling your rescue stories

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outstanding government relations lobbying representation and our law firm's 30 years' experience to advocate aggressively and successfully on behalf of physicians and physician organizations.

Is that good? Yes, it's very good. Is that enough? Probably not.

What can each PSA Member do? If you have already established a relationship with your State Representative and State Senator, great work! If you have not, PSA respectfully urges and encourages you to identify your State Senator and House Member and schedule a meeting in each Member's district office. Introduce yourself. Be prepared to tell your story.

What is your story and what do I mean by "rescue" in the title of this article? Your story involves not just the quality of medical education you received as well as your extensive experience and training as a practicing Anesthesiologist, but it also, in my view, means telling the compelling stories, which happen frequently, about how an Anesthesiologist is called into the operating room when there is an emergency that the CRNA can't handle, and how your training, education and experience saved the patient's life.

I urge you to document each of your "rescue" stories and use them in your discussions with your State Senator and State House Member.

I participated in a meeting recently in which a PSA leader explained to government officials several events that happened during that week in which complicated patients undergoing complicated surgical procedures experienced a life-threatening event during surgery. The Anesthesiologist was called. Only the Anesthesiologist had the requisite training, education and experience to understand the totality of the circumstances and save the patient's life. I call that the "source code." Only the Anesthesiologist has the source code. The CRNA does not have the breadth of training and experience in many situations to comprehend the entirety of the circumstances and address and resolve the problem. Only the Anesthesiologist can rescue the patient in dire circumstances.

One PSA and ASA leader told me at the recent Board meeting about her multiple rescues. This physician indicated she frequently saves lives under these circumstances. She indicated Anesthesiologists do this frequently, and don't make a big deal about it. She said "it's what we do." CRNAs, while clearly an essential part of the anesthesia care team, are not equipped to deal with those dire circumstances. It's like having a brilliant and experienced paralegal in a court room trial. With a lot of training and experience, the paralegal could handle many situations. But when a technical, substantive legal issue or complicated evidentiary issue arises, the paralegal does not have the "source code." Only the experienced, trained attorney has the "source code" to properly respond to the complication.

I urge you to document each of your "rescue" stories and use them in your discussions with your State Senator and State House Member. Confirm the importance of CRNAs in the process. Emphasize the critical nature of Anesthesiologist supervision. Adamantly explain PSA's stated goal and mission: patient-centered care, Anesthesiologist-led anesthesia services.

The "rescue stories," in my view, are easily understood and imperative to convince a Legislator, regardless of party affiliation, of the critical nature of continued Anesthesiologist supervision over CRNAs. Telling "rescue stories" does not disrespect CRNAs. It is a function of high-quality, patient-centered medical care.

As part of the quality of care discussion, you may want

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Legal implications of grassroots lobbying

Telling your rescue stories

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to bring along a copy of the World Health Organization article that was recently published and distributed at the ASA meeting, which concluded as follows:

Anesthesia is a vital component of basic healthcare and requires appropriate resources. Anesthesia is inherently complex and potentially very hazardous, and its safe provision requires a high level of expertise in medical diagnosis, pharmacology, physiology, and anatomy, as well as considerable practical skill. Therefore, the WFSA views anesthesiology as a medical practice. Wherever and whenever possible, anesthesia should be provided, led, or overseen by an Anesthesiologist (HIGHLY RECOMMENDED).

A copy of the WHO article can be accessed through the general webpage at: https://www.wfsahq.org/. The specific article can be found at: https://link.springer.com/epdf/10.1007/s12630-018-1111-5?shared_access_token=KVc7bNLPtgjsi6WPf3zid_e4RwlQNchNByi7wbcMAY7ppz5smjzBY6ja3vtSxHkfSCnG7VYzgVCqbBDDIZT5gsNjmLM8DqPuD8-rXeMGx9ebRBCDiiXkZez5najiDPGr_oMEIJe2os54Bv_bxg5Sk-J20ydZ5L3ItSNUsdr4t68%3D

So why am I writing this article? It is driven by the old adage people should not see how their laws and sausages are made. My dad was a butcher. I worked in the Senate for two years. I was a lobbyist for two years. I am one of the few people who can attest to the truth of the adage. I understand the process (as unappealing as the political process can be) and feel compelled to share my thoughts, recommendations and perhaps even exhortations.

There are two more adages I have learned along the way in my 30 years of experience practicing health care law, primarily representing physicians. All politics are local. Relationships mean everything.

Senators and House Members respond favorably to individuals they know, i.e. with whom they have a relationship, especially at the local level. That is why grassroots involvement in the political process is so important.

What is your investment? Your investment is time and effort in the grassroots political process. That investment of time and effort can yield significant results. PSA is doing everything it can through its physician leadership, government relations firm, political action committee and legal counsel. The last piece of the puzzle to achieve paramount political and legal success is your personal involvement and investment in the political process.

I urge you to begin documenting your “rescue stories” immediately, of course, de-identifying all protected health information in the process. The “rescue story” can be developed with general facts and no patient particulars. You can determine your House Member and State Senator by clicking on the following link/accessing the information at http://bit.ly/whosmypalegislator. Make a call to the House Member and Senator’s district office. Set up a meeting. Use your “rescue stories” in the meeting. And perhaps even send your “rescue stories” to PSA.

Many PSA leaders, past and present, have done a tremendous job on this. The purpose of this article is to encourage every PSA Member to become politically involved. The message is clear and simple. Quality of care and protecting patients is most important. Patient-centered. Physician-led. Anesthesiologist-driven.

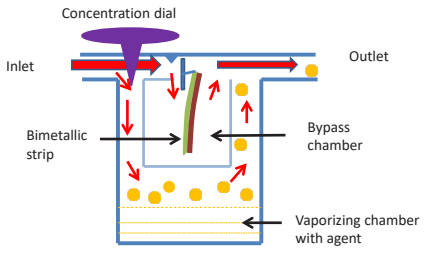
Thank you for taking the time to read and consider this recommendation. ■

Know Your Equipment...
VAPORIZER

Verghese Cherian, M.D.

Since most of the inhalational anesthetics that are used today are liquids at normal pressure and room temperature, they have to be converted into vapor before been administered. A vaporizer is a device that is used to make this conversion of these potent agents in a controlled manner. Most modern vaporizers are 'variable-bypass flow over' type. (Figure 1) It

Figure 1. A schematic diagram of a variable bypass vaporizer. (refer to the text for explanation)



essentially means that the fresh gas is split into two, one that flows into the vaporizing chamber to carry the anesthetic vapor and the other that flows through the bypass chamber which eventually dilutes the gas coming from the vaporizing chamber. Desflurane vaporizer is the exception.

Physics

To understand the functioning of a vaporizer it is crucial to revise some principles of thermodynamics!

The molecules of a liquid in a container evaporate and exert 'vapor pressure' on the walls of the container. As the temperature of the liquid increases more vapor is formed and the vapor pressure increases and the reverse happens when the temperature of liquid decreases. At a particular temperature when a dynamic equilibrium is reached between the liquid and the vapor it exerts the 'saturated vapor pressure' (SVP). The SVP of a liquid depends on its temperature. As the temperature increases so does the SVP and the temperature at which the SVP reaches the ambient pressure the liquid will boil (boiling point).

According to the Dalton's law of partial pressures, the total pressure exerted by a mixture of gases is the sum of the partial pressures of each gas. As a corollary to this, the concentration of a gas in a mixture is proportional to its partial pressure.

Therefore, within the vaporizing chamber of the vaporizer, the concentration of the anesthetic vapor would be SVP/Atmospheric Pressure x 100 (e.g. for sevoflurane with a SVP of 157 mmHg at 20°C, this translates to 20% sevoflurane!) The carrier gas passing through the vaporizing chamber if fully saturated contains 20% sevoflurane and gets diluted by the bypass gas to deliver the required concentration at the outlet of the vaporizer.

To ensure that the vaporizer output matches the dialed setting it is important to keep the SVP of the agent constant. However, as the vapor gets carried away by the carrier gas, more molecules evaporate from the remaining liquid. When a molecule changes from a liquid phase to the vapor phase it needs energy and it takes this 'latent heat of vaporization' from the remaining liquid making the liquid lose its temperature. If the temperature of the remaining liquid were to fall so will the SVP and it would affect the vaporizer output. This brings us to two physical principles.

1. *Specific heat* is the amount of heat energy needed to change the temperature of 1kg of a substance by 1°C. Therefore, if the vaporizer were to be made with a material with a high specific heat, such as

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copper (0.1 Cal.g-1°C-1), it can transfer energy to the anesthetic agent within the vaporizing chamber without losing its temperature and thus maintaining the SVP of the liquid. Since, thermal capacity is specific heat x mass, the ability to transfer energy is proportional to the mass of copper available. This explains why the vaporizers are so heavy.

2. Since the ambient temperature in the operating room is about 20°C, a material with good '*thermal conductivity*' can transfer this energy to the liquid inside.

Water, with its relatively high specific heat (4.186 joule.gram-1°C) was used in some older vaporizer (e.g. EMO) as a heat sink to maintain the temperature. Glass was popular because of the ease of construction but it has a low thermal conductivity and is prone to breakage. Copper is the commonly used metal for vaporizers.

If the thermal capacity of the vaporizer does not maintain the temperature of the agent the backup mechanism to ensure correct vaporizer output is the alteration of flow using a control gate made of a bimetallic strip. Two metals of different coefficient of expansion are bound together and as the temperature in the vaporizer decreases, the bimetallic strip bends to decrease the flow of gas into the bypass chamber. (Figure 1) This increases the flow through the vaporizing chamber so as to carry more agent molecules to maintain the output concentration. This mechanism of temperature compensation is called 'flow alteration'.

Partial pressure vs Volume percent: Although, the concentration of the anesthetic agent exiting the vaporizer is usually expressed as volume percentage (as labelled on the vaporizer dial), the uptake and distribution of the agent and the anesthetic depth is dependent on the partial pressure of the anesthetic.

Classification of Vaporizers

Vaporizers have evolved from the simple Schimmelbusch mask wherein ether was poured over multiple layers of gauze and the vapor was inhaled by the patient's spontaneous breaths. The construction of the early vaporizers was simple and the patient's spontaneous breath was able to draw air through it, which during its passage carried the anesthetic agent. Unlike these 'Draw-over' vaporizers, the construction of the modern ones provides significant resistance to airflow and needs a gas flow at higher than the atmospheric pressure to drive the anesthetic vapor. Such a vaporizer is known as 'Plenum'.

Vaporizers are classified according to the method of regulating output concentration.

1. *Variable bypass:* The fresh gas is split into two, one that flows into the vaporizing chamber to carry the anesthetic vapor and the other that flows through the bypass chamber which eventually dilutes the gas coming from the vaporizing chamber. (Figure 1) The concentration control dial determines the 'splitting' ratio of the fresh gas flow. This method of regulating output concentration can be used for both 'draw-over' (e.g. Oxford Miniature Vaporizer, Goldman) as well as 'plenum' (e.g. Boyle's bottle, Drager®) type of vaporizers. The GE healthcare Aladin ™ cassette is essentially the vaporizing chamber and the electronic control mechanism which resides in the anesthesia machine regulates the amount of fresh gas flow into the cassette. (Figure 2)

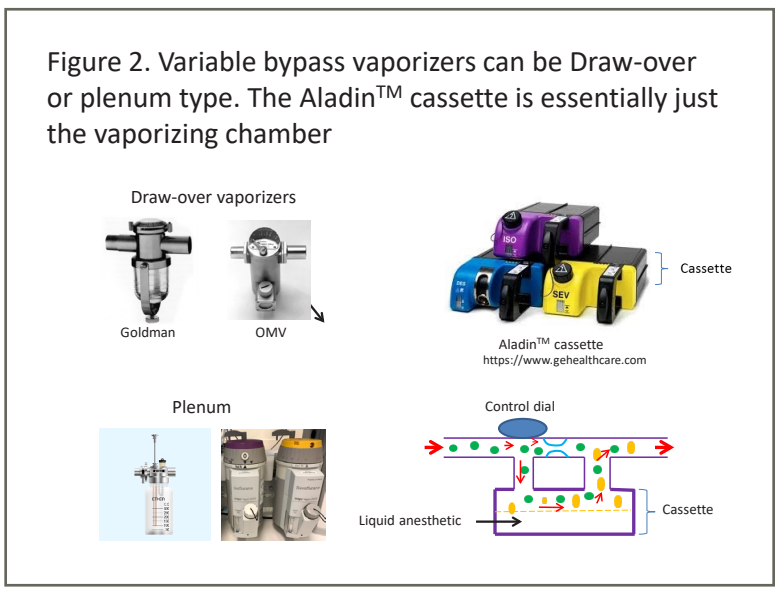

Figure 2. Variable bypass vaporizers can be Draw-over or plenum type. The Aladin™ cassette is essentially just the vaporizing chamber

2. *Measured Flow*: This type of vaporizer was invented in the early half of the 20th century because the then available variable bypass, glass bottle vaporizers were not temperature compensated and accounted for variable output as the temperature (and SVP) of the anesthetic agent decreased during use. In this system, a measured flow of oxygen from a dedicated flow meter passed through the vaporizer and became fully saturated with the anesthetic va-

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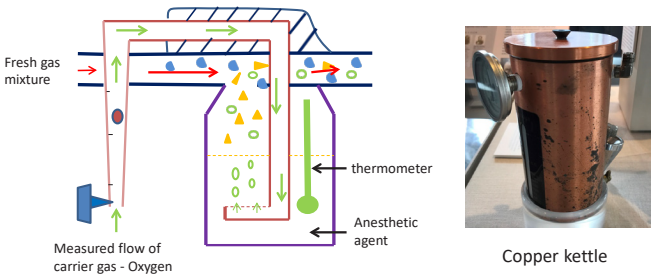
por and then merges with the fresh gas flow (oxygen & nitrous oxide) before being delivered to the patient. (Figure 3) These vaporizers were constructed with copper and had a thermometer within to measure the temperature of the liquid. Based on the knowledge of the SVP of the agent at the particular temperature the flow of oxygen through the vaporizer was adjusted to get the desired concentration of the agent. Nomograms connecting the temperature of the agent, the flow of carrier gas, the total gas flow and the delivered concentration of anesthetic were readily available to ease the use of these vaporizers.

The classic example of a measured flow type of vaporizer is the Copper kettle. (Figure 3) Copper was

Figure 3. A schematic of a 'measured flow' type vaporizer. E.g. Copper kettle



used because of its high specific heat and thermal conductivity so as to limit fluctuation in temperature of the anesthetic agent. Although it was initially conceived for chloroform, it became more popular for use of halothane.

Although none of the modern vaporizer uses this method of regulating output concentration, some authors have described the Tec6 Desflurane vaporizer as a 'measured flow' type, which is not correct.

3. *Pressure-regulated gas blender*: Desflurane has a SVP of 669 mmHg at 20°C and a boiling point of 22.8°C. Therefore, a contemporary variable bypass vaporizer is not suitable for desflurane for three reasons

a. The concentration of desflurane emerging from the vaporizing camber would be nearly 88% and would need a very high fresh gas flow to dilute it to clinically useful concentrations.

b. Although the latent heat of vaporization of desflurane is comparable to other inhaled anesthetics, the MAC is 4-9 times higher and so the absolute amount of desflurane needed to achieve equivalent MAC concentrations is significantly higher. The high rate of evaporation would cause substantial cooling of the remaining liquid and thus affecting the vapor output.

c. Desflurane will boil at 22.8°C which is at the higher end of the normal operating room temperatures. This would lead to uncontrollable vapor formation.

In early 1990s, Datex-Ohmeda developed the Tec-6 vaporizer especially for desflurane. This vaporizer consists of two independent circuits; one for the fresh gas flow (FGF) and the other for desflurane vapor. (Figure 4) These two streams mix only at the vaporizer outlet. The sump for desflurane is thermostatically heated to 39°C and the vapor pressure within is about 1300 mmHg. The shut-off valve of the sump is opened when the temperature is steady at 39°C and the concentration dial is turned to 'on' position. The differential pressure transducer between the two parallel circuits is the key to regulating the vapor concentration. Depending on the FGF, the transducer electronically signals the pressure regulating valve to release desflurane vapor from the sump to balance the pressure in the FGF circuit. At a FGF of 10L/min the desflurane vapor pressure is maintained at 1.1 atmospheric absolute (74 mmHg gauge). The concentration dial regulates the flow of vapor reaching the vaporizer outlet. Therefore, the Tec 6 is a temperature controlled, pressurized, pressure-regulated gas blender. The Dräger version of desflurane vaporizer is known as D-vapor and functions similarly.

4. *Injector*: In this type of vaporizer, the anesthetic agent is kept in a pressurized reservoir and forced through an injector into a heated vaporizing chamber and the vapor is carried away by the fresh gas flow. (Figure 5) The amount of anesthetic injected depends on the desired concentration and the FGF through the vaporizer and is microprocessor controlled. The Maquet vaporizer is an injector-type vaporizer.

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Know Your Equipment

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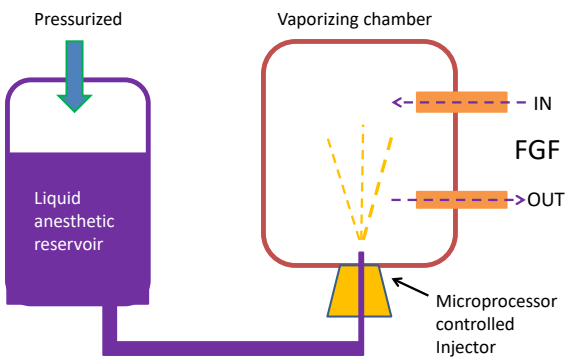
A relatively new technology called AnaConDa (anesthetic conserving device) is an anesthetic delivery system for administering volatile anesthetic to an intubated patient in the intensive care unit. An anesthetic-filled syringe is incorporated between the Y-piece and the endotracheal tube and the evaporated gas is transported along with the inspiratory flow to the patient. During expiration, the exhaled anesthetic vapor is adsorbed onto a carbon filter and redelivered to the patient during the next inspiration. (https://www.sedanamedical.com)

Figure 5: A schematic of an injector type vaporizer. E.g. Maquet vaporizer



Factors that influence the vaporizer function

1. *Fresh Gas Flow:* Variation in vaporizer output is noted at extremes of FGF and at higher dial settings. The output is found to be slightly less than the dial setting at FGF <250ml/min and at flows >15 L/min

2. *Carrier gas composition*: The vaporizers are calibrated with 100% oxygen. Nitrous oxide is soluble in halogenated liquid and therefore when it is used along with oxygen the output falls initially followed by slow increase as a steady state is reached.

3. *Intermittent back-pressure*: During positive pressure ventilation or with oxygen flush the back pressure in the system could push the gas back into the vaporizer. This vapor containing gas could pass through the vaporizing chamber and up the inlet into the bypass channel. When the pressure is released the vapor from the bypass channel would add to the gas flow and increase the vaporizer output. This is referred to as 'pumping effect'. To reduce this, most modern vaporizers have a one way valve at the outlet of the vaporizer and a long, convoluted inlet channel to the vaporizing chamber to prevent the vapor laden gas from reaching the bypass channel.

4. *Barometric pressure*: Plenum vaporizers are calibrated at sea level. At high altitude, as the ambient pressure decreases the pressure of the carrier gas falls and so does the number of molecules. However, since the SVP of the anesthetic liquid does not depend on the ambient pressure, the number of molecules of anesthetic vapor remains the same, leading to a higher volume percent, but exerting the same partial pressure. Since the anesthetic effect depends on the partial pressure of the anesthetic in the brain, the clinical effect remains the same. However, the desflurane vaporizer functions at absolute pressures and the pressure of desflurane vapor is adjusted to the pressure of the FGF so as to maintain an output concentration as dialed. So if this vaporizer is used in a lower ambient pressure the dialed volume percent of desflurane will be delivered. However, the partial pressure of the desflurane will be lower. Therefore, to achieve the same clinical effect, the dial setting needs to be changed as per the formula.

Required Dial setting=Normal dial setting (Vol %)*x* (760 mmHg)/(ambient pressure)

Incorporation of various safety features and availability of anesthetic agents with varied physical properties have made the construction of modern vaporizers complex. However, knowing of the basic physical principles help understand the working of these gadgets.

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doi: 10.4103/0019-5049.120142: 10.4103/0019-5049.120142

To Sell or Not to Sell

Legal Issues Encountered by Anesthesia Practices in Strategic Transactions with National Practice Management Companies

The practice environment continues to evolve rapidly for physicians in general, and anesthesiologists in particular. Each year a number of hospitals across our state change ownership and the reach of consolidated healthcare systems continues to grow. This includes both for profit systems and not for profit systems. CMS and private payers are moving away from traditional fee-for-service reimbursements and toward models intended to reward improvements in value and / or efficiency. Within this maelstrom, the traditional structure for many physician practices has come under considerable pressure. For the specialty of anesthesiology, this has resulted in a slow but steady shift toward employment, either by healthcare systems themselves or by large physician services corporations with national reach.

In this issue of the Sentinel and the next, readers will find two articles authored by John Hogan, an attorney with considerable experience in the sale of physician practices. He will present a short introduction to the most important legal issues for physicians to be aware of when considering a sale of their practice, i.e. a purchase agreement.

Accompanying the second article concerning employment agreements, which will be in the summer issue of the Sentinel, we will also discuss the context in which physicians should ponder these decisions. Beyond the legal and financial considerations, there are many "externalities" of significant importance that must be taken into account as new practice models emerge. The profession of medicine has historically been afforded many special privileges and has also shouldered important and unique responsibilities as a result. As our healthcare system evolves it is important for physicians to remain cognizant of, and to safeguard, those aspects of their professionalism that our patients have come to value most. ~ Gordon H. Morewood, M.D., F.A.S.A. and Scott I. Winikoff, M.D., F.A.S.A.

Consolidation of anesthesia group practices by national practice management companies continued to occur at a strong pace in 2018. With more than 80% of anesthesiologists in the U.S. still practicing independently in private practice, the pace of such transactions is widely expected to continue to be vigorous in 2019 and for at least the next few years. Many independent anesthesia groups have been, or will be, approached by national acquirors desiring to discuss a potential transaction. Still, others have or will choose to test the waters, through the retention of an investment advisor or directly on their own, by approaching potential acquirors to assess their interest in pursuing a strategic transaction.

This article summarizes legal issues that independent practices that pursue a strategic transaction typically confront in the Purchase Agreement among the acquiror, the anesthesia practice, and the physician owners of the practice. The Purchase Agreement is one of the two major transaction documents that are negotiated by the practice, the acquiror and their respective advisors. The other major transaction document is the Employment Agreement, which each of the physician owners of the practice will enter as part of the transaction. Legal issues typically arising under the Employment Agreements in such strategic transactions will be discussed in a future article.

The Purchase Agreement memorializes the following: the structure or form of the transaction,

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the representations and warranties made by the anesthesia practice and its owners to the acquiror, the terms of the escrow arrangement (if any), the documents to be delivered by the respective parties, the conditions precedent to the obligation of each party to close the transaction, the non-compete covenant and other restrictive covenants agreed to by the owners of the anesthesia practice, the indemnification obligations of the owners of the anesthesia practice to the acquiror, and certain other matters. Certain of these items are discussed below.

Form of Transaction

Typically, a strategic transaction between an acquiror and an anesthesiology group will involve the purchase by the acquiror and the sale by all of the physician owners of the group of all of the outstanding equity – shares of stock, membership interests, etc. – of the practice. The transaction is typically structured as an equity transaction in order to maximize the after-tax proceeds received by the physician owners, and/or in order to permit the acquiror to retain contracts, e.g., agreements with hospitals or health systems to provide anesthesia services on an exclusive basis, provider numbers held by the practice, etc. Such a structure often requires that all of the physician owners cooperate, in the sense that each physician owner must make an independent decision to sell his or her ownership interests. The acquiror is interested in owning all of the equity of the practice, so no physician owner can choose to continue to remain an owner. The need for the agreement of all the physicians to sell is not present if the practice has a "drag along" or similar agreement among its owners that requires all of the physician owners to join in a sale if a sufficient number of owners – such as two-thirds or three-quarters of the owners - have agreed to sell. There are other mechanisms to compel a physician to join the majority of his or her colleagues in a sale, but those mechanisms are somewhat more complicated and may raise their own legal issues.

Another structure that an acquiror may propose is a purchase and sale of the assets of the practice. A purchase and sale of assets is unusual in anesthesiology practices because, among other reasons, it requires that an acquiror have payor agreements and provider numbers of its own, since transfer of those assets of the group is typically not legally permissible or not practicable.

In the alternative, or in conjunction with a purchase and sale of equity or a purchase and sale of substantially all of the assets of the group, an acquiror may purchase, and the physician owners of the practice may sell, all of the professional goodwill held by the physicians. Such a structure presupposes that all or substantially all of the goodwill associated with the practice is held by the physician owners and not by the practice itself. The question of whether the goodwill associated with the practice is owned by the practice or by the physicians is a somewhat complicated one. The answer to the question depends on a factual analysis, including a determination as to whether the physician owners are subject to covenants not to compete under which they have essentially transferred their professional goodwill to

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the practice because the physicians do not have the legal right to compete with the practice.

Due Diligence

Regardless of the type of transaction agreed upon by the parties, an acquiror will almost always conduct a very thorough due diligence review of the anesthesiology practice. Such a due diligence review will usually include the following: an analysis of the billing and coding practices of the group, a review of the financial statements of the group, a review of past ownership of the group and a determination as to whether it is clear that past owners were bought out and no longer own an interest in the practice, a review of the practices of the group with respect to classifying providers as employees versus independent contractors, a review of the provider contracts and other contracts to which the practice is a party. The due diligence process can be daunting, and it is very helpful for the anesthesiology group to have well-maintained records in order to comply with the many requests for documents and information that will be made by the potential acquiror and its accountants, attorneys and other advisors. The practice is often assisted in the due diligence process by its investment advisor and/or by its attorneys. The due diligence process will be mirrored by a great number of representations and warranties that will be made by the owners of the anesthesia practice to the acquiror in the Purchase Agreement, and for which the owners of the practice will be financially responsible under the indemnification provisions in the Purchase Agreement.

Acquirors in strategic transactions with anesthesiology practices will often require that a portion of the purchase price – typically 5% to 10% of the purchase price - be placed into escrow

Occasionally, problems with the group will surface in the course of the due diligence process that are of sufficient concern to the potential acquiror that it will decide not to proceed with the transaction. The potential acquiror will have the right to do so, regardless of whether a Purchase Agreement has been signed by the parties or, as is more common, is intended to be signed later in the process.

Consent of the Hospital or Health System

Substantially all of the business of many anesthesiology practices is generated from a single contract with a hospital or health system, under which the practice is granted the exclusive right to provide anesthesiology services at a hospital or at some or all of the facilities in a health system. A potential acquiror will usually require that the hospital or health system consent to or otherwise indicate that it accepts the transaction, even if such consent is not legally required under the contract. Doing so allows the acquiror to gain a comfort level that the hospital or health system is sufficiently accepting of the transaction that renewal of the contract in the future will not become less likely due to the strategic transaction. Such a consent or acceptance may take the form of a legal document to be signed by the hospital or health system, or in some cases it may take the form of a meeting among representatives of the acquiror, the anesthesiology practice, and the hospital or health system. In this case, the acquiror and the group present the reasons they desire to enter into the proposed transaction and discuss and attempt to allay any concerns that the hospital or health system may have.

One of the key considerations to be determined by the parties to a potential strategic transaction is at what point in the process to disclose the proposed transaction to the hospital or health system. Typically, the discussion with the hospital or health system does not occur until fairly late in the process -- before a purchase agreement has been signed, but after the vast majority of due diligence has occurred and after the parties have reached agreement on the major points contained in the transaction documents.

Escrow

Acquirors in strategic transactions with anesthesiology practices will often require that a portion of the purchase price – typically 5% to 10% of the purchase price - be placed into escrow. The escrowed funds are then available if there is an indemnification claim by the acquiror, as discussed below. The escrowed amount typically is not a limit on the potential liability of the sellers under the indemnification provisions.

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All or a portion of the escrowed funds will be paid to the acquiror in the event of an indemnification claim only if there is agreement on the part of the sellers that they are responsible to indemnify the acquiror. In the event of a disagreement among the parties, the disagreement will be resolved by negotiation between the parties or by a judicial process if necessary. Funds are typically held in escrow for a period of one to three years. At the conclusion of the escrow period, funds that have not been returned to the acquiror on account of an indemnification claim are disbursed to the physician sellers as additional purchase price.

Covenant Not to Compete

The Purchase Agreement will include a covenant not to compete, under which each of the physician owners of the practice agrees not to compete with the acquiror in the practice of anesthesiology for a period of time following the closing of the transaction. The time period is typically five years. The specific terms of the non-compete covenant are negotiated by the parties. Those terms will include a covenant not to compete with the acquired practice in its service area, and may include obligations not to compete with the acquiror in other geographic regions in which it operates. The specific scope of the non-compete covenant is obviously an important part of the transaction terms, because if a physician owner of the practice does not remain as an employee of the acquiror throughout the period of the non-compete, he or she may have to relocate in order to practice anesthesiology.

The Employment Agreements between the acquiror and the physician owners of the practice will also include a non-compete covenant that will be for a different time period and may well be somewhat different in its particulars than the Purchase Agreement non-compete covenant. Issues related to the non-compete covenants in the Employment Agreements in strategic transactions will be discussed in a future article.

Indemnification

The Purchase Agreement will include indemnification provisions under which the physician owners of the practice agree to be financially responsible for any pre-closing obligations or liabilities of the practice that are not assumed by the acquiror. The theory behind the indemnification provisions is that the acquiror is paying a purchase price for the practice the amount of which assumes that there are no material unknown or undisclosed liabilities or obligations of the practice. If there in fact turn out to be such liabilities or obligations – an occurrence that, in my experience, is very unlikely, but is nevertheless possible – then the acquiror has in effect overpaid for the practice, and a portion of the purchase price should be returned to the acquiror via the indemnification provisions. The indemnification provisions typically include a "basket" that constitutes a threshold or a deductible before the indemnification obligations apply, as well as a cap that limits the dollar amount for which the physician owners are responsible. There are a number of variations with respect to the basket and the cap that serve to limit or to expand the potential liability of the physician owners. ■

This article does not constitute legal advice and does not create an attorney-client relationship. If you need legal advice, please contact an attorney directly.

John M. Hogan, Esq. is a shareholder at the law firm of Saxton & Stump, LLC, practicing in its Malvern, Pennsylvania office, and is the Chair of the firm's Corporate Healthcare and Life Sciences Group. John has represented many anesthesia physician group practices, both in Pennsylvania and throughout the United States, in strategic transactions with national practice management companies. John can be reached at jmh@saxtonstump.com.

It's Time For More Residents To Embrace Advocacy

Lucy Guevara, M.D.
PSA Resident Component President

Residency is one of the most difficult periods of your life as a physician. Ranging from everyday clinical duties, research opportunities and pursuit of a proper work-life balance, it often feels as if we as residents are being pulled in a million different directions. With this in mind, we must strive to remain as involved as possible in the political climate of our field. During these times of change and transition within the political landscape, it is even more important to bolster resident involvement in advocacy for our role as physician anesthesiologists.

With that in mind, I would like to urge all of us as residents to contribute to the ASA PAC. Achieving 100% resident contribution continues to be an overall goal not only for all the residency programs in Pennsylvania, but also nationwide. Each year the Resident Component strives to establish and maintain contacts with each program in order to achieve 100% resident participation. Each residency program with 100% ASA PAC contribution will be entered into a drawing for a pizza party.

This year the Resident Component is very pleased to announce Neal Shah, M.D. (University of Pittsburgh) as the incoming President-Elect and Chinyere Archie, M.D. (Temple) as the incoming Secretary. We look forward to a productive year with new leadership to assist in increasing awareness of the role of the PSA Resident Component as well as the importance of playing an active role in advocacy.

It is our hope that we can increase awareness for the Resident Component of the PSA, as unfortunately, many residents are still unaware of the existence, role, and opportunities that involvement on a greater level can present. We are well on our way to increasing awareness and participation. This year, we are proud to report that the PSA will be sending 20 residents to the ASA Legislative Conference in May. With the addition of UPMC Pinnacle Lititz this means we will have representation from all 9 residency programs! We would like to continue this trend and would ideally love to have at least two residents from each program: one senior (CA-2 or -3) and one junior (CB or CA-1). We also want to remind programs that the PSA will reimburse travel expenses and lodging for the Legislative Conference, so if you are interested in attending, please let us know and speak with your program director.

Residents are also invited to attend the bi-annual PSA Board of Directors meetings held in each March and September in Harrisburg. For anyone interested in advocacy and society involvement on a state level, these meetings provide a first-hand experience of the inner workings of our very active state society. Additionally, the PSA will reimburse travel costs (mileage and tolls) and provide lunch for all in attendance.

Achieving 100% resident contribution to the ASA PAC continues to be an overall goal

Finally, in addition to the *Sentinel's* "Resident Update" article (generally authored by a Resident Component officer), we would like to invite residents to author a peer-reviewed educational article for the *Sentinel*! Past articles that have been featured have included point/counterpoint perspectives on controversial topics which are excellent topics for the newsletter and for several OR conversations. We would love at least one educational article for each issue, so please do not hesitate to contact us at psa.residents@gmail.com if you are interested. ■

Obituary: Ervin Moss, M.D.

It is with deep sorrow that PSA writes to inform you of the passing of one of our most distinguished members of anesthesiology's pioneer generation, Ervin Moss, M.D. Dr. Moss was a very early patient safety advocate. He pioneered advocacy efforts in New Jersey and across the nation to establish technological and regulatory safeguards for patient safety. His career serves as a standard for all anesthesiologists.

Dr. Moss received his medical education from Chicago Medical School in 1954 and completed an internship at Newark Beth Israel Medical Center. Under the guidance of the renown Dr.E.A. Rosentine, Dr. Moss served as an anesthesia resident at the Kingsbridge Veteran Administration Hospital in the Bronx. From Dr. Rosentine he acquired clinical acumen, medical professionalism and, more importantly, an understanding of the role of the anesthesiologist as the primary guardian of a patient's safety. Following his residency in 1957, Erv practiced anesthesia for a few years in upper New York before joining Alexian Brothers Hospital in Elizabeth, NJ, where he remained for 26 years. He was an active leader within his hospital, where he served as President of the Medical Staff and as a member of the Board of Trustees. His service to the hospital was recognized in 1987 as the honoree for the Annual Charity Ball.

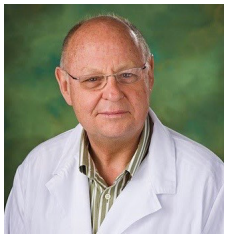
Dr. Moss served the New Jersey State Society of Anesthesiologists from 1968 to 2010 by occupying every office positio including the presidency. In 1990 Dr. Ervin Moss became Executive Medical Director of the NJSSA and continued to do so for the next fifteen years, the only practicing anesthesiologist to hold such a position within the ASA. In 1990, he was the founding Chair of the NJSSA Political Action Committee.

Under Dr. Moss' direction, the NJSSA decided that its attention should be on Risk Management, Patient Safety and Quality Care. In 1984, the dangers of office-based anesthesia were identified after the death of a 16-year-old patient during an abortion. From 1985 to 1989, a year before the creation of the Anesthesia Patient Safety Foundation, Dr. Moss' collaboration with the New Jersey Department of Health resulted in the most comprehensive anesthesia regulations ever in New Jersey hospitals. These regulations included basic standards for monitoring during anesthesia care, mandatory replacement of antiquated anesthesia machines, medical direction of certified registered nurse anesthetists by a physician and the stipulation that the director of an anesthesia department be board certified. Later, Dr. Moss was instrumental in developing similar regulations to govern anesthesia care in ambulatory surgery centers in New Jersey. Dr. Moss' perseverance resulted in the enactment of office-based anesthesia regulations in New Jersey. These regulations serve as models for Pennsylvania as we move forward on ensuring the highest quality care for all Pennsylvanians all the time.

Dr. Moss received numerous awards for his work during his career. These awards include the 2005 ASA Excellence in Government Award, the 2006 SAMBA Distinguished Service Award, and the NJSSA Distinguished Service Award. Dr. Moss was also recognized by the New Jersey Academy of Medicine with the prestigious Edward J.III Award- the first anesthesiologist to receive the award in 90 years. Finally, his commitment to the ASA is exemplified by the fact that he was the longest serving member of the ASA House of Delegates, with a record breaking 40 years of continuing attendance at the annual meetings. This achievement was recognized by the 2008 HOD. Dr. Erv Moss served the ASA and the New Jersey State Society of Anesthesiologists until 2010 when he retired from the HOD.

Dr. Moss had a lifetime of dedication to the improvement of patient safety under anesthesia. He achieved this with patience, persistence and a passion not only for the citizens of New Jersey but also for the rest of the country. He is a role model to all of us. ■

Modifying the Playing Field



Craig Muetterties, M.D.

I recently read a fascinating Wall Street Journal article. The story titled "Think You Need Only Your Passport to Travel? You'd Better Check" chronicled the misadventures of a family who planned a safari for themselves and their children. The couple were experienced travelers and had passports for themselves and their children in hand for their vacation. As they entered the final leg of their journey they were stopped prior to boarding the aircraft. Apparently the rules had changed and they were required to have birth certificates with raised seals prior to entry into the East African nation. There was loss of time and money and catecholamines were burned as they scrambled to obtain the documents.

Unfortunately, this couple was not informed of the rule change that this government had made. It was obviously an expensive lesson. The government that made these changes had a noble purpose. The rules were changed in an effort to thwart human trafficking. However, the travel industry apparently did not have any opportunity for input into the process. The problems that were created for travelers were never addressed when the rules changed. Now that the rules have changed, travel has become much more complicated.

The plight of these travelers is analogous to state and local politics. Well-meaning legislators may craft laws that affect the practice of medicine and can have disastrous consequences without input from all sides. Your society is tasked with the responsibility of knowing what legislation is being made and helping to inform lawmakers as they make decisions. Bills are currently before the legislature that address balance billing, physician involvement in the administration of anesthesia and other bills that can change the landscape of your practice. When these issues are addressed, it is essential that physicians are part of the process.

All of us can help.

Get to know your state senator and representative, drop in to their office and introduce yourself. Attend a function where you will have an opportunity to meet your legislator. You can often find these events advertised in the local newspaper or you can contact our society to see how you can participate. As you get to know your legislator, opportunities may arise where you can educate them on our issues.

Become a part of the process. Consider attending a board meeting of the society or helping with a committee. Lists of these committees can be found on the PSA website.

Contribute regularly to Z-PAC. 100% of the monies donated to the PAC are used for legislative issues. Your PAC donation is money well spent. A famous person once said "He who sows sparingly will also reap sparingly." Don't find yourself unprepared for an unpleasant change in the rules of the game because you have not paid attention to the rule-making process.

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This past week the American Association of Nurse Anesthetists (AANA) Board of Directors decided to no longer provide financial support to the Anesthesia Patient Safety Foundation (APSF). The AANA board objected to APSF's decision to publish a summary of the World Health Organization's (WHO) "Standards for a Safe Practice of Anesthesia" (https://www.apsf.org/article/the-safe-t-summit-and-the-international-standards-for-a-safe-practice-of-anesthesia/) in its February 2019 APSF Newsletter. This 2018 WHO standards policy, unanimously approved by the countries represented in the United Nations World Health Assembly, provides countries with guidance on how to improve anesthesia patient safety globally. ASA and the World Federation of Societies of Anaesthesiologists championed the acceptance of this important patient safety document.

The AANA Board of Directors objected to a set of statements with the WHO standards that (for anesthesia) "its safe provision requires a high level of expertise in medical diagnosis, pharmacology, physiology, and anatomy, as well as considerable practical skill" and "wherever and whenever possible, anesthesia should be provided, led, or overseen by an anesthesiologist …". It is notable that this statement had been previously published in June 2018 by Anesthesia & Analgesia as well as the Canadian Journal of Anaesthesia. The AANA strongly requested that APSF retract or modify the summary; the APSF declined the request as the article was factual and important to improving patient safety worldwide. Subsequently, the AANA Board of Directors decided to no longer financially support APSF's mission of patient safety.

APSF will continue to serve the specialty and ASA through its promotion of perioperative patient safety. Despite the AANA action, APSF remains dedicated to its basic vision that no one shall be harmed by anesthesia care. We believe that all anesthesia professionals, regardless of their titles and training, play vital roles in providing safe anesthesia and perioperative care. We respect all anesthesia professionals and their important contributions to anesthesia patient safety. ■

Linda J. Mason, M.D., F.A.S.A.
Mark A. Warner, M.D.
Daniel J. Cole, M.D., F.A.S.A.

World Health Organization-World Federation of Societies of Anaesthesiologists (WHO-WFSA) International Standards for a Safe Practice of Anesthesia

Anesthesia is a vital component of basic healthcare and requires appropriate resources. Anesthesia is inherently complex and potentially very hazardous, and its safe pro- vision requires a high level of expertise in medical diagnosis, pharmacology, physiology, and anatomy, as well as considerable practical skill. Therefore, the WFSA views anesthesiology as a medical practice. Wherever and whenever possible, anesthesia should be provided, led, or overseen by an anesthesiologist (HIGHLY RECOMMENDED). When anesthesia is provided by non- anesthesiologists, these providers should be directed and supervised by anesthesiologists, in accordance with their level of training and skill. When there are no anesthesiologists at a local level, leadership should be provided by the most qualified individual. Policies and guidelines consistent with this document should be developed at a local, regional, or national level by a team of anesthesia providers led by an anesthesiologist.

Every patient should be cared for at the highest standard of safety possible, independent of whether the provider is an anesthesiologist or a non-anesthesiologist. This means that there is only one standard of safety and this does not vary among provider groups. Therefore, local and national standards should be consistent with the recommendations in this document (HIGHLY RECOMMENDED). ■

WELCOME NEW PSA MEMBERS!

- Peter Abromaitis, MD
- Terry Buckwalter, DO

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society of
ANESTHESIOLOGISTS

777 East Park Drive
PO BOX 8820
Harrisburg, PA 17105-8820