HOSPITAL IN REVIEW

LAHEY CLINIC, FOUNDED IN 1923 BY WORLD FAMOUS PHYSICIAN FRANK LAHEY

Cornelius J. O'Connor, Jr., M.D.

The Lahey Clinic Medical Center is a multi-specialty physician led practice based in Burlington, MA. It is primarily affiliated with Tufts University School of Medicine. Lahey’s more than 450 physicians are supported by greater than 5000 mid-levels, nurses, pharmacists, therapists and other support staff in providing comprehensive care to adults in communities north and west of Boston. Over 20,000 surgical procedures were performed at Lahey last year.

The Lahey Clinic was founded in 1923 by the world famous surgeon Frank Lahey. It was the first multi-specialty physician practice on the east coast to recognize the value of the team approach to patient care. The original core group included Lahey, his O.R. nurse, a surgical assistant, anesthesiologist, Lincoln Sise, and a gastroenterologist, Sara Jordan. Thus, Frank Lahey established the importance of the anesthesiologist to the surgical team back in 1923. The original group practice on Commonwealth Avenue grew quickly, operating on their patients in Kenmore Square area hospitals (The New England Baptist, New England Deaconess, Peter Bent Brigham, and The Brooks Hospitals) until the Lahey Clinic Medical Center opened in Burlington, MA in 1980. The Clinic subsequently expanded to include a satellite facility in Peabody.

The Burlington hospital consists of 317 inpatient beds and 23 operating (continued on page 11)

REPORT OF COUNSEL

HEALTH CARE PAYMENT REFORM

Edward J. Brennan, Jr. Esq.

I. Health Care Payment Reform

The Massachusetts House of Representatives and the Senate have passed their own versions of legislation to reform the health care payment system in the Commonwealth.

The Senate passed its reform bill, S. 2260, in late May and the House passed its bill, H. 4127, in early June. While there are many similarities in both bills, there are some significant differences as well, which will need to be ironed out in a conference committee of the House and Senate, and passed by both branches before the Legislature ends its formal session on July 31.

(continued on page 8)
Officers, Directors, Delegates and Committees
Selina A. Long, MD, President
Michael R. Ennsl, MD, President Elect
Spiro G. Spanakis, DO, Vice President
Sheila R. Barnett, MD, Secretary (2013)
Daniel J.P. O’Brien, MD, Treasurer (2014)
Ruben J. Azocar, MD, Immediate Past President
Beverly K. Philip, MD, ASA Director (2015)
David L. Hepner, MD, ASA Alt. Director (2015)
Richard D. Urman, MD, MBA, Newsletter Editor
Edward J. Brennan, Jr. MSA Legal Counsel
Beth E. Arnold, Executive Secretary

Delegates: ASA House of Delegates
Ruben J. Azocar, MD (2013)
Sheila Ryan Barnett, MD (2013)
Michael R. Ennsl, MD (2013)
Fred E. Shapiro, DO (2013)
McCallum R. Hoyt, MD, MBA (2014)
Daniel J.P. O’Brien, MD (2014)
Lee S. Perrin, MD (2014)
David L. Hepner, MD (2015)
Selina A. Long, MD (2015)

Alternate Delegates:
Donald G. Ganim, II, MD
Vladimir V. Kazakian, MD
Cristin A. McMurray, MD
Nikhil Thakkar, MD
Joshua C. Vacanti, MD

M.S.A. District Representatives and Alternate Representatives
District I
Nikhil Thakkar, MD
District II
Browning Cooper, MD
District III
Nicholas Kiefer, MD
District IV
Fernando Almenas, MD
District V
Ruben J. Azocar, MD
District VI
Neil A. McDonald, MD

Standing Committees of the Executive Committee:
Dr. Selina Long-Chair, Fernando Almenas, Maged Andrews, Ruben Azocar, Konstantin Balonov, Sheila Barnett, Jeffrey Brand, Adam Carinci, Bronwyn Cooper, Fred Davis, Michael England, Donald Ganim, James Gesser, Norman Gould, Alex Hennaberg, David Hepner, Mark Hershey, Charles Ho, McCallum Hoyt, Vladimir Kazakian, Nicholas Kiefer, Dipak Kumar, Neil McDonald, Cristin McMurray, Daniel O’Brien, Lee Perrin, Beverly Philip, Scott Succi, Maitri Shah, Fred Shapiro, Spiro Spanakius, Nikhil Thakkar, Richard Urman, Joshua Vacanti, MaryAnn Vann

Committee on Ethical Practice and Standards of Care:
D.1 Craig E. Collins, DO (2013) Michael Bailin, MD (2014)
D.5 Peter M. Ting, MD (2013) Jeffrey Jackel, MD (2014)
D.6 Vladanmin Kazakian, MD (2013) Richard Shockley, MD
Adjunct: Drs. B. Cooper, G. Crosby, L. Dohlman, J. Gesser, R.Holzman, C. Joshi, H. Kummer, A. Lisbon, M. Ricciardone, D.Salter, D. Shook

Committee on Economics:

Committee on Bylaws and Rules:
Lee Perrin, MD-Chair, Corey Collins, DO, Mary Kraft, MD, Roman Schumann, MD

Committee on Nominations:
David Hepner, MD (2013) Chair, Fred Shapiro, DO (2014), Ruben Azocar, MD (2015)

Committee on Governmental Affairs:
Adjunct: Drs. N. McDonald, S. Spanakius

Judicial Committee:

Committee on Publications:
Website Subcommittee: Drs. S. Spanakius-Chair, B Kolar, S. Heald, R. Ortega, L Perrin, G. Stanley

Committee on Public Education:

Committee on Programs (CME)
Adjunct: Drs. I. Ahmed, A. Aponte-Feliciano, R. Azocar (advisor), R. Badre, S. Basta, G. Battit, J. Gesser, R. Schumann, N. Tahir

M.S.A. Rep. to the Inter specialty Committee of the Mass. Medical Society
Selina Long, MD, Representative, Fred Shapiro, DO, Alt. Representative

Specialty Delegate to the House of Delegates of the Mass. Medical Society
James S. Gesser, MD

Resident Affairs: Scott Succi, MD, Chair, Maged Andrews, MD, Vice Chair
I’m honored to continue to serve as Chair of Publications Committee and MSA Anesthesia Record editor. It has been a year since our last newsletter, and a lot has happened here in Massachusetts and nationwide directly impacting our specialty and our patients. In this edition, you will find a lot of useful information to keep you informed of what is happening and what MSA has been able to accomplish over the past year.

This edition highlights recent events and activities of a very busy year. As you will see, MSA has been active on the political, membership, and educational fronts as highlighted in the reports by our MSA President, ASA Director, Legal Counsel, and various Committees. Highlights include healthcare payment reform, nurse midwives expansion of scope of practice, drug shortages, CRNA supervision in the office-based setting, and the Anesthesia Quality Institute update. In addition, in this edition you will find a description of CME educational opportunities, Dr. Quinn’s report from resident (CORA) component, Dr. O’Gara’s summary of the presentation by Dr. Zerwas (ASA President-Elect), and Dr. Philip’s ASA Director update. As usual, we highlight a local anesthesiology practice, and we have selected Lahey Clinic with the help of Dr. O’Connor. We’re saddened to report the passing of two longtime members, Drs. Ellison C. “Jeep” Pierce and Joseph L. Murphy who made significant contributions to our specialty. Finally, read Dr. Fred Davis’ review of Dr. Gerald Zeitlin’s fascinating new book, *Laughing and Crying About Anesthesia*.

We have further developed our website (www.massanesthesiology.org) to better serve the needs of our members. Visit it often for latest news, meeting and education updates. The good news is that our membership numbers are up, and MSA remains a strong force locally and nationally advocating for our specialty.

We would like to thank our immediate past MSA president, Dr. Ruben J. Azocar for his extraordinary leadership and welcome our new president Dr. Selina A. Long, as well as the newly elected Executive Committee and ASA Delegation. I hope that this edition will highlight ample opportunities to participate and inspire you to become more involved with the MSA, ASA, and their respective PACs. We have listed all current officers and committee members, so feel free to contact any of them with questions.

Finally, please mark your calendars so that you can participate in many exciting upcoming events including CME courses, MSA Annual Meeting, ASA Legislative Conference and our regular MSA Executive Committee meetings to which all members are invited. I hope that you enjoy reading this edition of the MSA Anesthesia Record. If you have any comments or interested in contributing an article, please contact me.

Enjoy the rest of the summer!

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**ASA Annual Meeting**

**October 13-17, 2012**

**New England Caucus Meetings**

**Saturday 3:00 - 4:30 pm • Tuesday 4:00 - 6:00 pm**

**Washington Renaissance, W.D.C.**
Dear Fellow MSA Member,

Greetings and best summer wishes from the MSA!

Together with the ASA, the MSA has been busier than ever in the past several months, and I would like to take this opportunity to highlight some of that activity:

**Drug Shortages** - MSA lobbyists spoke with our state representatives this past May on Capital Hill in Washington, DC during the ASA Legislative Conference. We highlighted, with real-life stories from our practices, the need to report and provide secondary production and supply chains for vital, life-preserving drugs both for anesthesia and the rest of medicine. Shortly thereafter, in perhaps our most successful effort, the Senate passed S. 3187, the “Food and Drug Administration Safety Act;” the President signed it into law on July 9th.

**Mass Health Changes for CRNA Payment** - With the invaluable assistance of Dr. Alex Hannenburg, Past President of the ASA, and our legal counsel Mr. Edward Brennan, I submitted commentary on Mass Health’s proposed changes for CRNA billings, in order to gain some clarity. (action pending).

**Improving Member Services within the State organization** - these include increased state-level political awareness, further MSA website enhancements such as credit card payments and online membership renewal, MSA office streamlining, social medial connectivity. We plan to have an open, transparent, and self-nominating election cycle for officers slated to begin in January 2013.

With the ASA annual meeting coming up shortly in October, we anticipate that the House of Delegates will be busy defending our role as the “peri-operative physician,” defining scope of practice and truth and transparency issues, and furthering health-care access. An ambitious and forward-thinking agenda for our national society!

All of this wouldn’t be possible without your membership, your voice, and your support. If you’d like to learn more, MSA officers would be glad to visit your department talk about our activity and listen to your suggestions. If you’d like to get involved, you’re welcome at any of our executive meetings and most welcome to join committees, or to run for office. If you’d like to comment on our activities at any time, please e-mail me at Slong2@BIDMC.harvard.edu.

Best wishes for a safe, healthy and restful summer!

Sincerely,
Selina A. Long, M.D.
Dr. England is a native of Bay State who was born in Boston and raised in Lincoln. He received his undergraduate education at Cornell College in Iowa and medical education at Case Western Reserve University, Cleveland. It was during his first year in medical school when he met Dr. Nicholas Gravenstein, who encouraged him to participate in the ASA’s summer introduction to the field of anesthesiology. Although originally thinking that surgery was his calling, he recognized the “marriage” between the two fields, and it was a go!

It was this experience at MGH during the summer of 1974 that sealed his decision to enter the profession. An offer to join the residency program was made by Dr. Richard Kitz to join their department, and Dr. England happily accepted. He started residency training in July of 1978 following an internship in medicine at Salem Hospital. During that time, Dr. England developed an interest in cardiac anesthesia, and he consequently completed fellowship training in cardiac anesthesia at the current Tufts Medical Center. A portion of the fellowship year included exposure to the ICU and vascular anesthesia.

Dr. England joined the anesthesiology staff at Tufts in July 1981 under the leadership of Dr. Kurt Schmidt and has remained there ever since. As an early adopter of transesophageal echocardiography (TEE) beginning in 1983, he became one of the co-directors of the first public courses given in this field in 1990.

Currently at Tufts, he serves as the director of cardiac anesthesia with a research interest in improving our understanding of dysfunctions of coagulopathy frequent during these operations.

He is married to another physician, Dr. Julie Stiles, a pediatric radiologist and mammographer at Salem Hospital. They have two grown children and one grandchild. He is currently residing in Boston, and his favorite activities outside of work include bicycling, photography and boating. ~

REMINDER TO MEMBERS

IT’S THAT TIME OF YEAR THAT THE NEW MSA PRESIDENT, DR. LONG, WILL BE REVIEWING THE MSA COMMITTEES AND APPOINTING COMMITTEE MEMBERS - IF YOU ARE INTERESTED IN GETTING INVOLVED, PLEASE CONTACT THE MSA OFFICE BEFORE SEPTEMBER 1, 2012

(see page 2 for a listing of MSA Committees)
The Active membership of the Massachusetts Society of Anesthesiologists has surpassed the 900 mark, with the present count of 923 active members. This entitles the MSA to ten (10) ASA Delegates at the ASA House of Delegates, October, 13-17, 2012 in Washington, DC.

The MSA is working towards application for new members online, registering and paying for meetings online, and for the future the ability to vote on-line via the website.

Membership totals as of May 24, 2012:

- Active: 923
- Affiliate: 18
- Resident: 475
- Retired: 184

The following statewide officers were elected:

Results of the MSA District elections (1 year term):

<table>
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<tr>
<th>District</th>
<th>Representative</th>
<th>Alternate Representative</th>
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<td>D. 1</td>
<td>Nikhail Thakkar, M.D.</td>
<td>(vacant)</td>
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<td>D. 2</td>
<td>Bronwyn Cooper, M.D.</td>
<td>Konstantin Balonov, M.D.</td>
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<td>D. 3</td>
<td>Nicholas Kiefer, M.D.</td>
<td>Charles Ho, M.D.</td>
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<tr>
<td>D. 4</td>
<td>Fernando Almenas, M.D.</td>
<td>Dipak Kumar, M.D.</td>
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<tr>
<td>D. 5</td>
<td>Ruben Azocar, M.D.</td>
<td>(vacant)</td>
</tr>
<tr>
<td>D. 6</td>
<td>Neil McDonald, M.D.</td>
<td>Adam Carinci, M.D.</td>
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The following officers will continue:

- Secretary (2 year term)

- Delegates to the ASA
  - Ruben J. Azocar, M.D. (2013)
  - Fred E. Shapiro, D.O. (2013)
  - McCallum R. Hoyt, M.D. (2014)
  - Lee S. Perrin, M.D. (2014)
My year serving as President of the MSA has come to an end. I am glad to report a busy yet rewarding year. The Society continues working on issues of advocacy and scope of practice, membership services and educational activities.

The following are the examples of issues related to advocacy and scope of practice that affect our members:

• Participation in the Massachusetts Board of Registration of Medicine (BORIM) workgroup on CRNA supervision in the office-based setting.

According to state regulations, if no anesthesiologist is supervising a CRNA in the office–based setting, a qualified physician (surgeon) may medically direct and supervise a CRNA. The BORIM convened a working group to help it develop guidelines that would set forth qualifications for physician supervision of anesthesia services in the office-based setting. As a result, the Board is expected to recommend that surgeons supervising CRNA’s in the office-based setting complete CME requirements related to anesthesia topics.

• Acupuncture injections

A bill to allow acupuncture practitioners to inject therapeutic agents was proposed at the state level. The MSA opposed the bill with great concern for patient safety and lack of evidence-based data on the efficacy of such treatments.

• The Division of Industrial Accident guidelines for chronic pain management

After consulting with anesthesiologist pain specialists, in both academic and private practice, the MSA submitted comments to the Division of Industrial Accidents. My gratitude to all the pain physicians who submitted comments.

• Visit Representative Steven Walsh at the State House

A group from the MSA visited Representative Steven Walsh, who is the House Chairman of the Joint Legislative Committee on Health Care Financing. We brought to him our views on the role and value of anesthesiologists in patient care and safety, payment reform as it pertains to anesthesiologists and other hospital based physicians, and general issues relating to scope of practice.

• Drug Shortage hearing and visit to Representative Jeffrey Sanchez at the State House

The MSA was invited by the Legislature’s Joint Committee on Public Health to present testimony at the State House regarding the drug shortage issue. Dr. Alexander Hannenberg and I presented the challenges this problem has brought to all anesthesiologists nationwide and the negative impact on patient care and cost containment. Subsequently, the House Chairman of the Committee, Representative Jeffrey Sanchez, invited us to discuss personally the problem and generate potential solutions.

• Creation of a task force to determine the impact of the recently passed bill expanding the scope of practice of nurse midwives.

The new law allowing nurse midwives to practice without physician supervision was analyzed by the MSA. A task force was created to analyze the implications of this bill to practicing anesthesiologists in the State, coordinate a response in conjunction with the ASA, and inform our members of this recent issue.

In terms of membership, we have worked on improving services provided to our members, and have increased efforts to address areas in need of improvement. We moved our offices to Waltham in the summer of 2011. This central location is minutes away from the Massachusetts Medical Society and allows easier access to our headquarters for members. We continue to improve our website, which allows us to process membership dues payments and will soon be able to provide course registration online.

The Ad hoc Committee on Leadership clarified the roles of the MSA committees and the Executive Committee members. The description of the available roles for MSA members is now posted on our website. For members who want to actively participate in the society, we also created a transparent and merit based mentorship process to facilitate their growth into leadership.

The MSA continues to organize educational venues based on perceived gaps and requests from members. In the fall of 2011, we had our Ultrasound Regional Anesthesia Course that continues to be an excellent and well-attended venue. This year, we named this course after Dr. Abdel Mehio for his extraordinary contributions to the Society, and in particular to this course. In January of this year, we gathered for the second consecutive year in Puerto Rico for the MSA winter meeting. The program was comprehensive and three great speakers made this educational opportunity a success. Plans for our third Puerto Rico meeting are on the way. We will gather there from January 18 to the 21, 2013. Save the date! Finally, a Sedation and Analgesia course for the non-anesthesiologist took place in the spring.

This excellent program aims to educate those non-anesthesiologists providing Sedation and Analgesia to enhance patient safety in the State.

The New England Anesthesia Resident Conference Committee is now a reality. This steering committee will assure continuity of this important regional conference for all anesthesia residents.

(continued on page 10)
Comparison of House and Senate Health Care Payment Reform Bills

(continued from page 1)

II. Comparison of House and State 
Health Care Payment Reform Bills

Both bills are comprehensive and encourage movement from the fee-for-service model of payment to global payments that are based on quality and cost efficiencies. The bills encourage the current movement in the market place in that direction. However, the House bill is more regulatory than the Senate in this approach. Both branches predict savings to the Massachusetts economy of over $150-$160 billion over the next 15 years.

A. Limiting Health Care Spending Growth.

Both bills establish a statewide annual health care spending growth cap based on the state’s overall growth of the economy (Gross State Product or GSP), which would apply to most health care providers. In effect, health care spending would be allowed to grow at a number pegged to GSP. The Senate bill would allow annual growth from 2012 to 2015 at GSP plus .5%, and at GSP from 2016-2026. The House version is more controversial. It would allow growth at GSP from 2012-2016, but would limit annual growth starting in 2016 to GSP minus .5%. Under the House plan health care spending would be allowed to grow less than the overall economy from 2016-2026.

Transition to Global Payment.

Both bills encourage transition from fee-for-service to alternative payment methodologies such as global payments, shared savings arrangements, bundled payments and episode payments.

- The Senate and House versions encourage the transition by requiring state funded programs, such as MassHealth, public employee health insurance and state subsidized insurance offered through the Connector, to increase transparency (disclosure of quality and cost data) and “improve the functioning of the health care system.” Physician Organizations would consist of groups of 25 or more doctors. Physicians employed by hospitals or clinics would not need to be registered as a Physician Organization.

The Senate bill requires Provider Organizations (any entity, incorporated or not, representing 1 or more providers in contracting with insurance carriers for payment of health services) to register with a new state agency, the Institute of Health Care Finance and Policy. Such organizations would be required to disclose quality and cost data. A further requirement of State certification of Provider Organizations that negotiate network contracts with an insurer is included in the bill. There is an exemption for groups with less than $500,000 in annual net patient service revenues from insurers and which have less than 5 affiliated physicians if the Physician Organization does not accept risk contracts.

The number of physicians that would constitute a Physician Organization is of concern to MSA and MMS. Both organizations are lobbying that a Physician Organization be defined as including a higher number of physicians; for example 150-199.

- D. Accountable Care Organizations.

The House and Senate encourage the development of ACOs, and create a certification or licensure process for ACOs. The House bill is more specific as to the structure of ACOs, while the Senate allows certification based on best practice standards established by the market. The Senate would call ACOs certified by their proposal “Beacon ACOs,” which would be allowed preference in state funded health care programs.

- Neither bill states how providers within an ACO would get paid.

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It is my pleasure as your Director to give you an update on the national Anesthesiology issues. ASA and MSA advocate for the interests of you, our members.

In early May, the MSA leadership and our resident representatives participated in the annual ASA Legislative Conference in Washington DC. In the forefront of our practice concerns are the ongoing shortages of critical drugs we use. A November 2011 Government Accountability Office study found that the therapeutic class of drugs most affected by shortages was the anesthetic and central nervous class of drugs. “Drug Shortage” provisions giving FDA more authority to intervene have been incorporated into prescription drug and medical device FDA User Fee acts, and we are lobbying for their passage. Reception on the Hill for this issue is quite positive.

ASA addressed several Medicare payment concerns as well. We reminded our legislators about anesthesiology’s uniquely low payment from Medicare at 33% of private payment rates, and therefore advocated that anesthesiology should be “held harmless” for further payment cuts through the Medicare SGR (Sustainable Growth Rate) formula cuts. We were able to show our legislators that according to the Congressional Budget Office, anesthesiology services are not driving volume or growth in Medicare spending. Any long-term, complete fix of the SGR appears mired in partisan politics; however, annual adjustments continue to be made and our voice is being heard on these issues. We also advocated for repeal of the non-elected Independent Payment Advisory Board (IPAB) created by the 2010 healthcare reform law, which will have sweeping powers to mandate added payment reductions on top of SGR cuts. Support for this repeal is also growing, albeit slowly, with more partisan politics. Action may also depend on the US Supreme Court review of the 2010 Act due in June. In addition, we advocated for passage of the Health Care Truth and Transparency Act, to address patient confusion arising from the increasing numbers of mid-level providers who have a professional doctoral degree (e.g., Doctor of Nursing Practice) and call themselves “doctor”.

ASA is also proactively addressing the changing health care system, with its increased focus on care coordination and reduction of unnecessary services. At the Legislative Conference we brought forward ASA’s concept of the Perioperative Surgical Home™, where anesthesiologists would serve as the medical coordinators of the entire peri-operative care process. The goal is to provide strategic and financial support for the anesthesiologist as the Perioperative Physician. ASA has established a Committee on Future Models of Anesthesia Practice, which includes your Director, and we are seeking a national grant to fund this from the CMS Center for Innovation as well as pursuing other avenues to direct such “gain-sharing” opportunities towards anesthesiologists.

Opt-out activity has increased in several states, with ASA providing legal input as well as financial assistance with these battles. Membership needs are also being met with the development of a joint ASA-ASRA Ultrasound-Guided Regional Anesthesia Education and Clinical Training Portfolio, so that this function can remain within Anesthesiology’s control. ASA’s position on the subject of deep sedation by non-anesthesiologists remains a hot topic. Within ASA, discussions are ongoing about the organization’s role regarding the subspecialty societies for their management needs. Organizationally, a formal national search is in progress for ASA’s new chief staff officer CEO, and your Director is on the search committee. The land for the new headquarters building has been acquired in Schaumburg, IL and ASA is developing detailed plans for the building.

Our society’s annual meeting, ANESTHESIOLOGY 2012 will be held in Washington DC in October. An exciting program of educational, scientific and advocacy activities is being readied to address the interests of all attendees. ANESTHESIOLOGY 2012 will feature the inaugural “Ellison C. (Jeep) Pierce, M.D., Memorial Lecture on Patient Safety”, presented by former Administrator of the Centers for Medicare and Medicaid Services, Dr. Donald Berwick. The Opening Session will feature the political commentator couple James Carville and Mary Matalin, and there will be an all-attendee Welcome Reception on Saturday evening. Check out the meeting website http://www.asahq.org/Annual-Meeting/ and plan now to attend!

From this brief summary, it is indisputable that ASA has been working energetically on our behalf this year. Every anesthesiologist should contribute to ASAPAC to support ASA’s legislative and regulatory efforts for us. Each

(continued on page 17)
in the New England area. The Subcommittee on Industry Relationships has also delineated guidelines that will allow us to maintain the standards established by the ACCME, while obtaining sponsors and exhibitors for our conferences.

In April of 2011, the Anesthesiology community around the world lost a giant with the passing of Dr. Ellison C. “Jeep” Pierce. Dr. Pierce’s accomplishments and contributions to our specialty and our patients are well known to us all. To commemorate his life, Anesthesia Associates of Massachusetts, the Anesthesia Patient Safety Foundation (APSF), and the Massachusetts Society of Anesthesiologists created an award in Dr. Pierce’s name. This award recognizes a Massachusetts Anesthesiology resident who has demonstrated an on-going commitment to patient safety. The award provides financial support for the resident to participate in the APSF activities during the American Society of Anesthesiologists’ annual meeting. Last year’s recipient was Dr. Pavan Sekhar from Boston Medical Center. This year’s recipient is Dr. Daniel Saddawi-Konefka from MGH.

We all know Anesthesiology is a team sport. None of the aforementioned activities would have been possible without the support, advice, guidance and hard work of the officers, the Executive Committee, our legal advisor, executive secretary and most importantly many MSA members. I was lucky to have such a great team surrounding me and facilitating the fulfillment of my duties.

Many challenges remain ahead of us. Scope of practice, health care reform (local and federal) and the still ongoing medication shortages are some of the areas that remain active and require our involvement. We need your participation in any form, by renewing membership, sending your comments and opinions, and actively participating. ~

Dr. Ruben Azocar presenting the Dr. Ellison Pierce Patient Safety Award to Dr. Daniel Saddawi-Konefka from MGH
Anesthesia Record    www.massanesthesiology.org

Spring/Summer 2012

rooms. The ambulatory facility in Peabody has 12 beds, 5 operating rooms and a procedure room utilized by the Pain specialists.

Lahey Clinic has been awarded Magnet status for excellence in nursing care by the American Nurses Credentialing Center in 2009. Lahey Clinic has been recognized as a NICHE institution for its commitment to evidence-based, age sensitive nursing care to the elderly. The Massachusetts Department of Public Health has awarded Lahey Clinic its Stroke Gold Performance Achievement Award. The Clinic is listed as one of the top 50 Cardiovascular Hospitals by Thomson Reuters for 2012, thanks to the care administered in the Landsman Heart & Vascular Center. The liver transplant team was the first in New England to perform adult living-donor transplants.

The Department of Anesthesiology and Interventional Pain Management consists of 37 anesthesiologists, 25 CRNAs, supported by 3 mid-levels and 13 anesthesia technicians. The anesthesia technicians are frequently interested in advancing their careers; five have gone on to medical school in recent years.

Teaching is one of the pillars of Lahey Clinic’s guiding principles. The medical center fills over 130 graduate medical education slots every year. The Anesthesia department hosts four to five anesthesia residents every month in the operating rooms, and two residents a month in the Surgical Intensive Care Unit, as well as instructing pulmonary fellows, surgical residents, third and fourth year medical students and paramedic interns.

The Anesthesia Department covers 28 operating rooms between the Burlington and Peabody hospitals, an interventional neuro-radiology suite, three interventional radiology suites, two electrophysiology suites, three endoscopy suites, interventional pulmonary suite, lithotripsy suite, level II Trauma Center emergency room and over fifty PACU beds in three nursing units.

The department includes 2 interventional pain specialists supported by a mid-level practitioner and a group of nurses. They split their clinic time and procedures between the Burlington and Peabody facilities.

Of interest, on April 23, 1948, the Massachusetts Society of Anesthesiologists was conceived at a meeting of a few physicians held in the office of Dr. Urban Eversole, who at the time was the Chief of Anesthesia at Lahey Clinic. Dr. Eversole was an avid collector of Napoleonic memorabilia and donated many of these artifacts to the Clinic. They are on permanent display in the hall outside the Auditorium in the Burlington facility.

Sana Ata, MD has served as the Chairman of the Anesthesia Department since 2007; Paul Teague, MD serves as the Vice-Chairman.~

Teaching is one of the pillars of Lahey Clinic's guiding principles

(continued from page 1)
Comparison of House and Senate Health Care Payment Reform Bills-continued (continued from page 8)

It would be up to the ACO.

- The House bill requires that 75% of the governing body of an ACO be participants.
- Neither the House nor the Senate limit primary care physicians to membership in one ACO
- The House sets a limit on the size of ACOs in order to prevent a market with just a few super ACOs. The maximum number of lives covered by an ACO would be 800,000, and the minimum would be 30,000. No such limit is in the Senate bill.

E. Price Variation—High Cost Providers.

The House bill establishes an assessment or surcharge on high cost providers (like the luxury tax in baseball) to incentivize them to bring down their costs within a reasonable range. The bill would assess a surcharge on hospitals, free standing surgi-centers, Physician Groups and any other health care providers that have contracted prices that average more than 20% above the state’s median price for a service which cannot be explained by high quality. The surcharge (10%) would be used to support low cost hospitals that serve the poor. This provision is particularly controversial and is not contained in the Senate bill.

G. Patient Centered Medical Homes.

The House and Senate encourage the development of medical homes for primary care. The House bill is more specific as to structure. The bill would provide for additional payments for medical home services, such as staffing for care coordination.

H. Regulatory Agency.

Both bills reorganize how health care financing is regulated in Massachusetts. The House bill would:

- Establish a new state agency to be known as the Division of Health Care Cost and Quality. An executive director would run the day to day operations of the agency.
- Several state agencies currently regulating health care financing would be consolidated within the agency. The Division would regulate ACOs, Medical Homes, alternative payment methodologies, set rates for Medicaid, collect, analyze and disseminate cost and quality data that must be disclosed by all providers, and develop and implement inter-operable electronic medical records and order entry systems.

The Senate creates an Institute of Health Care Finance and Policy. The Institute would be an independent state agency and would collect, analyze, and disseminate health care data. The Institute would monitor the health care system, but would not have the extensive power and authority as the House proposal.

J. Health Information Technology.

Both bills require implementation of a fully interoperable health information exchange that will allow for the secure electronic exchange of health records among all providers in the state. The Senate sets implementation by 2015, while the House sets 2017 as the goal. Electronic order entry is also a goal, and physicians will be required to demonstrate competency in the meaningful use of electronic medical records.

K. Administrative Simplification for Health Care Providers.

Both bills require the development of standard prior authorization forms for use by all providers. Both would streamline state health care data reporting requirements.

The House would simplify the determination of a patient’s health plan eligibility so that a determination can readily be made at or prior to the time of service. The House would also require the adoption of a common application for credentialing physicians that an insurer would be required to use. Hospital-based physicians (anesthesiologists, radiologists, pathologists and emergency room physicians) would not be required to complete an insurers credentialing process except in limited circumstances.

L. Smart Tiering.

The House bill addresses the issue of provider tiering, which is a health insurance policy that encourages patients to seek care with low-cost providers. It does not allow tiering by facility, but by service.

M. Encouraging Primary Care – Includes Nurse Practitioners and PAs.

Both bills set forth policies to encourage primary care by providing loan forgiveness and other incentives to physicians, nurse practitioners and physician assistants who commit to specializing in primary care. To address the shortage of primary care physicians, both bills enhance the role of nurse practitioners and physician assistants, and allow them to be primary care providers. Primary Care Providers are defined as “health care professionals qualified to provide general medical care, supervise, coordinate, prescribe or otherwise provide or propose health care services, initiate referrals for specialty care and maintain continuity of care within scope of practice.”

While the statutory scope of practice of NPs does not specifically change, the bill does allow NPs to sign, certify, stamp and verify documents previously requiring a physician’s signature.

(continued on next page)
The House bill repeals the cap on the number of PAs a physician can supervise. Currently, a physician can only supervise 4 PAs.

**N. Prevention and Wellness Program.**

The House and Senate bills encourage community based prevention and wellness programs aimed at reducing the most costly and most prevalent avoidable health conditions. The Senate does it through grants and the House through tax credits to businesses that establish wellness programs.

**O. Medical Malpractice Reform.**

- Both bills extend peer review protection to ACOs.
- Both bills adopt the MMS proposed Michigan model of “Disclosure, Apology and Offer” and establishes a 180 day cooling off period before a party initiates suit; creates a process for providers and aggrieved patients to communicate and exchange documents prior to litigation in the hope of resolving disputes; and makes a providers apology inadmissible as evidence.

MSA is reviewing the provision of both bills, and along with other medical specialties and the Massachusetts Medical Society will be submitting recommendations to the conference committee.

**III. Nurse Midwives Expansion of Scope of Practice.**

Legislation expanding the scope of practice of nurse midwives was signed into law by Governor Patrick on February 2, 2012.

The new law, Chapter 24 of the Acts of 2012, eliminates the requirement that nurse midwives function under the supervision of a physician pursuant to regulations developed jointly by the Board of Registration of Nursing and the Board of Registration in Medicine concerning the ordering of tests, therapeutics and the prescribing of medications. It also eliminates the requirement that nurse midwives function as a member of a health care team which includes a physician with hospital admitting privileges for maternal and newborn services.

Chapter 24 allows a nurse midwife to order and interpret tests, therapeutics and prescribe medications in accordance with regulations adopted by the Nursing Board. The role of the Medicine Board is eliminated. Moreover, the new law allows nurse midwives to interpret tests. Thus, nurse midwives become the first category of advanced practice nurses authorized to interpret tests. Although nurse midwives no longer are required by statute to function under the supervision of a qualified physician, the law does require nurse midwives to practice within a health care system and have clinical relationships with obstetrician-gynecologists that provide for consultation, collaborative management or referral, as indicated by the health status of the patient. The Massachusetts Chapter of ACOG did not object to the provisions of Chapter 24.

The Board of Registration of Nursing and the Department of Public Health are authorized to develop regulations implementing the provisions of Chapter 24. It is expected that proposed regulations will be unveiled for a hearing shortly.

With the change in scope of practice of nurse midwives, a question arises as to how anesthesiologists should interact with nurse midwives. Each hospital and its medical staff are able to develop its own rules governing the appropriate role of nurse midwives, physicians and other clinicians within the institution. That ability is not changed. As to the issue of anesthesia care in obstetrics, the MSA would note that the ASA has adopted a Joint Statement of ASA and ACOG entitled “Optimal Goals for Anesthesia Care in Obstetrics.”

The pertinent section of the Joint Statement relative to nurse midwives is as follows:

**OPTIMAL GOALS FOR ANESTHESIA CARE IN OBSTETRICS**

1. A qualified physician with obstetric privileges to perform operative vaginal or cesarean delivery should be readily available during administration of anesthesia. Readily available should be defined by each institution within the context of its resources and geographic location. Neuraxial and/or general anesthesia should not be administered until the patient has been examined and the fetal status and progress of labor evaluated by a qualified individual. A physician with obstetric privileges who concurs with the patient’s management and has knowledge of the maternal and fetal status and the progress of labor should be readily available to deal with any obstetric complications that may arise. A physician with obstetric privileges should be responsible for midwifery back up in hospital settings that utilize certified nurse midwives/certified midwives as obstetric providers. ~
COMMITTEE ON PROGRAMS ANNUAL REPORT - MAY 2012

The MSA Program Committee has sponsored a number of successful programs this past year.

In March of 2011 we held our first Airway Workshop. The hands-on conference was well-received by participants and offered opportunities to work with new airway devices and a simulation model.

In December 2011, we held the Abdel Mehio Ultrasound-guided Regional Anesthesia Workshop. We had a good turnout for this active learning conference and allowed attendees to work with live models for nerve location, as well as phantoms for needle manipulation.

In January 2012, the 2nd Annual Winter Meeting was held in Las Croabas, Puerto Rico. The small but appreciative audience enjoyed hearing about the latest topics in anesthesia in this lovely beachside resort setting.

In April of 2012, we offered the Sedation and Analgesia Conference. This course, aimed largely at non-anesthesiologists, fulfills the goals of the MSA to promote knowledge and safety regarding conscious sedation.

The MSA has also made a commitment to ensure the continuation of the New England Anesthesia Residents’ Conference. This annual meeting provides an opportunity to residents from all the NE states to present research, case reports and learn about practice management from experts in the field. A NEARC subcommittee of the Program Committee has been actively promoting and gathering support for the meeting. This past March it was held at the University of Vermont, and the 2013 meeting will be held at Brigham and Women’s Hospital.

Upcoming meetings include:

The New England Society of Anesthesiologists 55th Annual Meeting, Sept. 13-16, Viking Hotel, Newport, RI

The MSA Ultrasound-Guided Regional Anesthesia Workshop, Dec 1, Waltham Woods Conference Center (MMS Headquarters)

The 3rd Annual MSA Winter Meeting, El Conquistador Golf Resort and Casino in Las Croabas, PR, Jan 19-21, 2013

We look forward to seeing you there. ~
As previously reported, MSA – alongside the Massachusetts Medical Society – has been in contact with the leadership at Tufts Health Plan to communicate our dissatisfaction with their purported formula for calculating unit values for labor analgesia (CPT 01967). Tufts had asserted that they had put in place a policy recognizing only time units for “face to face” care with a unit ceiling. Such a policy is inconsistent with national standard practice, has not been communicated to providers and had been explicitly renounced by plan officials in correspondence with MSA. Very recently, Tufts has announced a change in payment policy for CPT01967, effective July 2012, that abandons time-based payment altogether and converts to a case (procedure) rate. As always, the relationship between any provider or group is governed by their contract with the plan. The new Tufts policy language is reproduced below:

**Effective July 1, 2012**

**Anesthesia Professional Services for Planned Vaginal Delivery**

Effective for dates of service on or after July 1, 2012, Tufts Health Plan will compensate all obstetrical anesthesia professional services for procedure code 01967 (analgesia/anesthesia for planned vaginal delivery) at 13 time units (195 minutes) plus base units of value, regardless of the time units billed.

This change is documented in the Anesthesia Professional Payment Policy, available at tuftshealthplan.com/providers. Copies of the payment policy are also available by calling Provider Services at 888-884-2404.

In recent weeks, Medicare has acknowledged a miscalculation of the anesthesia conversion factor applied from 1/1/2011 through 2/29/2012. This miscalculation produces an underpayment of several cents per unit. Because of the lengthy period of time during which the incorrect value was used, very large numbers of individual patient claims are involved. On behalf of the MSA, I have appealed to NHIC (our Medicare carrier) to correct these claims at the provider or practice level and avoid the necessity of resubmission of many thousands of claims. NHIC tells us that providers need to identify the claims requiring adjustment and communicate this request to the carrier. In most instances, this should involve creating a spreadsheet with claim information. This is not the ideal solution (and not the approach Medicare would have taken with an overpayment!) but probably less burdensome than individual claims resubmission. ~
Many thanks to the doctors that volunteered and took the time from their busy schedules to visit the schools and educate the students about the importance of the anesthesiologist.

For example, Dr. Cally Hoyt, Director of Gynecologic and Ambulatory Anesthesia at BWH lectured and gave a tour of the Longwood Medical Area to the Boston Latin students.

The Massachusetts Society of Anesthesiologists will continue along with national effort to inform our anesthesia community about the benefits of supporting the ASA Political Activities Committee (ASA-PAC). This enables a ‘voice of support’ which has crucial impact on current national legislative issues: healthcare reform, ceasing Medicare payment cuts, and extending rural pass-through payments to anesthesiologists. The success of the Drug Shortage legislation is a testimony to how information, persistence, and visibility of our profession can make a difference.

The newly revised MSA Website will enable the MSAC Committee to merge their efforts and creativity. The Public Education committee will join the Committees on Publication and Website in a combined effort with Drs. Urman and Spanakis to design a section that will specifically address the educational opportunities MSA can provide for the public. They are developing a link on the site for the public to submit inquiries about our profession. Following the Annual Meeting we will post “MSA 2011-2012”, a pictorial presentation which highlights MSA activities.

Dr. Shapiro has been a member of the Executive Board and chairman, Public Education Committee since 2001, Past President of the Massachusetts Society of Anesthesiologists and current chair, Committee on Governmental Affairs.

Our new MSA website is being constantly updated, so visit www.massanesthesiology.org for latest news and upcoming meetings. Dr. Spiro Spanakis continues as Chair of the Website Subcommittee and with the help of MCD web design studios has done a superb job in making the website more informative and user-friendly, adding features such as online membership renewal. Feedback regarding ways to improve website content is encouraged.

It has been a pleasure serving as Publications Committee Chair for the past 3 years, and I look forward to working with new (and old) Committee members: Drs. Spanakis, Hepner, Kodali, Philip, and Shah.
of us knows members of our respective departments who are not members of MSA, ASA, or ASAPAC. Please join in the challenge to get them involved.

I am privileged to serve you as your ASA Director from Massachusetts. I especially thank the MSA Executive Committee and you the MSA members for your help and support. If you have any questions or comments, or needs that could be addressed, please do contact me at MSA. ~

Pictured above, left to right; Dr. Ruben Azocar, outgoing president; Dr. Fred Shapiro; Dr. Beverly Philip, ASA Director; and incoming President Dr. Selina Long at the Annual Meeting in May.

** ** ** **

In Memoriam

The specialty of anesthesia has lost a wonderful proponent and advocate in the person of “Joe” Murphy, who passed away on June 19, 2012. Dr. Murphy was a graduate of The College of the Holy Cross and received his medical training at the New York Medical College. He served his internship and residency at the Naval Hospital in St. Albans, Vermont, and then took over as chief of Anesthesia at the U.S. Naval Hospital in Guam, relieving Dr. Jess Weiss in that position. Following his discharge from the Navy he became a staff member of the anesthesia group at the Framingham Union Hospital, now called the Metro West Medical Center. Within a short period of time Joe became Chief of that group and then served a term as Chief of Staff at that Hospital. As he approached retirement age, Joe sought out a position wherein he could void undue stress, and practice anesthesia on a more leisurely pace. He became Chief of Anesthesia at the Marlborough Hospital, in Marlborough, MA, where he worked for several years with the late Dr. Cesare Coletta, another anesthesiologist who passed away not too long ago.

Joe was an active member of the Massachusetts Society of Anesthesiologists and a devoted member of the New England Society of Anesthesiologists. It was at the New England Society meetings where Joe really shined. His mellow Irish tenor voice could be heard singing ballads and popular tunes at virtually every Fall Conference of the NESA. He was an outstanding advocate of the patient and was frequently heard arguing for better standards of care. His voice was unmistakable in its character with a true, rather than cultivated, Boston accent. On one occasion as my wife and I were leaving one of our favorite restaurants in Naples, FL, I heard this sonorous voice someplace behind me, and commented to my wife that ‘That sounds like Joe Murphy’. It was --- several paces behind us, leaving the same restaurant!

Joe was befriended by many because of his honesty and candid approach to all the problems life could present, both personal and professional. He was a deeply religious man and devoted to his charming wife and their six children and many grandchildren. We shall miss you, Joe, and we are glad to have known you! Rest in Peace. ~

George E. Battit, M.D.
The Committee on Resident Affairs (CORA) had a very productive year, ensuring resident participation in key events and promoting the Lifebox Campaign. We had excellent representation at this year’s ASA Annual Meeting in Chicago. At least one delegate from every residency program in Massachusetts except one attended the various meetings and caucuses. The highlight was a strong showing at the Resident House of Delegates Meeting. Several officers from CORA will be heading to Washington, DC in May to participate in the ASA Legislative Conference. For a couple officers, it will be our second time attending this important advocacy event for the specialty.

CORA was very involved in promoting the Lifebox Campaign. Lifebox is a not-for-profit organization that seeks to improve the safety and quality of surgical care in low-resource countries. We worked with several anesthesiologists from Beth Israel Deaconess to spread the word about the ‘Boston Challenge’, a friendly competition amongst anesthesia residency programs to raise funds for this important cause. CORA also organized the successful Post-ITE Party at Umbria in downtown Boston, which was an excellent opportunity for anesthesia residents from across Massachusetts to meet and network after our yearly in-service examination.

In publicizing and soliciting funds for the event, we took the opportunity to raise awareness for the Lifebox Campaign. To date, about $3,000.00 has been raised through the ‘Boston Challenge’ and $500.00 was donated as a direct result of CORA officers approaching program directors and securing funds for both Lifebox and the Post-ITE party. In particular, we would like to thank the anesthesiology departments at Brigham and Women’s Hospital, Boston Medical Center, Beth Israel Deaconess and Massachusetts General Hospital for their support.

The 2012-2013 CORA Officers are:
Chair: Scott Suciu, M.D., BMC
Vice Chair: Maged Andrews, M.D., BMC
Secretary: Bev Chang, M.D., BWH
Treasurer: Dennis Sprockel, M.D., BMC
Social: Michael Kim, M.D., BMC
Social: Brian O’Gara, M.D., BIDMC

No items were referred to the Committee on Bylaws. The Committee corresponded by email and identified several areas that may need to be addressed in the future. There are no proposed bylaws amendments for 2012.
In late May 2011 MSA president Dr. Ruben Azocar established the New England Anesthesia Residents’ Conference committee as a subcommittee of the MSA Programs committee. Its charge is to assure the continuity of NEARC, to provide support to the program hosting this annual event, and to assure the spirit of NEARC as a meeting of and by residents for residents. Committee members included a core group with representatives from UMASS Worcester, Boston Medical Center, Tufts Medical Center and the Beth Israel Deaconess Medical Center. With our collective experience of past NEARC meetings, now in their 6th year, our strategy includes development of a web presence of NEARC related information, guidance to future hosts for planning a meeting, and outreach and education of NE anesthesiology residency programs and anesthesiology state societies to garner participation and support. I am very pleased to report the results of this year’s work. NEARC now has a ‘home’ on the web within the MSA website. It is located in the resident’s section under ‘meetings and events’. Information regarding every past meeting has been compiled in an attractive and easy to review fashion for those interested. The site contains suggestions for future hosts, as well as material reflecting the subcommittees work. We invite you to visit the NEARC section of the MSA website.

This spring, the subcommittee’s outreach effort has begun. On behalf of the MSA the subcommittee sent an information and invitation letter containing the web-reference to all NE anesthesiology program directors as well as to every NE anesthesiology state society president. A personal follow-up conversation is planned for the near future. With these achievements, the subcommittee has made excellent progress to meet its initial charge. The future outlook includes an invitation to the MSA resident’s component to take an active role and provide leadership in maintaining, improving and updating the NEARC web presence with new information as it becomes available.

The NEARC, initiated by MSA members 6 years ago, has become a success story of our society and for the NE anesthesiology residency programs. It can serve an important role in the academic mission of these programs and help fulfill ACGME requirements. It places New England on the map alongside similar conferences such as the Mid-West anesthesia residents’ conference and the Pennsylvania anesthesia residents’ conference (PARC).

The subcommittee wishes to thank Beth Arnold of the MSA for her unfailing administrative assistance in implementing our vision. ~
by Brian O’Gara, M.D.

The Massachusetts Society of Anesthesiologists Annual Meeting in May of 2012 was a notable occasion for many reasons. It was at this meeting where MSA members in attendance welcomed in their new leadership, and had the privilege of listening to a lecture given by Dr. John Zerwas, President-Elect of the American Society of Anesthesiologists. The central theme of Dr. Zerwas’ presentation was how and why the ASA is an indispensable part of an anesthesiologist’s daily practice.

Of the many ways that the ASA is able to advance the practice of anesthesiology and secure its future as a vital component of the newly forming American health care system, Dr. Zerwas focused on its three qualities of financial security, organizational excellence, and exceptional member benefits. Thus, the first part of his talk focused on describing the finances of the ASA. Over the course of the last twelve years, the total operating revenue of the society has grown steadily from just over $17m to just under $40m. The majority of these funds can be attributed to dues from ASA members, but as it continues to expand capabilities to provide outstanding educational products, meetings, and publications, the ASA is focused on developing and strengthening those new forms of generating revenue. As these additional revenue streams continue to grow, the total operating revenue of the ASA will consist of a lesser fraction of dues so that the financial security of the society is less dependent on the generosity of its membership. Another positive indicator of the financial strength of the ASA has been its ability to control its operating costs, with revenue exceeding expenses in all but 4 of the last 12 years. Of the total operating expenses of the ASA for 2010, the lion’s share was spent on education and advocacy. These two areas comprise nearly 60% of expenditures, which reflects the ASA’s focus on improving the quality of care that anesthesiologists provide, as well as ensuring that they are able to practice in a supportive and robust healthcare environment.

The second area in which the ASA demonstrates its essential value to the practicing anesthesiologist is in its organizational excellence. To illustrate this quality, Dr. Zerwas spoke about the changes in hiring practices for the ASA support staff. In 2007, the majority of employees at the ASA listed a high school diploma as the highest level of education achieved. By hiring the most experienced and educated staff member for each position, by February 2011 the number of employees with a Masters or Doctorate degree was nearly triple that of 2007, with a total of 81 employees being trained at a Bachelors level or above. The staff at the ASA is not only receiving higher level education, but is also comprised mainly from those with prior experience in working for a national medical organization. This experience and knowledge will help the ASA operate at its most efficient and continue to provide exceptional services to its members. Just as the ASA focused on hiring those with a strong desire for continuing education, there was an enormous effort to expand the catalogue of educational products for its members. This explosion in the creation of educational materials spurned the development of the first education department at the ASA, headed by Julie Hopkins PhD, MBA and Chief Learning Officer Diane Gambill, PhD. Even in light of these improvements in staffing and emphasis on promoting education, perhaps the most impressive marker of the ASA’s organizational excellence is in its ability to retain its membership. With its commitment to providing exceptional value to its existing members and passionate recruiting of new members, the ASA has seen its membership increase each year for the last six years. This is a tremendous source of pride for the ASA, as not many other national medical organizations can show that level of sustained growth.

The ASA’s remarkable ability to retain membership and to recruit new (continued on next page)
Summary of ASA Guest Speaker - continued

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constituents stems from its desire to provide exceptional benefits to each of its members. Here Dr. Zerwas highlighted the ASA’s outstanding educational products, the Anesthesiology Journal, the ASA national meeting, and public and media relations as the most valuable benefits of ASA membership. Innovative educational products offered by the ASA include a customized online learning center where members can purchase course materials, track CME requirements, and take online educational courses. The ASA’s leading research journal Anesthesiology remains at the forefront of advancing the practice, and will incorporate an iPad application and a “Page 2” section devoted to utilizing new technologies in everyday care. As health care reform continues to be a divisive and integral component of the upcoming Presidential election, the ASA’s national meeting in Washington D.C. this upcoming October will provide a unique opportunity for members to witness the society’s strong advocacy presence on Capitol Hill and to unite in securing a successful future for the practice. As the society comes together to celebrate and recognize the accomplishments of its members at Anesthesiology 2012, there is a growing need for good public relations between our practice and major media outlets so that the outstanding care given by anesthesiologists can be better recognized by the public eye. Dr. Zerwas identified major efforts by the ASA’s public relations teams to develop relationships with media industry leaders to ensure that our specialty will be portrayed favorably in response to major events. As an example, the ASA and the Michigan Society of Anesthesiologists have launched a public awareness campaign designed to inform the citizens of Michigan of all aspects of the practice of Anesthesia through print and radio advertising. The ASA also recognizes the need to support organizations such as FAER, the Anesthesia Quality Institute, the Anesthesia Patient Safety Foundation, as well as The Anesthesia Foundation and Wood Library. Through their support of these organizations devoted to improving the quality of patient care and honoring the proud tradition of the practice, the society continues to raise public awareness of the central role Anesthesiologists play in patient safety and advocacy as well as the rich history of the specialty. These exceptional benefits are just a few shining examples of why the ASA is an indispensable part of an anesthesiologist’s daily practice.

To conclude his lecture Dr. Zerwas provided the audience with an update of the advocacy efforts made by ASA staff and its members surrounding the legislation of the Patient Protection and Affordable Care Act (PPACA). Collaborating with Congressman Andy Harris MD, an anesthesiologist and ASA member, the team in the Washington D.C. has ensured that the interests of the practicing anesthesiologist will be heard by those charged with approving this landmark health care reform legislation. For example, Dr. Zerwas identified the work done by ASA leadership in visiting Capitol Hill and working with Democratic leaders in both the House and Senate to raise awareness of the importance of avoiding further reductions in Medicare payment rates to anesthesiologists. Some of the other important battles being fought on the behalf of anesthesiologists by ASA leadership include the aversion of a national opt-out clause for physician supervision of anesthetic providers and the rural pass-through measure, as well as eliminating national drug shortage as a source of inadequate or inefficient perioperative care. As the focus on healthcare shifts to controlling costs and minimizing complications and moves towards the creation of Accountable Care Organizations and perioperative or surgical “homes,” Anesthesiologists are in a unique position as consultants to help improve the quality of surgical and perioperative care. Dr. Zerwas highlighted how ASA physicians such as Dr. Norm Cohen are at the forefront of these new healthcare initiatives. Despite the strong presence of the ASA leadership on national committees and on Capitol Hill, the movement to ensure that the anesthesiologist will play an important role in healthcare reform cannot happen without the support of its membership. In closing, Dr. Zerwas urged the audience members of the MSA annual meeting to inspire their colleagues to join the grassroots movement of the ASA and to support the ASAPAC. With the continued support of American anesthesiologists, the ASA will make sure that the specialty will have its seat at the bargaining table. ~

MARK YOUR CALENDAR FOR NEXT YEAR’S
MSA ANNUAL MEETING
Thursday May 23, 2013
MIT Endicott House, Dedham
BOOK REVIEW

LAUGHING AND CRYING ABOUT ANESTHESIA

By Fred G. Davis, M.D.

What do the following, Oxford Eye Hospital, Aristotle Onassis, John Mayow, Yitzhak Perlman, Crampton Smith, Bjorn Ibsen, Blegdam Hospital for Infectious Diseases, Gordh needle, Robert Ruark, Emanuel Feuermann, Bulawayo-Matabeleland, have in common? They are all mentioned in Gerald Zeitlin’s memoirs on the “modern” history of anesthesia or should I say anesthesia. His perspective is not only entertaining but perceptive and thought provoking.

Laughing and Crying about Anesthesia details a series of experiences, anecdotes, and observations both personal and professional of one Gerald Leon Zeitlin FFACS, MD (anesthetist, anesthesiologist, historian, comedian, rabble-rouser, critic, cheerleader, keen observer, father, husband, partner, consultant, and intensivist—You take your pick.

The book consists of 265 pages divided into 27 Chapters and even includes 3 Intermissions. The author steps lightly back and forth between England and the USA. Theaters to ORs, Casualtys to ERs, Sisters to Nurses, Oxford to Harvard, and from Academics (MGH, Brigham), to private practice (Lynn, Union) to Clinics, (Lahey), from historical to modern, with comments and opinions on all.

How many of you have been awakened in the middle of the night when a V-2 rocket destroyed your local library or have been interviewed by Sir Robert Macintosh (not MacIntosh), the first full time Professor of Anaesthesia in the world, while he was taking a shower -- (Sir Robert not Gerald). Who was the second? Jerry worked with him too.

This is the way the book goes—certainly not a formal, strict, chronological unfolding of our specialty, but a deeply personal inside look at the good the bad and the ugly, one topic often hopping into another.

Throughout this sometimes peripatetic tale is one consistent and vital theme: it is the relentless striving of our profession to study and improve itself in the search for the Holy Grail of patient safety. Through the study of Critical Incidents by Jeff Cooper, Closed Claims with Fred Cheney, The Harvard (now ASA) Standards for monitoring, focusing attention on this challenge by Ellison “Jeep” Pierce as ASA president, all have led to an undeniable, spectacular improvement in safety for the patient undergoing anesthesia. In spite of, as Gerald loves to point out, our lack of understanding as to how general anesthesia actually works!

The teller of this story, because it is told rather than written, is curious, observant, self-aware, and brings you along as his story and our specialty develop.

Dr. Zeitlin stops along the way to describe people, events, trends, controversies, advances and setbacks that will provide thought provoking moments. Gerald clearly enjoys the role of provocateur as well as raconteur, but his observations, while often sharp with even an occasional bite, are never mean spirited and cannot conceal the soft heart and twinkling eye that those of us who know Jerry associate with him.

In the interest of full disclosure I must confess to knowing Gerald and therefore perhaps to being a jaundiced? prejudiced? reviewer, but this association also gives me the opportunity to tell a story on Gerald. His son refused to send in his honest, positive review of this book because he felt it would be nepotism. Gerald told me this with no small amount of fatherly pride.

Would his English teacher take off a couple of points for typos–etc? Probably, but it still works—its a story told, not written.

Anesthesiologists will enjoy this book and will also learn some things in the process. Seniors like me will be reminded of how far we have come and reminisce. Our younger colleagues will be introduced to what they missed that should not be taken for granted.

Non anesthesiologists will have a delightful insight into the career of an anesthesiologist and, through this lens, a unique view of the specialty and its history. To be read while awaiting your surgery? I am not sure - although it might liven up your informed consent conversation. Take this journey with Gerald– it’s well-worth it! ~

Gerald L. Zeitlin, FFRCS, MD

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UPDATE ON THE ANESTHESIA QUALITY INSTITUTE

Introducing the Anesthesia Incident Reporting System (AIRS)

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

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

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

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

This is why critical incident reporting, based on either actual adverse events or “near misses,” is a common concept in anesthesia department quality management (QM) at the local level. Most hospitals and most anesthesiology departments mandate the reporting of critical or “sentinel” events, and most academic departments have regular “Morbidity and Mortality” conferences to discuss unusual cases. Such systems work best when there exists a ‘safety culture’ among practitioners, with free and open discussion about negative events. The desire for improvement must outweigh fear of the consequences of reporting.

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

The AQI believes the time is ripe for a national system for reporting critical events in our specialty. The US aviation system has had such a system in place since 1976. Called the Aviation Safety Reporting System, it is funded by the Federal Aviation Administration and administered by NASA. Blinded data gathered from reported incidents is available on the FAA website, in the Aviation Safety Information Analysis and Sharing system, and is available for public research.

**History:** Similar efforts have occurred elsewhere around the world. The Australian Incident Monitoring System (AIMS) was created almost 20 years ago to capture serious events and near misses in the operating room. Reporting was via paper forms, sent to a central office. This registry spawned numerous academic papers up until 2005, when it became a victim of its own success. The system was expanded to include any in-hospital adverse events (losing its focus on anesthesia) and was then expanded internationally (losing its focus on local practice). With these changes, anesthesia providers stopped contributing to it, and AIMS ceased to be a useful tool for anesthesiologists. However, the need for such a system did not go away. The Australian and New Zealand Tripartite Anaesthetic Data Committee was formed in 2006 to reintroduce national anesthesia event reporting using the tools of the Information Age. This system, now active throughout Australia and New Zealand, uses anonymous web-based reporting to gather events.

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Anesthesia Quality Institute-continued

(continued from previous page)

The Critical Incident Reporting System (CIRS) was created in Switzerland in the 1990s to fill a similar role, and is still in use by Swiss anesthesiologists today. With the recent publication of the “Helsinki Declaration” proposing universal professional standards for anesthesia QM, there is thought of expanding this system across all of Europe. Similar systems are in place in Great Britain, Scandinavia, and locally at several US medical centers. And after decades of disinterest, the US government has recently provided some support: The US Patient Safety and Quality Improvement Act of 2005 authorized the creation and accreditation of Patient Safety Organizations (PSOs) as a means of aggregating healthcare quality data across multiple institutions. These regulations were completed in 2009, and have spawned a number of national quality registries based in hospital corporations, state governments and professional associations.

Development of AIRS:
In January, 2010, even as the AQI was launching NACOR, the AQI Board requested a plan for an incident reporting system. Since that time we have researched incident reporting systems in other countries, conversed with dozens of experts in the US and abroad, and conducted a detailed analysis of the legal issues such a system would raise. The AQI was designated as a Patient Safety Organization in September, 2010. We formed the AQI-AIRS Steering Committee, and recruited a select group of experts to advise us on the best approach to building the system. Ably led by James Caldwell, M.D., of the University of California, San Francisco, and Patrick Guffey M.D. of the University of Colorado, this volunteer committee of subject matter experts defined the scope of incidents we would seek, the data we would solicit, and the uses we would make of the results. Members of the Steering Committee are shown in Table 1.

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

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

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

The report itself consists of three short pages. Structured data is gathered by radio-buttons, and is augmented by a single field for a free-text narrative description of the event. Reports can be made either anonymously or confidentially. An anonymous report leaves no record of the sender anywhere in AIRS. In a confidential report AIRS will maintain contact information from the sender as part of the record. This allows the reporter to modify an initial report with follow-up information on the patient or event; it also allows AQI personnel to contact the reporter to elicituate important or ambiguous details. All AIRS reports are made over a secure, encrypted internet connection, and are maintained in strict confidence (and firewall isolation) on the AQI server.

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

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

Second, we will periodically examine the entirety of AIRS for emerging trends in anesthesia patient safety. These might be related to new medications, new techniques, evolution of patient risk factors, or even the impact of electronic records. As with the Closed Claims Project, we will periodically publish our findings to alert practicing anesthesiologists to common and recurrent problems. By combining data between NACOR and AIRS we will have both a quantitative and a qualitative picture of anesthesia safety in the United States. AIRS will enable us to find and fix the next new problem in our specialty, whether it’s post-operative visual loss, bronchospasm from rapacuronium, or rare electrical interference in a new monitor. We urge you to visit the website the next time you see an unusual event, and keep our web address handy in your O.R. With your assistance, AIRS will be our specialty’s latest weapon in the long quest to improve patient care. ~
NEW BOARD REGS BRING NEW CME REQUIREMENTS

On February 1, 2012, a revision to 243 CMR 3, a portion of the Board’s regulations, will take effect. Two changes to the regulations involve CME requirements. Physicians renewing their licenses after February 1 must have completed 3 hours in effective pain management, identification of patients at high risk for substance abuse, and counseling patients about side effects, and the addictive nature and proper storage and disposal of prescription drugs. This is a statutory requirement that was enacted by the Legislature in 2010.

A free online resource to obtain the necessary credits is available at www.opioidprescribing.com. If your license is due to expire between now and February 1, the Board encourages you to take the online course, or obtain credit from another program, as soon as possible. The 3 credits will qualify as either Category I or II credits, and they may be counted as risk management credits.

The revised Board regulations also include a new requirement for 2 CME credits in end of life care. There are a number of programs offering end of life care CME, among them the Massachusetts Medical Society (www.massmed.org).

The end of life care requirement also takes effect on February 1, and the Board similarly encourages physicians with license expiration dates between now and February 1, to obtain the necessary credits as soon as possible. End of life care CME credits also qualify as Category I or II, and may be counted as risk management credits.

The revised 243 CMR 3 can be found here:


If you have questions, please email Charlene Morelli at: Charlene.morelli@state.ma.us
ABA Releases Online Tutorial on MOCA® Program

RALEIGH, N.C. (October 27, 2011) — To enhance its ongoing effort to provide clarity on the Maintenance of Certification in Anesthesiology (MOCA) program, The American Board of Anesthesiology, Inc. (ABA) has developed an online tutorial to address frequently asked questions and concerns of constituents.

The Maintenance of Certification (MOC) concept originated with the American Board of Medical Specialties (ABMS) in 1999 as a professional response to the need for public accountability and transparency of practice improvement initiatives by physicians. The ABA recognized the importance of this initiative and developed the MOCA program to help board certified anesthesiologists demonstrate to society their lifelong commitment to quality clinical outcomes and patient safety.

The ABA designed this tutorial to familiarize viewers with the pathway to ABA certification and maintenance of certification as well as educate them on their specific MOCA program requirements.

Subjects covered by the tutorial include:

- Pathway to Maintenance of Certification
- Evolution of Certification Process
- MOCA Program Requirements
- Entering Requirements in ABA Portal Account

“We hope our diplomates and future diplomates will find this tutorial useful as we make transparent the road to board certification and the Maintenance of Certification in Anesthesiology program,” said David L. Brown, M.D., Secretary of the ABA Board of Directors.

“This tutorial is just one more way that the ABA is providing information to our diplomates on MOCA,” said Dr. Brown. “This video will supplement other resources we have made available on the ABA website, such as the Frequently Asked Questions section and MOCA requirements by certification year.”

To view the MOCA tutorial go to:
http://www.theaba.org/Home/Videos
MEMBERSHIP CHANGES 4/11-7/12

New Active
Timothy Abbott, MD, Cooley Dickinson
Abdullah Abolkhair, MD, Baystate MC
Ghasson Aljafar, MD, Baystate MC
Fernando Almenas, MD, AAM
Thomas Anderson, MD, MGH
Alvaro Andres Macias, MD, BWH
Ray Anton, MD, Hartford Surgi Center
Emad Attallah-A-Wasif, MD, Baystate MC
Heather Ballard, MD, BODMC
Konstantin Balonov, MD, Tufts MC
Xiaodong Bao, MD, Holy Family MC
Brian Bateman, MD, MGH
Steven Beckman, MD, UMMHC
Hubert Bentzon, MD, CHMC
Sheri Berg, MD, MGH
Evans Berman, MD, Lawrence General
Felicity Billings, MD, BWH
Evans Blaney, MD, BWH
Adam Brown, DO, Falmouth Hosp.
Robin Burns Lambert, MD, Berkshire MC
Alberto Cabantog, MD, St. Vincent
Adam Carinci, MD, MGH
Laura Chang, MD, BWH
Sanjeev Chhangani, MD, MGH
Liv Corber, MD, Baystate MC
Henry Crowley, MS, Same Day SS
Qi Cui, MD, BIDMC
Peter Folocamo, MD, Brockton Hosp
Lawrence Gibbons, MD, AAM
Sean Gibbons, MD, CCH
Jeremy Goldfarb, MD, M E&E
Christine Greco, MD, CHMC
Artem Grush, MD, Mass E&E
Holly Happe, MD, Mass E&E
James Hardy, MD, BWH
Stefan Hariskov, MD, MetroWest MC
Geoffrey A. Hart ND, BWH
Mohamed Haytham, MD, UMass
Thomas Ho, MD, Guardian Anesth
Jeffrey Jankun, MD, BIDMC
Ryan Joyce, MD, Holyoke Hospital
Nicholas Kiefer, MD, Beverly Hosp
Rahul Koka, MD, CHMC
Cindy Ku, MD, BIDMC
Aseesh Kumar, MD, Walter Reed, MD
Dipak Kumar, MD, AAM-Sturdy
Maria Karnina Iskander, MD, Baystate MC
Anjolie Laudach, MD, CHMC
Christopher Lee, MD, CHMC
Wilfred Lewis, MD, AAM
Penny Liu, MD, Tufts MC
Anthony Lomonaco, MD, Beverly Hosp
Marissa Lopez Bisbe, MD, Holy Family
Shanee Man, MD, Lowell General
Ganna Margulian, MD, Guardian Anesth
Brian Martin, MD, Baystate MC
Kai Matthes, MD, CHMC
Neil McDonald, MD, AAM
Pankaj Mehta, MD, Baystate MC
Richard Miller, MD, MGH
Haytham Mohamed, MD, Athol Memorial
David Moss, MD, Tuft MC
Punam Narang, MD, Boston VA
Kathleen Nozari, MD, MGH
Michelle Nyman, MD, AAM
Joanne Oh, MD, Winchester Hosp.
Gerald Park, MD, BIDMC
Jeffrey Preluba, MD, MGH
Keith-Austin Scarfo, MD, Guardian Anesth
Doris Ore Sosa, MD, Lawrence Gen'l
Robert Peloquin, MD, MGH
Yvonne Peng, MD, Baystate MC
Sujatha Pencakota, MD, BWH
Rehan Siddiqui, MD, MGH
Emily Singer, MD, AAM
Mieke Soens, MD, BWH
Adam Stoller, MD, SS Hosp
Naveed Tahir, MD, Baystate MC
Kevin Vilisaint, MD, CCH
Lisa Vukanic, MD, St. E
Kevin Walecka, MD, AAM
Kenneth Walton, MD, Cambridge Hosp
Luke Yuan-Je Wang, MD, CHMC
Alexander Wolf, MD, Baystate MC
Shahzad Yuki, MD, CHMC
Daryl Wong, MD, BIDMC
Xiping Zhang, MD, Melrose Wakefield

Retired
Rene Aillon, MD, Pittsfield
Paul D. Allen, MD, Brookline
Fred Davis, MD, Cambridge
Kenneth Davison, MD, Needham
Kassim Drocat, MD, Weston
Nabil Fahmy, MD, Belmont
Lynda Hinds, MD, Sudbury
Charles Kelley, MD, Lowell
Jason O'Neil, MD, Boston
Han Y. Park, MD, Andover
Danna Peterson, MD, Shrewsbury
Dilip Rajadhayaksha, MD, Shrewsbury
Venkata Ravi, MD, Lexington
Robert Schneider, MD, Dedham
Donald Stevens, MD, Littleton
Anastasios Triantafillou, MD, Yarmouth
Anil Vyas, MD, Sudbury
Heinrich Wurm, MD, Waltham

Deceased
Albert Finck, MD
Abdel Mehio, MD
Vijay Joshi, MD
Joseph L. Murphy, MD
Joan Peterson, MD
John Petrowski, MD
Ellison Pierce, MD
Robert Siegel, MD

Active, Moved Out of State
Boris Gellman, MD, CA
Peter Calkin, MD, MI
Robert Dingeman, MD, CA
Michael Entrup, MD, PA
Kurt Fink, MD, PA
Peter Fischer, MD, NC
Matthew Goins, MD, VA
Edward Hendricks, MD, VA
Amir Islami-Manuchehry, MD, CA
David Joswick, MD, NY
Stephen London, MD, HI
Emily Mahler, MD, VA
David Monge, MD, MI
Florence Odutola, MD
Ruth Padilla-Garcia, MD, PR
Deborah Pederson, MD, OR
Timothy Pederson, MD, OR
Tjorvi Perry, MD, MN
Joseph Reyes, MD, NV
Andrew Shaye, MD, VT
Nicholas Watson, MD, MI
James Williams, MD, CA
Karim Zuegge, MD, WI

Membership Totals (8/1/12)
Retired 183
Active 940
Resident 492
Affiliate 19

BOX SCORE
Membership Totals (8/1/12)
Active 940
Resident 492
Affiliate 19
Retired 183

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**ASA PLACEMENT SERVICE**

http://placement.asahq.org

Organizations may now submit positions directly online. Newly submitted practice opportunities will be made available on the ASA website within 24 hours of submission. All practice opportunity postings will be available for a period of 60 days. This online service has replaced the quarterly placement bulletin, which had been mailed to interested ASA members. Please note that ASA reserves the right to reject any job submission it deems inappropriate.

This new feature of the ASA website will allow your position to be made available to more than 36,000 anesthesiologists. Also, you now have the option of including a phone number, fax number and/or email address to your listing. To update your available position simply click on your posting, make any necessary changes and click on the submit button. Your changes will be updated within 24 hours. The placement service remains free of charge.

Any questions regarding the ASA Placement Service should be directed to the ASA Executive Office at (847) 825-5586 or by email at p.fitzpatrick@asahq.org.
2012 SEA-HVO Fellows Announced

[Washington, DC - June 1, 2012] Health Volunteers Overseas (HVO), in collaboration with the Society for Education in Anesthesia (SEA), is pleased to announce that nine anesthesia residents have been awarded the 2012 SEA-HVO Traveling Fellowship.

They are: Titilopemi Aina, MD, MPH (University of Florida), Ben Brooksby, MD, PhD (Oregon Health and Sciences University), Ername Eromo, MD, MBA (Massachusetts General Hospital at Harvard University), Christina Hayhurst, MD (University of Virginia), Pamela Hockert, MD (University of Texas Southwestern), Grace Hsu, MD (Beth Israel Deaconess Medical Center at Harvard Medical School), Kavish Kapoor, MD (Penn State Milton S. Hershey Medical Center), Frank Lee, MD (Johns Hopkins Medical Institute), and Jamey Snell, MD (New York University Medical Center). Each Fellow will serve a one month assignment at an HVO anesthesia training site in Ethiopia, Peru, South Africa, or Vietnam.

The SEA-HVO Fellowship allows senior anesthesia residents the opportunity to improve anesthesia care in developing countries by teaching and mentoring their counterparts. The SEA-HVO Fellows will be challenged to learn about diseases that are rare in the United States but becoming less so with globalization. They will learn important lessons on delivering health care in a resource-scarce environment and working with health care providers in a different cultural environment. Most importantly, they will contribute to the future safety of patients receiving anesthesia in developing nations.

The SEA-HVO Traveling Fellowship would not be possible without the generous support and donations from Dr. Jo Davies, Dr. Chris and Rebecca Dobson, Dr. Lena E. Dohman, the Feintech family, Dr. Ronald L. Katz, Dr. Gary E. Loyd, the Foundation for Anesthesia Education and Research, and SEA members.

The Society for Education in Anesthesia is a non-profit educational organization for anesthesiology educators who desire to improve their skills in anesthesia education. For more information on the various activities of SEA, visit their website.

Health Volunteers Overseas is a private, nonprofit organization founded in 1986 to improve global health through the education of local health care providers. In 25 years of service, HVO’s training has transformed lives through the design and implementation of clinical and didactic education programs in child health, primary care, trauma and rehabilitation, essential surgical care, oral health, blood disorders and cancer, infectious disease, nursing education and wound management. In more than 25 resource-poor countries, HVO volunteers train, mentor and provide critical professional support to health care providers who care for the neediest populations in the most difficult of circumstances. For more information, visit the HVO website.

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UPCOMING CME EVENTS ACCREDITED BY THE MSA

55TH Annual NESA Fall Conference
Sept. 13-16, 2012
The Viking Hotel, Newport, RI
www.NESA.net

MSA Ultrasound-guided Regional Anesthesia Course & Workshops
Dec. 1, 2012
Waltham Woods Conference Center, MMS

MSA Anesthesia Update in Puerto Rico
Jan. 18-21, 2013
El Conquistador Golf Resort & Casino
Las Croabas, PR
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