Georgia Society of Anesthesiologists, Inc.

scope Newsletter

Summer 2012

GSA needs 'other' Georgia

James E. "Jet" Toney
Executive Secretary

The Society is at a crossroads, one that either leads to all of Georgia or one where all roads lead to and from Atlanta. Members will decide the direction more travelled by the amount of involvement each invests in helping meet the Society's mission of education and advocacy.

GSA needs the "other" Georgia. Specifically, GSA needs leaders to step forward from areas outside of the 28-county Atlanta standard metropolitan statistical area. GSA needs members from throughout the Empire State of the South to be involved in the decision-making which will not only guide the organization but determine how effectively GSA will represent its members and the specialty of Anesthesiology during these turbulent times.

But the organization misses a portion of its soul when the "other" Georgia is not represented on the Board and in the Executive Committee. When GSA members go to Washington to meet with Members of Congress to discuss very serious health care proposals, the more rural officials want to know why their local doctors are not in Washington. When your lobbyists are walking the halls under the Golden Dome in Atlanta, representatives and senators want to know who are their local anesthesiologists and how bills will impact the patients (voters) in their legislative districts.

THE SOCIETY IS AT A CROSSROADS

GSGSA

I am privileged to have been associated with the GSA for 20 years now. During this productive journey I have enjoyed working with and for leaders from throughout the state. The perspective of physicians from the "other" Georgia has served to enlighten me as to how the business of anesthesia is conducted outside the massively populated areas of North Georgia. The leaders who stepped forward out of Savannah, Columbus, Albany, Rome and Augusta have enriched my professional life and guided GSA to exceptional progress during their tenures.

But where are you now? Where are Valdosta and Gainesville and Tifton and Dalton and Dublin? GSA needs you.

The Society is blessed to have had dedicated, unselfish leaders from Atlanta throughout its history. Metro-area members are currently serving in numerous positions of responsibility or are in the queue.

Technology Makes It Possible

Today's electronic communications technology makes possible the involvement of physicians around the globe, so distance from GSA headquarters is no longer a high hurdle to participation. GSA staff is dedicated to helping officers, chairs, delegates and committee members perform their functions.

Be Involved NOW!

GSA President-Elect Dr. Jay Johansen is accepting nominations for all positions of responsibility and activity in GSA. He is interested in hearing from any member who wishes to become involved at any level.

Nominate and Participate Now!
Contact Dr. Jay Johansen | GSA President-Elect | jjohans@emory.edu

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Summer 2012

Editor's Corner

Kathryn Stack, MD, Chair, Communications Committee, Editor, GSA *scope*

GSA energizes Capitol Hill

This year's ASA Legislative Conference in DC once again brought together an energetic group representing Georgia's many anesthesiology practices. Some of the nation's foremost experts in healthcare and anesthesiology issues headlined two full days of lectures, panels and interactive meetings that culminated in the third day's small group trips to Capitol Hill.

In this issue are post-conference thoughts from some of the GSA delegation.

As Congress was not in session during this week, the first anniversary of Osama Bin Laden's death, the halls of the Congressional offices were quiet, and our meetings with staff and aides were relaxed, non-harried and well-received. Topics emphasized during this year's conference included the following:

- raising awareness about early notification by pharmaceutical manufacturers of impending drug shortages;
- addressing the lack of oversight and rogue power bestowed the advisory board established by the Patient Protection and Affordable Care Act (should the Supreme Court rule that part or all of the law is constitutional by the end of June);
- addressing repetitive SGR fixes that might continue to cut anesthesiology Medicare fee rates - rates which already trail other specialties by nearly two-thirds;
- passing "rural pass through" legislation that would allow patients in rural hospitals to be cared for by anesthesiologists who would have the same fiscal advantage currently afforded to CRNAs only; and,
- legislation mandating truth and transparency from healthcare providers in communicating levels of medical training and expertise to patients.

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State Issues

GSA blasts Chiropractic MUA

Steve Walsh, MD | President 2012

The Georgia Board of Chiropractic Examiners has tabled a controversial proposal to authorize chiropractic manipulation under anesthesia. GSA President Dr. Steve Walsh testified in opposition to adding rule chapter 100-18 titled *Manipulation under Anesthesia* and a new rule 100-18-.01 *Requirements for Authority to Perform Manipulation under Anesthesia* at the Board's May 17 hearing in Macon.

"The Georgia Society of Anesthesiologists opposes the adoption of this new chapter and rule on the dual basis that the authority granted weakens long-standing patient safety protections and that the authority granted therein is beyond the scope of chiropractic practice. These positions are supported and based on conclusions of the American Society of Anesthesiologists (ASA) and decisions by the Texas Court of Appeals, Third District," Dr. Walsh stated.

"As an anesthesiologist who has practiced for over 25 years and certified by the American Board of Anesthesiology in both Anesthesiology and Pain Management, I am in full agreement of the previously stated opinions. I have no chiropractic training. As an anesthesiologist, I am trained to anticipate risk and have the full obligation to protect the patient from injury when drugs limit a patient's normal protective reflexes. For that reason, I believe sedation and anesthesia should not be combined with chiropractic adjustment or manipulation."

In the Texas Court of Appeals, Third District TBCE and TCA v. TMA and TMB both MUA and certification for MUA were examined. On both these issues the court ruled in favor of the physician parties finding MUA to be a surgical procedure and therefore outside the scope of chiropractic practice. The court also found TBCE was not authorized to "certify chiropractors to perform manipulation under anesthesia".

Referring to a report of an ASA Taskforce on MUA, Dr. Walsh stated the taskforce clarified that "the basis for manipulation under anesthesia (MUA) is that fibrotic changes in peri- and intra-articular tissues restrict motion and cause pain." Sedation or anesthesia "is being proposed to reduce muscle tone and limit protective reflexes so that effective manipulation of the joint/spine can be provided." The taskforce raised concerns that "although there are specific patient selection criteria as well as documented contraindications, these may not be followed… raising concerns about the accuracy and suitability of patient selection."

The Medical Association of Georgia also testified in opposition to the proposed MUA expansion.

For a complete copy of Dr. Walsh's testimony, please go to "News" at www.gsahq.org.

GSA Energizes ...continued from page 2

Most impressive about my trip to Capitol Hill was the presentation by aides of two Congressmen from Georgia, Dr. Tom Price and Dr. Paul Broun, who both have introduced bills in the House of Representatives (HR 3000 and HR 4224, respectively) to repeal and replace Obama's Patient Protection and Affordable Care Act. It is extremely reassuring to see Representatives from my district and state immersing themselves into the healthcare reform issue with the introduction of bills with real possible solutions. Neither proposed bill has the required companion bill in the Senate, but it sure is a good start out of the State of Georgia!

One other opportunity I would highly recommend attending at the annual ASA Legislative Conference is the ASA's Leadership Spokesperson Training Program. Led by three leaders of the PR and Marketing and Communications offices at the ASA, this was three valuable hours spent learning to succinctly pack an interview with talking points, to avoid common interview pitfalls and, finally, applying these techniques during a videotaped mock interview.

Other very important information for ASA members that came to light at this program -- the assistance of the ASA Communications Office is available to any member who is faced with an upcoming interview on topics relevant to the ASA. Should you be contacted by the media or other organizations to speak on topics related to Anesthesiology, contact the ASA's Communication Office with the topic(s) of discussion after confirming the interviewer's submission deadline.

The ASA office will research the interviewer and their media outlet for any potential bias, assist in establishing talking points, provide a mock interview to help perfect your technique and answers and even provide an associate to be a silent participant in your phone interview! I highly recommend taking advantage of this great spokesperson program and all the ASA has to offer its members when it comes to effectively communicating with the public and media.

Summer meeting fundraiser

Residents to combat pulse ox gap

Faye M. Evans, MD

The GSA Resident Component will sponsor a fundraiser for Lifebox at the GSA 2012 Summer Meeting at Reynolds Plantation. Over the course of the weekend meeting, residents will seek to educate fellow anesthesia providers about the importance of improving the safety and quality of surgical care in low-resource countries.

Lifebox, a nonprofit company, in cooperation with the World Federation of Societies of Anaesthesiologists and the American Society of Anesthesiologists, is leading an initiative to combat the global pulse oximetry gap. One hundred percent of operating rooms in high-resource countries possess pulse oximeters yet 70 percent of operating rooms in sub-Saharan Africa do not. By providing low-cost, robust pulse oximeters and "how-to" knowledge to low resource countries, Lifebox can help provide anesthesia providers the tools and training they need to make surgery safer.

Increasing interest in ensuring that pulse oximetry is available in all operating theatres across the world began in 2008 when the WHO's Safe Surgery Checklist was introduced in an effort to reduce major complications from surgery. Pulse oximetry has been described as "one of the most urgent improvements that could be made to anesthesia safety." Still today, there are many patients receiving anesthesia without a pulse oximeter.

The Lifebox pulse oximeter devices are available for $250.00 each. The resident component's goal at the summer GSA meeting is to raise enough money to purchase and donate eight Lifebox oximeters. We are currently accepting monetary donations as well as donations for services or products that could be auctioned at the summer meeting.

There will be a Lifebox information exhibit at the GSA meeting.

For additional information, please contact either Lyndsay Fry, MD: lyndsay.fry@emory.edu or Melissa Rader, MD: melissa.m.rader@emory.edu.

Let's save lives together.

Imagine administering anesthesia to your patient without the use of a pulse oximeter. In more than 77,000 operating rooms across the developing world, your colleagues have no alternative – it's just too expensive. Access is the most significant barrier to widespread pulse oximetry use.

A $250 donation to Lifebox puts this essential safety device into the hands of colleagues who need it most. Each pulse oximeter comes with training materials and a WHO Surgical Safety Checklist, shown to significantly reduce operating room complications and mortality rates.

When you donate a pulse oximeter, you're making an investment that will save lives for years to come.

Become a part of the Lifebox mission.

Visit us at www.asahq.org/gho/lifebox to donate and learn more.

Practice Survey

Are non-physicians doing chronic pain?

The GSA is conducting a quick poll on interventional pain management by non-physicians in the state. The purpose of the survey is to determine the type and frequency of such actions.

The genesis of this survey is an inquiry from a Society member who is chief of staff at a hospital and has been asked to consider whether or not privileges should be granted for CRNAs doing epidural steroid injections. The nurses are armed with a ruling from the Georgia Board of Nursing opining that such procedures are within CRNA scope of practice. Nationally, such rulings have been the source of lawsuits, state law changes, court rulings and appellate decisions and policy debate.

Please notify GSA Executive Secretary Jet Toney at jet.toney@politics.org of examples of non-physician providers conducting interventional pain medicine. All responses will remain confidential, though Mr. Toney may contact respondents for additional information. Anonymous USPS correspondence will be accepted at GSA headquarters at 1231-J Collier Rd. NW, Atlanta, GA 30318.

Please notify GSA of examples of non-physician providers conducting interventional pain medicine at jet.toney@politics.org

The American Society of Anesthesiologists has issued a position paper at www.asahq.org on non-physician delivery of interventional pain treatment. The following is a portion of that response:

ASA: Interventional Pain Management is the Practice of Medicine

Interventional pain management by unqualified providers presents serious risks to patients, such as persistent or worsened pain, bleeding, infection, nerve damage, brain damage, paralysis or even death. Therefore, it is the position of the American Society of Anesthesiologists that interventional pain management of patients suffering from chronic pain constitutes the practice of medicine. Appropriate medical training is necessary to evaluate, diagnose and safely treat patients suffering from chronic pain and to respond to complications of treatment should they arise. The public safety requires that interventional pain management in statute and regulation as clearly recognized as the practice of medicine and the interventional treatment of pain is provided only by qualified MDs/DOs.

Due to the complexities involved in the treatment of pain, pain medicine is recognized as a separate medical subspecialty by the American Board of Medical Specialties. Physicians choosing to specialize in pain medicine must now complete a one-year multidisciplinary pain fellowship in addition to successful completion of four years of medical school and four years of anesthesiology residency or appropriate residency training in physical medicine and rehabilitation, neurology or psychiatry. Medical school is a four-year program, where the first and second years are spent learning the scientific principles of human anatomy and physiology, biochemistry, pharmacology, genetics, microbiology, immunology, pathology of disease states, and similar courses in both the natural and behavioral sciences, as well as in introductory clinical experiences. The third and fourth years of medical school are devoted to full-time clinical rotations and clerkships where the medical student is introduced to the comprehensive clinical care of patients, primarily in the hospital inpatient setting. After successfully completing a residency program and a one-year pain medicine fellowship, they may apply to enter the examination process leading to board-certification in Pain Medicine. The requirement for multidisciplinary pain medicine fellowship training is recognized by the Accreditation Council for Graduate Medical Education who oversees and accredits the programs.

Careful selection of patients for interventional procedures is necessary in order to increase the chances for success and reduce the risk of harm. Patient selection requires a detailed evaluation of the complex pain patient, including but not limited to, a medical history, physical examination, diagnostic testing and imaging, and determination of the diagnosis prior to developing a multimodal medical treatment plan incorporating interventional pain management procedures. The advanced skill set of a physician with specialty education and training in pain medicine involved in this patient evaluation and development of a treatment plan are integral to the practice of medicine.

Many complex interventional pain procedures require the use of advanced imaging techniques (e.g. fluoroscopy, digital subtraction angiography, computerized tomography and others) to accurately guide needles to the proper location, evaluate potentially therapeutic or dangerous spread patterns for medications injected via the needles and assist in the intraoperative placement of devices. Proper knowledge of imaging safety considerations and technical interpretation of advanced imaging and management of potential life threatening complications require highly specialized medical training.

As an example, fluoroscopic imaging either alone or in combination with digital subtraction angiography is a vital imaging technique used to assist interventional pain physicians in the diagnosis and treatment of pain. A clear understanding of how to obtain and interpret fluoroscopic images is critical to obtaining successful outcomes and avoiding devastating complications. While this tool helps to safely and effectively perform interventional pain procedures, the risk of radiation overexposure to patients and staff increases when professionals who are partially or inappropriately trained engage in operating the fluoroscopy unit. Hence, in addition to formal pain medicine training, many states have established a rigid certification process for physicians to use this device.

For further information, please contact Ronald Szabat, ASA Executive Vice President & General Counsel, or Lisa Percy Albany, ASA State Legislative and Regulatory Issues Manager, at (202) 289-2222.

Issues elsewhere foretell ours?

Mark Huffman, MD
Chair, Government Affairs

Perhaps the most effective and informative aspect of ASA's annual legislative conference is the State Issues Forum which snapshots actions in various other states relevant to the practice of Anesthesiology and health policy. The presentations of our peers in other states is also predictive of issues we might face in the Georgia General Assembly in 2013 and forward.

The following chronicles public policy actions which our sister state component societies have faced. Some have enjoyed success, others defeat. But most important, those state component society members/leaders are fighting for our profession and for the protection of patient safety.

CRNA Issues

California: The California appellate court affirmed a lower court's ruling that former Governor Schwarzenegger did not abuse his discretion when he determined that "opting out" of the federal physician supervision standard was consistent with state law. The lower courts held that the California law does not require them to administer anesthesia under physician "supervision." Instead, the statute authorizes nurse anesthetists to administer anesthesia "ordered by" a physician. CSA, along with California Medical Association have requested a review of the case by the California Supreme Court.

Colorado: The Colorado Society of Anesthesiologists appealed the lower court's decision that state law doesn't require supervision. CSA is also arguing that Colorado's captain of the ship doctrine requires physician supervision.

Arizona: Governor Jan Brewer signed legislation that permits a CRNA to administer anesthetics under the direction of and in the presence of a physician or surgeon in connection with the preoperative, intraoperative, or postoperative care of a patient or as part of a procedure performed by a physician or surgeon. The bill clarifies that a CRNA's authority to administer anesthetics or issue a medication order does not constitute prescribing authority. Enacted.

South Carolina: The medical board ruled against the nursing board's approval to allow CRNAs to perform TEE procedures.

Virginia: Legislation was signed into law providing that nurse practitioners may only practice as part of a patient care team. CRNAs are classified as NPs in Virginia. A patient care team is defined as "a multidisciplinary team of health care providers actively functioning as a unit with the management and leadership of one or more patient care team physicians for the purpose of providing and delivering health care to a patient or group of patients." As part of the patient care team, nurse practitioners are required to maintain appropriate collaboration and consultation,

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Learning at the Lake

GSA 2012 Summer Meeting

July 20-22, 2012

The Ritz-Carlton Lodge, Reynolds Plantation
One Lake Oconee Trail, Greensboro, GA 30642

Jointly sponsored by...

American Society of Anesthesiologists

Georgia Society of Anesthesiologists, Inc.

Target Audience:

Physicians
Retired Physicians
Residents
Anesthesiologist Assistants (AA)
CRNAs
Medical Students
Business Managers

Activity Co-Directors:

Matthew Klopman, MD
Emory University

Lily Young, MD
Emory University

This CME activity is supported by educational grants. A complete list of supporters will be published in the course syllabus.

Activity Agenda/Schedule

Friday, July 20, 2012

3:00 – 7:00p	**Registration**
4:00 – 9:00p	**Exhibitor Set Up**
5:00 – 7:00p	**Board Meeting**
7:00 – 8:30p	**Welcome Hospitality with the Exhibitors – Exhibit Hall** Lifebox Fundraiser - hosted by GSA Resident Component
8:30p	**Dinner on your own with family and friends**

Saturday, July 21, 2012

6:00 a	**Exhibitor Set Up**
6:30 – 7:20a	**Registration/Breakfast with Exhibitors**
7:20 a	**Welcome** **Steven Walsh, MD - GSA President**
	Introductions **Matthew Klopman, MD & Lily Young, MD** **Summer Meeting Activity Co-Directors** **Emory University**
7:30-8:15 a	***Drug Shortages and their Impact on Anesthesiologists*** **Arnold Berry, MD** **American Society of Anesthesiologists,** **VP for Scientific Affairs** **Emory University, Professor of Anesthesiology** **Atlanta, GA**
8:15-9:00 a	***Ultrasound for Vascular Access*** **Gregg Hartman, MD** **Dartmouth Hitchcock Medical Center,** **Professor of Anesthesiology** **Vice-Chair and Clinical Director** **Lebanon, NH**
9:00-9:30 a	**Break with Exhibitors**
9:00-12:00 p	**Resident Section Meeting**
9:30-10:15 a	***Ultrasound for the General OR*** **Gregg Hartman, MD** **Dartmouth Hitchcock Medical Center** **Professor of Anesthesiology** **Vice-Chair and Clinical Director** **Lebanon, NH**
10:15a-11:00 p	***Obestric Anesthesia Update 2012*** **Caren Chaknis, MD** **Georgia Health Science University, Assistant Professor** **Augusta, GA**
11:00a-11:45 p	***Offsite Anesthesia and Sedation: Current Recommendations*** **Caren Chaknis, MD** **Georgia Health Science University, Assistant Professor** **Augusta, GA**
11:45a-12:30 p	***Ultrasound Guidance and Regional Anesthesia: An Overview*** **Heather Samady, MD** **Emory University, Assistant Professor** **Atlanta, GA**
12:30 p	**Meeting Adjourned/Lunch with family and friends**
1:00 p	***12th Annual GSA Golf Tournament (The Oconee Course)***
3:00-4:00 p	***9th Annual Family Ice Cream Social***
6:30-8:00 p	**Evening Reception**
7:30-9:00 p	***Faculty Dinner – Linger Longer***
9:30-11:30 p	***GSA Dessert Cruise*** **The Spirit of Oconee (pre-registration required)**

Sunday, July 22, 2012

6:30-7:30 a	**Registration/Breakfast with Exhibitors**
7:00-7:30 a	**General Business Meeting for GSA Members**
7:30-8:15 a	***Advances in Mechanical Ventilation*** **Christine Lallos, MD** **Piedmont Anesthesia Associates, Staff Anesthesiologist** **Atlanta, GA**
8:15-9:00 a	***Update on Continuous Peripheral Nerve Blocks*** **Heather Samady, MD** **Emory University, Assistant Professor** **Atlanta, GA**
9:00-9:30 a	**Break with Exhibitors**
9:30-10:15 a	***ASA Update*** **Jerry Cohen, MD** **American Society of Anesthesiologists, President** **University of Florida, Associate Professor of Anesthesiology, Gainesville, FL**
10:15-11:00 a	***The Joint Commission and Medication Management*** **Jerry Cohen, MD** **American Society of Anesthesiologists, President** **University of Florida, Associate Professor of Anesthesiology, Gainesville, FL**
11:00-11:45 a	***Contemporary Use of Lumbar Drains*** **Cinnamon Sullivan, MD** **Emory University, Assistant Professor of Anesthesiology** **Decatur, GA**
11:45-12:30 p	***Renal Injury: When does it really start and how soon must we act?*** **Christine Lallos, MD** **Piedmont Anesthesia Associates, Staff Anesthesiologist** **Atlanta, GA**
12:30 p	**Meeting Adjourned**

Faculty Disclosure/Resolution of conflicts of interest:
The American Society of Anesthesiologists and The Georgia Society of Anesthesiologists adhere to ACCME Essential Areas, Standards, and Policies regarding industry support of continuing medical education. Disclosure of the planning committee and faculty's commercial relationships will be made known at the activity. Speakers are required to openly disclose any limitations of data and/or any discussion of any off-label, experimental, or investigational uses of drugs or devices in their presentations.

In accordance with the ACCME Standards for Commercial Support of CME, the American Society of Anesthesiologists will implement mechanisms, prior to the planning and implementation of this CME activity, to identify and resolve conflicts of interest for all individuals in a position to control content of this CME activity.

Special Needs Statement:
The Georgia Society of Anesthesiologists is committed to making its activities accessible to all individuals. If you are in need of an accommodation, please do not hesitate to call and/or submit a description of your needs in writing in order to receive service.

Commercial Support Statement:
Cancellations and/or changes in registration or participation in all or any portion of the meeting must be received at GSA headquarters by Monday, January 16, 2012, to qualify for refund. Absolutely no refunds will be issued for changes received at GSA headquarters after Monday, January 16. The cancellation policy will be strictly enforced.

Accreditation Statement:
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of American Society of Anesthesiologists and The Georgia Society of Anesthesiologists. The American Society of Anesthesiologists is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation:
The American Society of Anesthesiologists designates this live activity for a maximum of 9 AMA PRA Category 1 Credit(s)TM. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

To Register... Contact Kristin Strickland, GSA Member Services Manager: 404-249-9178 x 6; kristin.strickland@politics.org

Educational & Learning Objectives

Arnold Berry, MD
American Society of Anesthesiologists, VP for Scientific Affairs
Emory University, Professor of Anesthesiology | Atlanta, GA

Drug Shortages and their Impact on Anesthesiologists
At the conclusion of the presentation, the learner will be able to:
- Describe the common causes of drug shortages
- Locate an updated list of current and expected drug shortages
- Develop a local protocol to obtain needed drugs as they become scarce
- Revise anesthetic plans when the local supply of a drug is exhausted

Caren Chaknis, MD
Georgia Health Science University, Assistant Professor | Augusta, GA

Obestric Anesthesia Update 2012
At the conclusion of the presentation, the learner will be able to:
- List common maternal coexisting diseases which affect maternal and fetal outcomes.
- Summarize the recommendations to prevent local anesthetic systemic toxicity (LAST)
- Debate the pros and cons of strict NPO versus light meals during labor

Offsite Anesthesia and Sedation: Current Recommendations
At the conclusion of the presentation, the learner will be able to:
- Describe commonly performed off-site procedures
- List contraindications to an off-site anesthetic
- Prepare an off-site location for an anesthetic
- Develop a local protocol for off-site anesthetics

Jerry Cohen, MD
American Society of Anesthesiologists, President
University of Florida, Associate Professor of Anesthesiology | Gainesville, FL

ASA Update
At the conclusion of the presentation, the learner will be able to:
- Describe the Affordable Care Act and healthcare finance reform issues facing Anesthesiologists
- Contrast current practice models with proposed practice models
- Explain the basis for limits on scope of practice
- Explain the FTC's involvement in States' ability to limit the practice of medicine to physicians

The Joint Commission and Medication Management
At the conclusion of the presentation, the learner will be able to:
- List the essential Joint Commission rules that apply to Anesthesia medication management
- Describe how TJC formulates policy
- List CMS requirements for Anesthesia practice and medication management
- Modify practice to comply with applicable rules and regulations
- Summarize important medication safety strategies beyond TJC guidelines
- Plan for a successful TJC survey

Cinnamon Sullivan, MD
Emory University Hospital, Assistant Professor | Atlanta, GA

Contemporary Use of Lumbar Drains
At the conclusion of the presentation, the learner will be able to:
- Describe the indications and contraindications for placement of a lumbar drain
- Discuss intraoperative management strategies of a lumbar drain
- Defend the need for gradual and limited CSF removal
- Explain the rationale for emergency postoperative lumbar drain placement

Gregg Hartman, MD
Dartmouth Hitchcock Medical Center, Professor of Anesthesiology
Vice-Chair and Clinical Director | Lebanon, NH

Ultrasound for Vascular Access
At the conclusion of the presentation, the learner will be able to:
- Describe the literature surrounding the use of surface ultrasound for central venous access
- Discuss the newest ASA and ASE guidelines on ultrasound for vascular access
- Differentiate venous from arterial structures using surface ultrasound
- Use an algorithm to confirm venous placement of a guide-wire prior to placement of a large bore catheter or introducer

Ultrasound for the General OR
At the conclusion of the presentation, the learner will be able to:
- Describe applications of TEE to general anesthetic practice
- Identify TEE scan planes and basic views
- Employ Doppler color flow analysis
- Integrate basic TEE information with available hemodynamic data to simplify the differential diagnosis and management of the hemodynamically unstable patient

Christine Lallos, MD
Piedmont Anesthesia Associates, Staff Anesthesiologist | Atlanta, GA

Advances in Mechanical Ventilation
At the conclusion of the presentation, the learner will be able to:
- List recently developed modes of mechanical ventilation
- Describe how each mode of ventilation differs from standard volume-control ventilation
- List advantages and indications for each mode of ventilation presented

Renal Injury: When does it really start and how soon must we act?
At the conclusion of the presentation, the learner will be able to:
- Describe the RIFLE criteria
- List patient factors that increase the risk of acute kidney injury
- Predict the risk of renal failure based on a patient's RIFLE classification
- Detect early signs of acute kidney injury
- Employ renal protective strategies when indicated
- Understand the mechanisms of perioperative acute renal failure
- Understand our role in the preoperative setting to minimize the risk of perioperative acute renal failure
- Determine if renal protective strategies really work.

Heather Samady, MD
Emory University, Assistant Professor | Atlanta, GA

Ultrasound Guidance and Regional Anesthesia: An Overview
At the conclusion of the presentation, the learner will be able to:
- Describe the impact of ultrasound guidance on the practice of regional anesthesia
- Differentiate nerves from surrounding structures using ultrasound
- Use ultrasound to identify major nerves including the brachial, lumbar, and sacral plexuses and the associated peripheral nerves
- Confirm adequate spread of local anesthetic with ultrasound

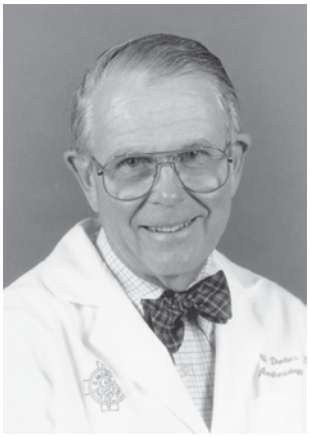
Update on Continuous Peripheral Never Blocks
At the conclusion of the presentation, the learner will be able to:
- Compare the different catheter insertion techniques with the use of ultrasound guidance
- Discuss management techniques and reimbursement issues in the inpatient and outpatient setting
- Manage complications that arise on insertion and post-operatively

Cancellation Policy:
Cancellations and/or changes in registration or participation in all or any portion of the meeting must be received at GSA headquarters by Monday, July 16, 2012, to qualify for refund. Absolutely no refunds will be issued for changes received at GSA headquarters after Monday, July 16. The cancellation policy will be strictly enforced.

To Register... Contact Kristin Strickland, GSA Member Services Manager: 404-249-9178 x 6; kristin.strickland@politics.org

Register at www.gsahq.org

In Memoriam: Dr. Ronald Ward Dunbar



Dr. Ronald Ward Dunbar, a former president of GSA, died Friday, April 27, 2012 at his home in Atlanta.

Dr. Dunbar was a very active member in the GSA. In 2001, he received the Crawford Long Award for meritorious services for his long-time work as the editor of the GSA newsletter. Dr. Dunbar also served as a Georgia delegate to the American Society of Anesthesiologists (ASA), where he was appointed to a number of important committees.

In addition to his work with GSA, Dr. Dunbar served as an examiner for ASA and editor of the scientific journal, Anesthesia and Analgesia. He spent 40 years at Emory University School of Medicine, serving in a variety of roles including a professor of anesthesia and chief of the anesthesia department at Emory Hospital. At the time of his death, he was an Emeritus Professor of Anesthesiology for Emory University School of Medicine.

Prior to his tenure at Emory, Dr. Dunbar received his undergraduate degree and medical degree from Northwestern University. He completed his residency in anesthesia at The Massachusetts General Hospital. Dr. Dunbar also served as a captain in the U.S. Army. He was stationed in Landstuhl, Germany for three years, before joining the faculty at the University of Kentucky Medical School.

Dr. Dunbar is survived by his wife Jane, son Steve, and daughters Debbie, Julie, Beth, and Kristin, their spouses, and 12 grandchildren. He was preceded in death by his son Mike in 1982.

In lieu of flowers, donations can be made to Lake Fire and Rescue in care of Mountain Patrol, 6 Fred Lane, Lakemont GA 30552.

Compiled from GSA files and www.ajc.com

GSA members lead AAAA

Claire Chandler, GSA Educational Affiliate member, has been named president of the American Academy of Anesthesiologist Assistants (AAAA). She succeeds another GSA member, Michael Nichols, 2011 AAAA president. The transition occurred in April.

"Being a GSA member is great preparation for serving as president of AAAA," said Nichols. "All politics are local, so having a strong local foundation prepares one to expand their focus on a national level."

Claire Chandler

Michael Nichols

Nichols says that GSA membership also helps A A s build stronger relationships with anesthesiologists.

"Just as AAs and anesthesiologists work side-by-side in the operating room, so too should they work in the halls of the state capitol," Nichols said.

Chandler said she hopes to strengthen relationships between AAs and anesthesiologists by promoting AA involvement in state societies.

"By joining the GSA, contributing to the GSA-PAC and being an active member, AAs can demonstrate the benefits of working as a team with anesthesiologists outside of the OR," Chandler said.

An educational member of the ASA since 2005 and a member of GSA since 2009, Chandler is an active GSA leader and devoted PAC contributor. Between 2009 and 2011, Chandler served as an ad hoc member on the ASA Committee on Communications. Currently, she serves as an ad hoc member of the ASA AA Education and Practice Committee. She attended the ASA legislative conference the past two years.

Chandler resides in Atlanta where she is an Anesthesiologist Assistant with the Department of Anesthesiology for Emory Healthcare. She also serves as a clinical instructor for AA students.

AAAA is the national organization dedicated to the ethical advancement of the Anesthesiologist Assistant profession and to excellence in patient care through education, advocacy and promotion of the Anesthesia Care Team.

Issues Elsewhere ...continued from page 7

as evidenced in a written or electronic practice agreement, with at least one patient care team physician. VSA was successful in retaining the current requirement that nurse anesthetists practice under the supervision of a physician, podiatrist, or dentist.

Interventional Pain Management

Missouri: HB 1399/SB 682 would prohibit non-physicians from practicing interventional pain management. The Federal Trade Commission (FTC) wrote a letter in opposition to HB 1399, writing that it may reduce patient access to pain management services and increase prices; however, the bill the FTC commented on is not moving-forward. This bill passed the Senate. ASA has assisted MSA's grassroots efforts.

Tennessee: HB 1896 would limit the performance of interventional pain management procedures by an APN or PA in unlicensed settings. Specifically, an APN or PA may only perform invasive procedures involving any portion of the spine, spinal cord, sympathetic nerves or block of major peripheral nerves under the direct supervision of a Tennessee physician who is actively practicing spinal injections and has current privileges to do so at a licensed facility. Direct supervision is defined as being physically present in the same building as the APN at the time the invasive procedure is performed. The FTC also submitted a comment letter in opposition to the Tennessee Legislature. Passed House and Senate.

Anesthesiologist Assistants:

Wisconsin: Enacted into law, S.B.383 provides licensure for anesthesiologist assistants. Since 1980, AAs in Wisconsin have been practicing under delegatory authority. The bill also created a Council on Anesthesiologist Assistants under the Medical Examining Board.

GSA sends 18 to Capitol Hill on practice, safety issues

From staff and member reports

GSA members joined hundreds of practicing and resident anesthesiologists in Washington, D.C., May 2-4, for the annual ASA Legislative Conference. Members created four teams to visit the Congressional offices of Georgia's 15 U.S. Representatives and Senators. Because Congress was not in session, GSA members were afforded the unusual luxury of quality time in educating health policy staffers on the issues impacting patient safety and quality outcomes in Georgia and nationally. Issues discussed include the following:

- Distinguishing the difference in the years of education and training for anesthesiologists vs. AAs and CRNAs.
- Highlighting the need for stronger laws (HR 451) regarding misrepresentation in medical fields, as nurses more frequently use the term "doctor" (nursing PhDs) and nursing students use the term "resident".
- Reviewing the drivers of Medicare growth (Imaging and Testing, Minor Procedures, etc) and showing the Congressional Budget Office's figures on Anesthesia services as below the sustainable growth rate target.
- Educating staffers on the need for Medicare Part A "Rural Pass-through" (HR 1044) for anesthesiologists due to the shortage of rural healthcare providers, as current regulation only allows for Part A payments to CRNAs and AAs.
- Reinforcing the need for an alternative to the Independent Payment Advisory Board (IPAB), as the model will not only increase costs but shift them to the private sector and limit Medicare patients' access to care.

For more information, search "key issues 2012" at www.asahq.org.

Amanda Brown, MD
"This past May, I did something unusual -- I went to Washington to talk politics. I would recommend this event to every anesthesiologist, but particularly for those who perceive Capitol Hill as far removed from the concerns of their individual practice.

I went to Washington to talk politics.

The initial workshop on state issues allowed us to discuss opt-out challenges and medical board challenges to the practice of medicine by non-physicians.The speakers highlighted that our specialty needs vigilance both at the state and federal levels, and attentiveness to regulatory bodies like the FTC, which has weighed in on practice issues purely for market competitiveness, patient safety notwithstanding.

Washington D.C. -- Dr. Amanda Brown of Macon sits under historic map of Georgia counties in U.S. Representative John Barrow's office. Dr. Brown and 16 other anesthesiologists and AAs visited all 15 Georgia Congressional Offices to meet with health policy staff.

The remainder of the conference served as a crash course on possible national legislative actions at hand. The invited speakers ranged the political spectrum, from Dr. Donald Berwick to Ilya Shapiro of the Cato Institute. The interplay between government programs, private industry and the fundamental problem of cost complicated all perspectives regardless of political vantage point. Sorting out particular legislative concerns from the intricacies of legislative sponsorship, committee membership and the competing positions of other interest groups added another layer of intricacy, but I commend the ASA team for tackling both national politics and operational politics in one day.

When we met with legislative aides, I found I didn't have much patience for why things aren't being done. But I certainly had some comments about the consequences of inactivity. Practicing hodge-podge medicine in the setting of drug shortages, and dealing with poorly managed patients transferred from rural pass-through hospitals provides compelling medical fodder. I would venture most anesthesiologists have a meaningful experience to share. The ASA conference enables that conversation and I encourage attendance in subsequent years."

Justin T. Drummond, MD
"After recently attending the ASA Legislative Conference in Washington D.C., it is clear that anesthesiologists nationwide are very active and working tirelessly to further the practice of Anesthesiology and protect our future. ASA members are making large strides.

As healthcare changes, ASA is working closely with legislators to provide not only insight into our practice, but also create an atmosphere of dialogue and improvement in the way we provide care.

After the experience at the ASA legislative conference, I am better informed and motivated by our great colleagues. I encourage everyone to continue to contact our legislators and contribute when possible to support the ASA and GSA-PAC. It is important to keep our momentum as the healthcare climate evolves."

ASA members are making large strides.

Marcus Lehman, MD
"The ASA Legislative conference created a wonderful opportunity for a resident like me to see the larger picture of anesthesiology as a practice in our healthcare system. Interacting with our specialty leaders and understanding the scope of the issues which I see in my daily work showed me the ways that I can actually affect change. For people like us, who are often so busy, realizing where our efforts are best spent is an invaluable bit of knowledge. I look forward to continuing to learn at the ASA Legislative Conference in 2013!"

demystify the process of proactive advocacy

Hailey Gillis Amick, MD
"I found ASA Legislative Conference quite the enriching experience indeed. The conference was well-organized, informative


Dr. Drummond


Dr. Lehman

and gave great insight into the current state of affairs in healthcare politics as well as the impact of all our efforts as the ASA in guiding these political currents. It was delightful to hear from the members of our specialty directly involved in this battle everyday as well as from all the individuals fighting for the ASA in Washington. This served as a wonderful opportunity to re-examine some of our key issues as a specialty. We took the opportunity to take them to the front steps of both the Congress and Senate which provided a unique opportunity to engage in advocacy for the specialty to which I am, for the most part, quite new but hold very dearly. I look forward to future experiences and opportunities to serve as an ambassador in our profession."

Gaurav Patel, MD

"Attending the ASA legislative conference in Washington, D.C., was a fantastic opportunity yet again. This was my third time attending the conference and being the ASA's voice on the Hill. As I prepare to graduate residency and enter as an attending anesthesiologist, the importance of healthcare advocacy on behalf of our specialty carried even more meaning. The conference highlighted the major hurdles our field faces, including drug shortages, empowering patients, improving access and reimbursement. I am truly at the beginning of my career, and the conference highlighted how necessary it is to become involved early. We are advocating not only for our specialty but for the patients and families we take care of on a daily basis.

We certainly have a rough road ahead for healthcare in general, but I continue to be encouraged and positively motivated by the hundreds of anesthesiologists that attended the conference."

Washington, D.C, -- (l-r) GSA President Dr. Steve Walsh, ASA Vice-Speaker Dr. Steve Sween, GSA Vice-President Dr. Kathy Stack, and GSA Resident Liaison Dr. Hailey Amick. The team visited four Congressional offices on May 2 to discuss federal health law and regulation.

Jay Johansen, MD

"This was my first time at the Legislative Conference and it brought home some important lessons. It helped to demystify the process of proactive advocacy at our nation's capital. Political action comes down to interpersonal interaction with our legislators. It also requires teamwork at the local, state and national levels. Our National and State societies are on the front-lines protecting our specialty on a daily basis. We saw this at the opening State Issues Forum on Monday evening. Our current, future and past issues are being played out in other states and on the national stage. The perspective is important and helps focus our local effort. It is frightening to see how easily we can lose our livelihood through legislative and regulatory process. It is also educational to see the national polices of other special interest groups that may or may not be aligned with anesthesiologists.

I will attend next year and encourage my fellow members to do so."

political battles are won at home

Claire Chandler

"I've learned that the most fundamental political battles are won at home. All politics are local, whether it starts there or not. We cannot predict what might fall into our legislative or regulatory laps any given session. But chaos runs down hill quickly so we must cultivate relationships, with each other and with our state and federal policymakers.

In my experience with AA attempts at legislation, and a point which is echoed at every ASA legislative conference, preparation and relationships are key to success.

Collaboration between Anesthesiologists and AAs on legislative initiatives, both locally or nationally, is a powerful combination. A team of physicians and non-physician providers fighting for the same cause is unusual and crosses standard party lines. It becomes a truly bipartisan effort. Democrats and Republicans must listen.

Let us work as a team in and out of the OR."

GSA Washington Legislative Conference Attendees

Scott Ballard, MD - Atlanta
Timothy Beeson, MD - Martinez
Arnold Berry, MD, MPH- Atlanta
Amanda Brown, MD - Macon
Claire Chandler, AA-C - Atlanta
Lee Davis, MD - Atlanta
Justin Drummond, MD - Atlanta
Scott Foster, MD - Alpharetta
Hailey Gillis, MD - Decatur
Mark Huffman, MD - Marietta
Jay Johansen, MD, PhD - Alpharetta
Marcus Lehman, MD - Atlanta
John Neeld, MD - Atlanta
Guarav Patel, MD - Atlanta
Kathy Stack, MD - Atlanta
Steve Sween, MD - Atlanta
Jet Toney - Loganville
Steve Walsh, MD - Roswell
Thomas West, MD - Lakemont

Drs. Stack, Johansen get 'media savvy'

GSA President-Elect Jay Johansen, MD, and Vice-President Kathy Stack, MD, participated in ASA's Leadership Spokesperson training in conjunction with the legislative conference. The media relations and presentation skills training is provided by the ASA to rising leaders in the state anesthesiology component societies.

"This is a great program organized by media specialists from our national office," Dr. Johansen said. "You get a brief overview of good and bad video interviews, followed by your own personal interview with a critical review by experts -- small group, great teachers. This program helped me understand the unique differences, challenges and opportunities that video interviews present."

Rising leaders in the state and local medical organizations benefit from the high quality training. "Graduates" of the three-hour sessions are more prepared to answer media inquiries and to discuss issues with state and federal policy makers.

Contact GSA headquarters to express interest in future training sessions.

Dr. Amick

Dr. Patel

Ms. Chandler

Guest

Obstructive Sleep Apnea: The Not-So-Silent Killer

Brian J. Thomas, JD
Senior Claims Attorney & Director of Risk Management
Preferred Physicians Medical

Editor's Note: It is the editorial policy of scope to include informational articles from vendors who are frequent exhibitors at GSA educational conferences.


Mr. Thomas

As the prevalence of obesity in the general population is rapidly increasing, so too is the incidence of obstructive sleep apnea. Anesthesiologists face significant challenges and risks when treating patients with diagnosed obstructive sleep apnea or patients who exhibit all the signs and symptoms of obstructive sleep apnea. Concurrent with the increase in obesity and obstructive sleep apnea, recent data reflect an increase in allegations of medical negligence involving obstructive sleep apnea patients. These cases often involve catastrophic brain damage or death. In light of the increased risks presented by obstructive sleep apnea patients, anesthesiologists frequently seek risk management advice for managing these challenging patients.

Obstructive Sleep Apnea Defined

Obstructive sleep apnea (OSA) is defined as upper airway collapse during sleep that may be accompanied by sleep disruption, hypoxemia and arterial oxygen desaturation. OSA is common in obese patients due to the propensity of fat deposition in the pharynx causing the upper airway to close. However, non-obese patients can have OSA from tonsillar hypertrophy or craniofacial abnormalities, especially in pediatric patients. OSA disrupts normal sleep patterns and results in arousal events that may lead to other symptoms including, but not limited to, hypertension, coronary artery disease, congestive heart failure, fatal arrhythmias, myocardial infarction, daytime somnolence, diabetes, and restrictive pulmonary disease.

Preoperative Assessment

Preoperative assessment of patients for potential identification of OSA includes: 1) medical record review, 2) patient and/or family interview, 3) physical examination, 4) sleep studies, and 5) preoperative x-rays for cephalometric measurement in selected cases. All obese patients, BMI > 30, undergoing surgery should be suspected of having OSA preoperatively. There are several screening tools and scoring systems available to assist anesthesiologists in evaluating whether a patient might have OSA. However, it should be noted these screening tools and scoring systems have not been clinically validated and should be used as a guide in evaluating patients for OSA. In the absence of a sleep study, a presumptive diagnosis of OSA may be made using the STOP-BANG scoring model (see Figure 1).

Other physical characteristics such as enlarged tonsils, prominent tonsillar pillars, enlarged nasal turbinates, narrowed maxilla or mandible, pronounced tongue and enlarged adenoids are often reflected by a high Mallampati score used by anesthesiologists to predict difficulty with intubation. A high Mallampati score, with anticipated intubation difficulty, should alert the anesthesiologist and perioperative team to the high potential for OSA.

Perioperative Management

Prescribing sedatives preoperatively may be problematic for OSA patients, as they

Figure 1

S	Snoring. Do you snore loudly - loudly than talking or loud enough to be heard through closed doors?
T	Tiredness. Do you often feel tired, fatigued or sleepy during daytime?
O	Observed apnea. Has anyone observed you stop breathing during our sleep?
P	Pressure. Do you have or are you being treated for high blood pressure?
B	BMI >35kg/m2
A	Age >50 years
N	Neck circumference >40cm
G	Gender - Male

High Risk of OSA ≥ 3 yes answers

Low Risk of OSA < 3 yes answers

are often sensitive to sedatives, especially if the OSA is untreated. Even minimal sedation can cause airway obstruction and ventilatory arrest. Therefore, many anesthesiologists do not give preoperative sedatives to patients with OSA, unless the patient can be carefully monitored.

The most serious perioperative complication is the loss of airway control after induction of general anesthesia. Because of reduced oxygen reserve due to decrease in lung volume in the morbidly obese patient, these patients cannot tolerate a lack of ventilation for appreciable periods before hypoxemia results. It is for that reason anesthesiologists should be prepared for a difficult intubation and have all of the necessary resources and equipment, including supraglottic devices, to follow the ASA difficult airway algorithm. It may also be prudent under certain circumstances to have an experienced surgeon available at the time of induction of general anesthesia in case tracheostomy becomes necessary. An alternative to general anesthesia for OSA patients is regional anesthesia (epidural, intravenous regional or peripheral nerve block).

Postoperative Care

The period of awakening from anesthesia can be problematic for patients with OSA. In patients who have undergone surgery for treatment of their OSA, the airway can be narrowed from swelling and inflammation. Also, the lingering sedative and ventilatory depressant effects of the anesthetic can pose difficulty. Perioperative vigilance should continue into the postoperative period. Some patients require postoperative intubation and mechanical ventilation until fully awake. A CPAP machine can be used in some patients postoperatively to reduce obstruction, especially if a patient has been on a CPAP preoperatively. For some patients, it may be prudent to admit them to an intermediate care or intensive care area postoperatively to facilitate close monitoring and airway support measures. Narcotics can precipitate or potentiate apnea that may result in ventilatory arrest. If narcotics are deemed necessary in the post-operative period, appropriate monitoring of oxygenation, ventilation and cardiac rhythm should be provided.

Summary

Patients with OSA present many challenges to anesthesiologists. Obese and morbidly obese patients are particularly prone to this sleep disorder. Anesthesiologists frequently elicit the symptoms and suspect OSA during examination of the airway and sleep history. Special care must be taken in the management of anesthetic induction, intubation and maintenance of these patients with particular attention to titration of neuromuscular relaxation and analgesic use. Perioperative and postoperative management should ideally include CPAP therapy for those patients with diagnosed OSA. Outpatient procedures must be approached with caution and should include clinical judgment and patient selection criteria based on the severity of OSA, presence of coexisting co-morbidities, invasiveness of surgery, type of anesthesia, anticipated postoperative opioid requirements, and adequacy of post-discharge observation. Anesthesiologists should make their own independent evaluation as to whether a patient is an appropriate candidate for anesthesia in an outpatient surgery facility and admit those patients who do not meet those criteria.

References:

1. Isono S. Obstructive Sleep Apnea of Obese Adults. Anesthesiology. 2009;110:908-21.

2. ASA Practice Guidelines for the Perioperative Management of Patients with Obstructive Sleep Apnea. Anesthesiology. 2006;104:1081-93.

3. Doyle JD. Obstructive Sleep Apnea And the Surgical Patient: What the Anesthesiologist Should Know. Anesthesiology News – Guide to Airway Management. Supplement. 2009.

4. Ogan OU, Plevak DJ. Anesthesia Safety Always an Issue with Obstructive Sleep Apnea. See, http://www.apsf.org/newsletters/html/1997/summer/sleepapnea.html.

5. Joshi GP. The Adult Patient with Morbid Obesity and/or Sleep Apnea Syndrome For Ambulatory Surgery. Presentation – American Society of Anesthesiology Annual Meeting, October 16, 2010.

6. Leone, BJ. Obstructive Sleep Apnea and Anesthesia. Revista Mexicana de Anestesiologia. Vol. 30, Suppl. 1, April-June 2007.

Risk Management Tips

Due to the high prevalence of undiagnosed OSA and OSH in the surgical patient population, anesthesiologists should be aware of the clinical presentation. If OSA is diagnosed or suspected, many guidelines and clinical recommendations include:

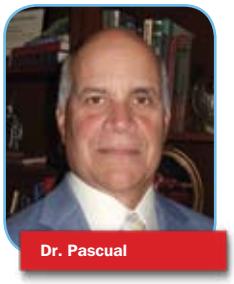
- Ask patient if a sleep study has been ordered, document if ordered and refused.
- Communicate the patient's OSA high risk status to the surgeon and recommend SpO2 with monitoring.
- Document the OSA conversation with the patient and surgeon on the anesthesia record.
- Notify PACU staff about patients with OSA high risk status.
- If formal diagnosis of OSA with CPAP, have patients bring CPAP machine and use postoperatively.
- Consider preoperative testing of arterial blood gases to document the severity of OSA and the baseline PaCO2.
- Airway issues – consider awake intubation, have alternate means to secure airway available, pay attention to positioning ("ramped" position may be indicated).
- Use lowest effective dose of opiate analgesics or sedating drugs and tailor analgesic doses with regional anesthesia, antagonists should be readily available.
- Administer opioids according to ideal body weight, NOT actual body weight.
- Monitor OSA patients a median of 3 hours longer than non-OSA patients and 7 hours after last episode of airway obstruction.
- Educate patients and caregivers about the risks of OSA and the need for caregivers to monitor patients more closely, have caregiver sign discharge instructions.
- If patient is admitted, orders and monitoring must be reviewed, use of CPAP should continue.

Fed OIG: 'company model' may be kick-back

From ASA and GSA staff reports


Dr. Stephenson


Dr. Walsh


Dr. Pascual

The Department of Health and Human Services Office of Inspector General (HHS-OIG) has issued a long-awaited Advisory Opinion (No. 12-06) on "company model" arrangements. The opinion expresses the view that the "company model" arrangements for providing anesthesia services in ambulatory surgical centers could violate the federal anti-kickback statute.

"This is a significant and timely response by the Inspector General," GSA President Dr. Steve Walsh said. "This creates bright line guidance for physicians who own and operate ASCs, especially endoscopy centers."

Under the "company model" referring physicians, who typically also own the facility where surgical procedures are performed, form a separate anesthesia company in order to share in anesthesia revenue.

ASA reports that the organization has repeatedly brought this issue to the attention of the HHS-OIG. In February, the ASA sent formal communication to Inspector General Daniel R. Levinson outlining ASA's concerns with the "company model."

GSA Practice Management Co-Chair Dr. John Stephenson said this finding should "stop much of this activity in its tracks." Dr. Stephenson also serves on the ASA Practice Management Committee which has advocated for federal enforcement for more than two years.

"The OIG advisory is a very positive development for Georgia anesthesia groups as they resist attempts by endoscopists to pressure them to enter into questionable arrangements," Stephenson said.

"This is a huge victory for Anesthesiologists because physicians are under the glare of the national health care debate. Physicians must conduct themselves beyond reproach to be part of the solution instead of part of the problem. The Company Model will give physicians a black eye when prosecutions begin."

- Dr. Pascual

The Advisory Opinion was issued in response to a request submitted by an anesthesia practice (the "Requestor") regarding two different proposed arrangements, both of which represent a departure from current practice between the Requestor and the Centers.

This creates bright line guidance

Under Proposed Arrangement A, the Requestor would begin paying the Centers a per-patient fee, excluding Federal healthcare program patients, for "Management Services" such as paying for space in the referring physician's facility and paying for the services of Center personnel to transfer billing documentation to the anesthesiologists' billing office.

Under Proposed Arrangement B, the physician-owners would establish anesthesia companies and engage the Requestor as an independent contractor to provide anesthesia services, paying the Requestor a negotiated rate.

The HHS-OIG concluded that both arrangements posed regulatory concern. With regard to Proposed Arrangement A, the OIG stated, "Based on the facts presented here, we think there is risk that the Requestor would be paying the Management Services fees with regarding to non-Federal health care program patients to induce the Centers' referral of all of its patients, including Federal health care program beneficiaries."

With regard to Proposed Arrangement B, the OIG concluded: "Based on the facts presented here, it appears that Proposed Arrangement B is designed to permit the Centers' physician-owners to do indirectly what they cannot do directly; that is, to receive compensation, in the form of a portion of the Requestor's anesthesia services revenues, in return for their referrals to the Requestor. This conclusion is consistent with, and supported by, the Requestor's representation that it is under competitive pressures to enter into the Proposed Arrangements to stem the loss of its business."

"Significantly, under the "company model" (Proposed Arrangement B), the safe harbors would not protect the distribution of profits to the referring physicians even though the regulatory "safe harbors" might protect the payments to the Requestor (the anesthesiologists)."

For a link to the OIG opinion and ASA letter, go to www.gsahq.org.

stop much of this activity in its tracks

States' Rights, Patient Safety and the FTC

By Michael McPherson
VP, Cornerstone Communications Group
GSA Lobbying Team Member


Mr. McPherson

U.S. Representative Tom Graves (R-GA 9) has asked the Federal Trade Commission (FTC) to cease interfering with individual state health care policy and regulations. In a letter to FTC Chairman Jonathan Leibowitz, Graves and four other Congressmen asked the FTC to stop intruding on "state regulation of the practice of medicine or dentistry and withdraw from the actions" already taken.

Because protecting patient safety is at the core of GSA's mission, the organization will continue to monitor FTC intrusion in state health care policy. Accordingly, GSA congratulates Rep. Graves and the other co-signers for recognizing the importance of states retaining the responsibility for licensing and regulating provider actions and scope of practice within state jurisdictions.

In the following paragraph, the letter spells out the jurisdiction of the FTC, and illustrates how state regulatory bodies do not fall under FTC oversight:

> …Congress explicitly limited the jurisdiction of the FTC to natural persons, partnerships, and corporations organized to facilitate business for their profit or that of their members. State health boards, by their definition, function, and purpose, do not fall into any of these categories or conditions, as they are agencies established by, and under the jurisdiction of, their state legislature. State legislatures determine the process by which individuals are appointed and/or selected to serve on the state boards. Thus, the ability of state boards to regulate the practice of medicine and dentistry is in accordance with the authority granted by state legislatures, which ultimately retain the right to oversee the policies, actions, and composition of state boards. We believe the FTC has exceeded its authority and with these actions has compromised the integrity and expertise of state established health regulatory boards.

Examples from Texas and North Carolina are used in the article to demonstrate where the FTC made suggestions about which providers may offer what services and/or filed complaints against the regulatory board. Similar FTC actions are mentioned as occurring in Alabama, Florida and Tennessee.

Where the letter defines the FTC intrusion into state regulation of medicine as threatening to health care providers, it suggests that the (FTC) actions "may very well compromise patient safety."

Congressman Graves and others offer the following in support of state legislatures and the creatures thereof:


Rep. Graves

> State health boards, established by state legislatures, are official agencies of the state entrusted to utilize their knowledge of health care and health regulation to ensure the protection of the public. The mission of state boards is unequivocally outside the realm of the FTC's expertise, and the FTC's intervention may very well compromise patient safety. Moreover, the authority of state boards is undeniably not a subject of FTC jurisdiction. If an issue arises with respect to the conduct of a particular state agency it is for the state to address, not the FTC. Without a clear Congressional directive to the contrary, which has not been afforded to the FTC, states through their agencies and otherwise have the constitutional autonomy to determine the policies that best protect the health and safety of state residents.

In many state legislatures, fights over scope of practice issues happen nearly every year. Physicians across the board have to constantly struggle with Medicare/Medicaid reimbursement rates set by state and federal agencies. To have a "Trade Commission" weigh in on the practice of medicine (as if healing the sick were a commodity!) is a little more than physicians should have to worry over.

GSA congratulates Rep. Graves

Yet, as the FTC is an arm of the executive branch, it is important to lend strength to the voice of those who champion the cause of patient safety. This is especially true in those states where -- without suggestion from the FTC – policy makers have chosen to go against the judgment of their physicians in search of cheaper service and more convenient access to providers.

> the (FTC) actions "may very well compromise patient safety"

At a minimum, the FTC intrusion should send shockwaves through houses of medicine across the states and inspire physicians to do their part to assure health care licensing, scope and policy remain a state responsibility.

Otherwise, the FTC actions may pave a road which meanders toward federal licensing of health care providers.

Mr. McPherson has seven years experience working in Georgia government. An Atlanta native, he was chief of staff for a ranking state senator and has run for the state House. At Cornerstone Communications Group, he lobbies for one of the state's largest local governments and other politically involved clients, including the GSA. A historian, Mr. McPherson represents the growing number of young professionals who bring intelligence, dignity, ethics and resourcefulness to the profession of public policy advocacy.

GSA Committees 2012

Volunteers conduct GSA mission

It is the mission of the Georgia Society of Anesthesiologists to associate and affiliate into one organization all physicians and others in Georgia who are engaged in the practice of, or otherwise especially interested in, anesthesiology and its subspecialties; to encourage specialization in this field; to raise the standards of the specialty; to safeguard the professional interests of its members; and in all ways to develop and further educate within the specialty of anesthesiology for the general elevation of the standards of medical practice and patient safety.

Like all successful professional organizations, GSA operates on the fuel of members committing time, talent and attention to conducting the Society's mission. Paramount to the continued success of the 900-member GSA is participation from members from throughout the state with appropriate staff support administering the daily tasks and communications.

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