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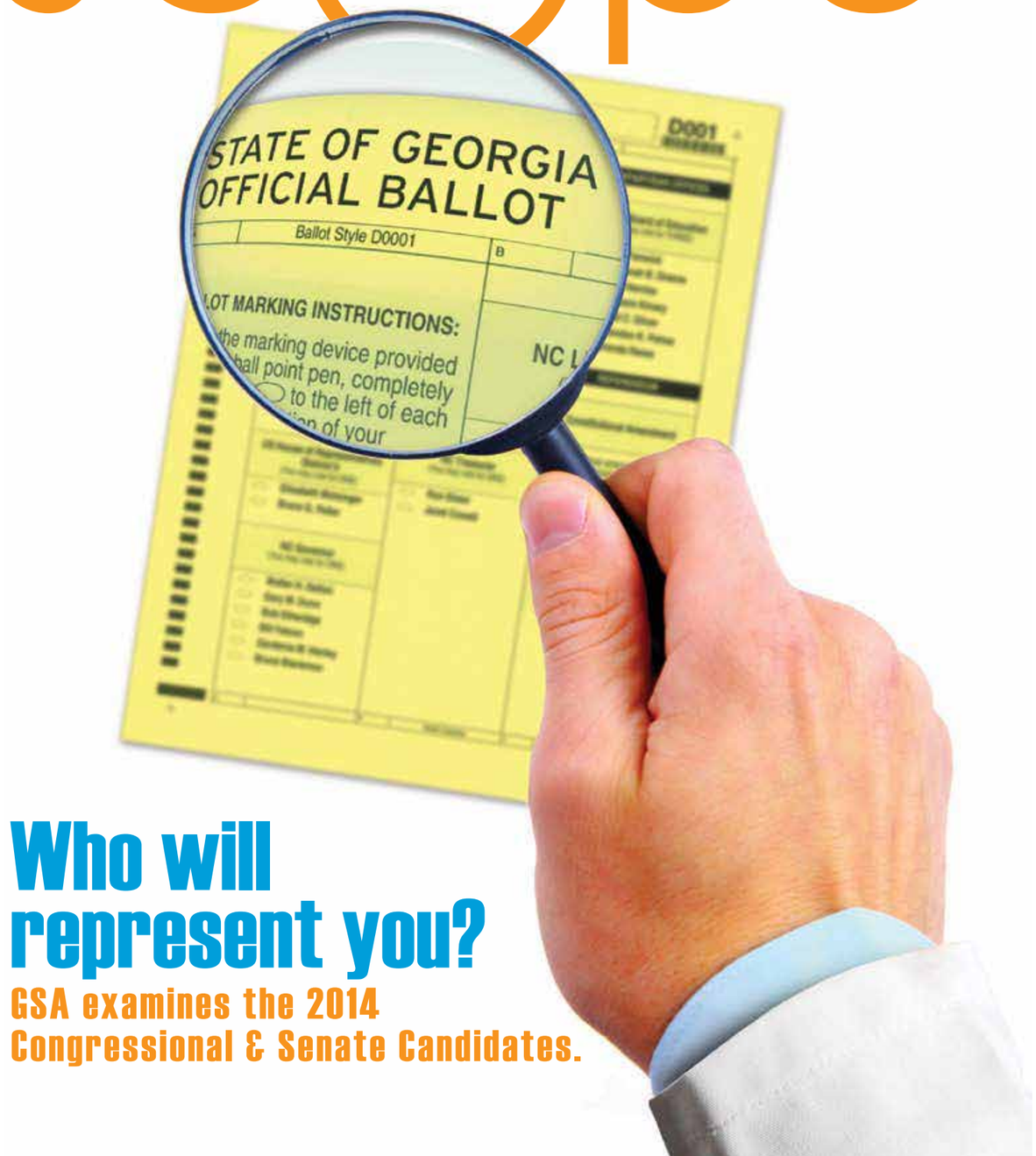
scope magazine



Who will represent you?

GSA examines the 2014 Congressional & Senate Candidates.

scOpe

scOpe is the quarterly magazine of the Georgia Society of Anesthesiologists, Inc. The print version is mailed to 900-plus members, exhibitors and advertisers. The digital version is posted in the members section at www.gsahq.org. scOpe is intended to inform members of contemporary issues and opportunities in anesthesiology, pain management, peri-operative care and patient safety. Opinions expressed in this publication do not necessarily reflect the official position of the Society or its leadership. Direct correspondence to:

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Editor's Corner

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Grateful, respectful, anxious

How John Neeld's "Winning the War" set a national course correction

In the spirit of the holidays, I wish to say that I am, of course, most grateful for my family and friends and the joy they bring. I am also incredibly grateful for the opportunity to practice anesthesiology in a city that I love with a talented group of physicians, AAs, and CRNAs whom I respect a great deal. I have no doubt that we have collectively made a measurable difference in the lives of many by working together in the care team model. We are all valuable members of the Anesthesia Care Team.

San Francisco -- Dr. John B. Neeld, Jr., MD, delivers his "Winning the War" Emery E. Rovenstine Lecture at the 2013 ASA annual Meeting. Several thousand physicians, AAs and staff attended this monumental presentation.

However, there is a storm brewing which should not be ignored. The forecaster: Dr. John B. Neeld, Jr., MD. The broadcast location: the 2013 ASA Annual Meeting in San Francisco, CA, October 14, 2013.

Our own John Neeld, chair emeritus of Northside Anesthesiology Associates and former President of the ASA, delivered the Emery A. Rovenstine Memorial Lecture to a packed, attentive house of several thousands. In his lecture, "Winning the War," Dr. Neeld outlined the bold efforts of the American Association of Nurse Anesthetists (AANA) and other organizations in state and federal legislative and regulatory arenas. They are working to undermine and dismantle the time-tested model of physician-led health care. He asserts that the only effective counter to these efforts is definitive proof of the value that anesthesiologists bring to patient care. In the era of evidence-based

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National practice news

Quality data impacts practice quality

Anesthesia Quality Institute

From AQI Staff Reports

Quality Management (QM) is an important function of all anesthesia practice. It is an individual clinicians' professional obligation to think about the patient care they provide and attempt to improve it.

On the practice level, assessing outcomes allows for identification of system problems that can be resolved by a change in policy or group practice. For example, measurement of the rate of postoperative nausea and vomiting (PONV) in the post anesthesia care unit (PACU) can identify patient populations at higher risk. A policy of providing prophylaxis in the operating room (OR) for these patients can reduce the overall rate of PONV.

On the national level, aggregation of data on rare complications (e.g. postoperative visual loss) can lead to appreciation of problems too rare to be studied at the local level. Once identified as a recurring problem, detailed review of cases can suggest common features and targets for improvement.

AQI is currently the only anesthesia registry in the country.

This kind of national quality management, based only on clinical anecdotes, can nonetheless have substantial positive effects on anesthesia practice. This principle is illustrated by the case series published by the Anesthesia Closed Claim Project (CCP) in the scientific literature and by the individual case vignettes from the Anesthesia Incident Reporting System (AIRS) which appear each month in the American Society of Anesthesiologists (ASA) Newsletter.

Important for meeting federal regulatory requirements and the demands of non-federal payers.

The Anesthesia Quality Institute (AQI) is dedicated to continuously improving the quality of care in anesthesia. Through these efforts a number of programs have been developed by AQI to promote the needed change in the quality of care for patients of anesthesia.

Through the need for improvement in Anesthesia Quality Management, AQI was created in 2008 as a non-profit subsidiary of the ASA for the purpose of 1) organizing the quality management, patient safety, and comparative effectiveness efforts of the society, and 2) creating a national registry of anesthesia cases and outcomes.

This kind of national quality management... can have substantial positive effects on anesthesia practice.

As AQI is currently the only anesthesia registry in the country, using AQI allows the practice to improve the patient's quality of care, lower anesthesia mortality rates, and lower anesthesia incidents.

Currently just short of 9,000 anesthesiologists participate in NACOR, or 20-25 % of clinically active anesthesiologists nationwide. This number continues to grow as more practices and facilities recognize the need for registry data and external benchmarks. In addition to providing a measuring stick for judging and improving the quality of patient care, registry participation will be increasingly important for meeting federal regulatory requirements and the demands of non-federal payers.

The Center for Medicare and Medicaid Services (CMS) has released draft rules for public comment on the definition and certification of Qualified Clinical Data Registries (QCDRs), as a mechanism for meeting incentive requirements for Meaningful Use of Healthcare Technology, hospital Pay for Performance, and individual provider participation in the Physician Quality Reporting System. Similar language has appeared in several other federal writings in the past six months, including proposals for new healthcare payment models contained in the draft House legislation repealing the Sustainable Growth Rate formula. It is clear that registry participation is a desired outcome of healthcare reform. While intrusive, this is sensible as a counterbalance for new models of payment that incentivize cost effectiveness. Transparent national outcome reporting is essential to assure the public that physicians and hospitals are not skimping on necessary and indicated care.

While CCP and AIRS are positive examples for our specialty, one of the largest national gaps in anesthesiology is the generation and reporting of systematic data on adverse outcomes from every case, every day. An estimate from the 275 groups participating in the National Anesthesia Outcomes Registry (NACOR) is that no more than half have a system for collecting this kind of data, while fewer than 25% are able to report clinical outcomes to NACOR on a routine basis. This number has been increasing lately, and will soon reach a critical mass where true national benchmarking of adverse outcomes is a possibility.

The National Anesthesia Clinical Outcomes Registry (NACOR) was launched on January 1, 2010 with six early adopting practices. Data is now available to support academic and health policy research by physician scientists in any AQI-participating practice. NACOR now includes over 11 million cases from 151 fully-contributing groups. NACOR includes data from almost 9,000 anesthesiologists, or about 25 % of the active practitioners in the U.S.

AQI released the Participant User File (PUF) in early 2013: an aggregated, de-identified, cleaned version of selected NACOR data fields. This data is already being studied by more than a dozen investigators, and several papers are in the works which will provide us a new and comprehensive understanding of the nature of anesthesiology in the United States. The AQI is using this information internally to provide high-level dashboards of summary data for ASA and state-society leaders, anesthesia subspecialty societies, and important ASA committees. Information and instructions for accessing AQI data can be found on the AQI website http://aqihq.org/puf_inquiry.aspx.

While intrusive, this is sensible as a counter balance for new models of payment that incentivize cost effectiveness.

AIRS: The Anesthesia Incident Reporting System is growing. Currently we have more than 800 serious adverse events, unsafe conditions, and near misses. We are seeking ideas for how to get more providers to contribute incidents. AIRS currently has submitted 25 written items for the ASA Newsletter highlighting opportunities to improve care. A mobile app for reporting these events is currently in the works and is set to be released by mid-October. These written articles can be found on http://aqihq.org/articles.aspx.

AQI continues to add educational materials to our website, based on requests from participating practices and collaborating IT vendors. We have launched half a dozen 'dashboards' to provide continuous national aggregate data ASA officers, selected committees and subspecialty societies.

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Practice alert

Anesthesia in the news

By Judy Semo
Judith Jurin Semo, PLLC©
Washington, DC

Change is the one constant in the current anesthesia market and the health care community in general. This article provides an overview of several recent developments that may be, or should be, of interest to anesthesiologists.

1. "Company Model" Developments.

a. New Helpful OIG Advisory Opinion. On November 12, 2013, the Department of Health and Human Services, Office of Inspector General ("OIG") posted an advisory opinion, No. 13-15, available at http://oig.hhs.gov/fraud/docs/advisoryopinions/2013/AdvOpn13-15.pdf, which should assist anesthesia practices to resist efforts by hospitals to require anesthesia groups with exclusive contracts to agree to carve-outs to allow referring physicians to benefit from their referrals by having their own anesthesia arrangements and retaining a portion of the anesthesia revenue.

The OIG had much the same concerns in No. 13-15 as it had in its 2012 advisory opinion (No. 12-06) regarding a company model arrangement. Specifically, the OIG commented in the new advisory opinion that: "The Proposed Arrangement appears to be designed to permit the Psychiatry Group [the referring physician practice] to do indirectly what it cannot do directly; that is, to receive compensation, in the form of a portion of Requestor's anesthesia services revenues, in return for the Psychiatry Group's referrals of ECT patients to Requestor for anesthesia services."

Unlike Advisory Opinion 12-06, the new advisory opinion involves a hospital that forced its longtime exclusive anesthesia group (the "Requestor") to agree to a carve-out to its otherwise exclusive contract. Initially, in 2011, shortly after a psychiatry group relocated to the hospital, the hospital insisted upon a provision allowing one of the psychiatry group members, a psychiatrist (who also was Board-certified in anesthesiology), to provide anesthesia services to ECT patients, and requiring the anesthesia group to provide up to six weeks of coverage for the psychiatrist. In negotiating the next contract in 2012, the hospital negotiated for inclusion of an "Additional Anesthesiologist Provision" under which the anesthesia group would negotiate with the Psychiatry Group if that group or the hospital thought an additional anesthesiologist was needed to provide anesthesia for ECTs. If the parties could not reach agreement for the anesthesia group to provide such services, the Psychiatry Group could make its own arrangements, so long as the last offer from the Psychiatry Group was at a fair market value rate.

The Psychiatry Group then asked the anesthesia group to provide additional part-time coverage under an arrangement in which the anesthesia group would reassign its right to bill for the services its anesthesiologists would provide. The Psychiatry Group would bill and collect for those services and, in turn, would pay the anesthesia group a fixed, per diem rate for the anesthesiologists' service, and would retain the difference between the amount collected and the per diem rate. The anesthesia group contended that the amount was below fair market value and below what it would receive if it billed for the services directly.

The OIG commented that the proposed per diem payments would not qualify for protection under the safe harbor for personal services and management contracts for several reasons, including (1) the aggregate compensation to be paid over the term of the agreement would not be set out in advance and (2) according to the anesthesia group, would not be consistent with fair market value. The OIG further noted that the safe harbor protects only those payments made by a principal (here, the Psychiatry Group) to an agent (here, the anesthesia group), and that "no safe harbor would protect the remuneration Requestor would provide to the Psychiatry Group."

The OIG concluded:

The Proposed Arrangement therefore presents the significant risk that the remuneration Requestor would provide to the Psychiatry Group—i.e., the opportunity to generate a fee equal to the difference between the amounts the Psychiatry Group would bill and collect for Requestor's anesthesia services, and the per diem amounts the Psychiatry Group would pay to Requestor—would be in return for the Psychiatry Group's anesthesia referrals to Requestor. We discern no safeguards in the Proposed Arrangement that would minimize this risk. Therefore, for the combination of reasons stated herein, we cannot conclude that the Proposed Arrangement would pose no more than a minimal risk of fraud and abuse under the anti-kickback statute.

Significantly, the OIG went beyond the scope of the advisory opinion request and expressed separate concern with respect to both (a) the hospital's relationship with the Psychiatry Group, to the extent that the hospital was providing the Psychiatry Group with a benefit in exchange for the Psychiatry Group's referrals; and (b) the hospital's relationship with the anesthesia group, to the extent the anesthesia group agreed to the Additional Anesthesiologist Provision in exchange for access to the other referrals from the hospital.

Exclusive contracts with hospitals are quite common. Not only does the new OIG advisory opinion point to the risks involved in arrangements in which referring physicians are able to retain anesthesia revenue. It also points to the regulatory risks in structuring exclusive arrangements with hospitals, particularly if a hospital seeks concessions from the anesthesia group that serve to benefit a referring physician or referring physician practice.

b. Pilot Program. In November 2013, the ASA Committee on Practice Management launched a three-month pilot program to solicit information on proposed "company model" arrangements. For purposes of this article, the term "company model" is being used to describe those arrangements in which referring physicians require anesthesiologists to enter into contractual or employment arrangements that result in the transfer of some portion of anesthesia fees to referring physicians, which may violate federal and state laws. The purpose of the pilot program is to gather information about current types of such arrangements.

c. Survey. ASA conducted a survey in June 2013 of ASA members regarding their experience with company model arrangements. An article summarizing the results of the survey will appear in the December 2013 issue of The ASA Newsletter.

2. Anesthesia Billing Under Scrutiny. Billing for anesthesia services continues to come under scrutiny.

a. Whistleblower ("Qui Tam") Action. In September 2013, a U.S. District Court unsealed a complaint first filed in January 2011 that alleges that Vanderbilt University Medical Center ("VUMC") routinely improperly billed for anesthesia and other services. The suit was filed under seal by three former VUMC anesthesiologists on behalf of the federal government, 21 states, and the District of Columbia. The False Claims Act allegations include claims that "[s]ince at least 2003, Vanderbilt has routinely submitted and continues to submit false claims for "medically directed" anesthesia services even though it knows that those services do not meet the criteria for medical direction nearly 100% of the time."

The complaint further alleges that "Vanderbilt designed, created, and maintains electronic billing and record keeping systems which provide template treatment records to support Vanderbilt's false billing practices. For example, to document anesthesia services, Vanderbilt's software provides physicians with only one choice for describing the level of treatment: "medically directed." The software does not permit physicians to select an alternative, lower paying level of service, such as "medical supervision," even though Vanderbilt's treatment of patients almost never meets all of the necessary criteria for medical direction."

Although the case is in an early stage and no decision has been issued, the allegations in the case serve as a reminder of:

1. The complicated nature of anesthesia billing;
2. The need to comply with the rules when billing for medical direction;
3. The need to document compliance with medical direction;
4. The need to assess carefully immediate availability issues;
5. The need to address billing compliance concerns that employees raise; and
6. The need to consider whether an electronic health record is accurately documenting the services being provided.

Qui tam plaintiffs (known as "relators") have substantial incentive to file False Claims Act actions on behalf of the government: If the lawsuit is successful and subject to certain exceptions, they stand to receive between 15 to 30 percent of the award, in addition to attorney's fees, depending upon such factors as whether or not the government chooses to intervene.

Those wishing to read the 71-page complaint may find it at http://posting.nashvillescene.com/images/blogimages/2013/09/12/1379039349-vumcbilling.pdf.

b. The OIG Focus on Anesthesia Billing. Although it is not a new development, anesthesiologists should be aware that the OIG 2013 work plan identifies personally performed anesthesia services as a target area of review. See http://oig.hhs.gov/reports-and-publications/archives/workplan/2013/Work-Plan-2013.pdf, at p. 21).

c. OIG Podcast on Anesthesia Services. On May 8, 2013, the OIG posted a podcast on "Anesthesia Service Payments," which is available at https://oig.hhs.gov/newsroom/podcasts/reports.asp. The transcript is available at https://oig.hhs.gov/newsroom/podcasts/2013/anesthesia-trans.asp. The podcast points to the need to assess carefully how "immediate availability" is defined and to document all elements of the anesthesia services provided.

The podcast describes the investigation of the UC Irvine case and how the auditors investigated the claims by going on-site to the hospital and looking at the distances involved. The following excerpt from the transcript points to immediate availability issues, not properly listing the service involved (personal performance vs. medical direction or medical supervision), and insufficient documentation to support the services billed:

After reviewing selected numbers of Medicare and Medicaid claims, we found that anesthesiologists oversaw multiple procedures, in different buildings or on different floors, where they were not immediately available. Anesthesiologists also incorrectly billed Medicare and Medicaid, indicating that they had personally performed the services instead of supervising, or medically directing, the services. And finally, there was insufficient documentation to support the services. For example, we found cases where there were missing physician initials on the anesthesia records, or no post-operation records at all.

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Data... Continued from Page 3

AQI is also participating in a pair of new quality initiatives by ASA. One is the inaugural Anesthesia Quality Management meeting scheduled for November 2013 in greater Chicago. This weekend course is intended for anesthesia department quality management officers and is designed to teach the basics of quality management in an anesthesia practice. More information can be found on the ASA website at http://education.asahq.org/qm2013.

AQI released the Participant User File (PUF) in early 2013: an aggregated, de-identified, cleaned version of selected NACOR data fields.

A second initiative is in development with ASA's Quality Management and Departmental Administration (QMDA) Committee of a 'Quality Consultation' program intended to provide high-functioning anesthesia practices with overall national benchmarking of their efforts, documentation of clinical performance, and suggestions for further improvement. The consultation is based on a review of practice structure, NACOR data, personal interviews, and a one-day site visit by a team of practicing and experienced anesthesiologists. To receive more information on quality consultations contact Dr. Richard Dutton M.D., M.B.A. at R.Dutton@asahq.org

For more information on AQI go to www.aqihq.com or contact AQI's communications associate Ashley Jones at A.Jones@asahq.org

Meet the Candidates
U.S. Senate

Congressman Jack Kingston

Congressman, Former State Representative and Insurance Broker
Candidate for
U.S. Senate (R)
Savannah, GA

Jack Kingston is United State Representative for the First Congressional District and serves as Chairman of the House Labor-Health and Human Services-Education Appropriations Subcommittee that oversees funding for federal health care programs. In this role he works to advance reforms that make government more accountable, effective, and efficient. He is a leader in the fight to repeal and replace Obamacare with reforms that empower patients and doctors over bureaucrats.

Question 1 Response
The relationship between a patient and his or her doctor is a crucial one in directing health care decisions. Physicians not only know the patient and family history but also are able to develop a personal relationship with patients enabling them to better discuss sensitive health concerns.

Question 2 Response
Any steps intended to reduce health care costs must be undertaken in a manner that ensures the highest quality and safety in patient care. Rather than adopt a one-size-fits-all approach, I believe rules governing practice restrictions should be made by states.

Question 3 Response
America leads the world in medical research because of the great synergy created between private enterprise and research institutions such as hospitals and universities. Federal health care policy should support continued innovation to increase safety and bring down costs.

Question 4 Response
Health care reform should increase access and bring down costs. Unfortunately Obamacare has done just the opposite and must be repealed and replaced. I have cosponsored the American Health Care Reform Act that expands insurance options, eliminates billions in new taxes, makes health care expenses tax deductible, and expands access to Health Savings Accounts.

Question 5 Response
Health decisions should be made between the physician and patient. Physician anesthesiologists should be available to a patient if needed to comprehensively address their specific health condition and safely complete the procedure. The federal government should not ration or limit care through a top-down approach to healthcare management.

Question 6 Response
Obamacare is currently the biggest threat to physician led care because it empowers unelected and unaccountable bureaucrats over patients and doctors. I have led the charge to defund, repeal, and replace this disastrous law.

Steen Miles

Former State Senator
Retired News Reporter
Candidate for
U.S. Senate (D)

Steen "Newslady" Miles is a veteran journalist, who currently writes a weekly column for The Champion Newspaper DeKalb County. Also a former state senator, Steen has authored or co-authored many significant pieces of legislation including Georgia's anti-smoking law and stricter requirements for young drivers.

Question 1 Response
Most patients believe physicians should be leaders of patient care teams; I agree. Although we are trending toward team approaches in health delivery, it is imperative that a person with the necessary training, experience and specialty lead the team. I believe that person in the primary role should be the physician.

Question 2 Response
The circumstances in which someone other than a physician should lead patient care is by designation of the physician and in non-acute, chronic or serious medical conditions.

Question 3 Response
Absolutely there is a correlation between physician-led health care, patient safety and medical research. Proper diagnoses and patient treatment plans are essential to patient safety along with knowledge of clinical trials and other information that is properly in the hands of trained, skilled physicians.

Question 4 Response
While in favor of nurse practitioners and others being able to do routine examinations, diagnostic tests and dispense medications, I would oppose any legislation offered to diminish the roles of physicians as the primary leaders of the patient care team.

Question 5 Response
It is critical that trained physician anesthesiologists be available to all patients who undergo surgery. The physician anesthesiologist is a specialist in proper levels of anesthesia and monitoring which is crucial to patient safety. A physician anesthesiologist is in a peer position to the surgeon, not an assistant.

Question 6 Response
My biggest concerns are the physician shortage and growing trend toward health retail clinics. These clinics should be limited to routine vaccinations and physical examinations. Acute, chronic and serious health concerns require a primary physician. Legislation should limit health services at retail clinics. We should also consider legislation to incentivize students to become physicians.

Congressman Paul Broun, MD

Congressman, Physician,
Candidate for
U.S. Senate (R)
Athens, GA

After graduating from the University of Georgia and the Medical College of Georgia, Broun devoted four decades to medicine. Dr. Broun is passionate about the medical profession and enjoys helping patients. Since his election to Congress, Dr. Broun continues to practice medicine as a medical officer in the U.S. Navy Reserves. Dr. Broun is a strong constitutional conservative. He sponsored more legislation to reduce federal spending than any other member of Congress.

Question 1 Response
Physicians should remain leaders in care. Obamacare threatens this relationship, putting government in charge of care. Mandates and incentives allow non-physician practitioners to provide front line care. I have led efforts to replace Obamacare with solutions like my Patient OPTION Act.

Question 2 Response
In no situation should someone other than a physician lead in delivering patient centered care. Physicians are trained in this capacity and it is their job to be leaders in healthcare, not the job of government or non-physician providers.

Question 3 Response
Absolutely. When physicians are the first line of care, they are better able to get to know their patients, monitor health, and respond to concerns. Putting government in the middle would interfere. Physician-led health allows doctors to drive medical research by sharing experience and best practices, leading to better outcomes.

Question 4 Response
We must do everything we can to stop Obamacare. It will push government to the forefront of patient care. It is also vitally important that physicians retain the sole ability to prescribe pharmaceutical products to patients and that patients are clearly informed on the level of care they are receiving from a provider.

Question 5 Response
We must ensure patients are given anesthesia by, or under close supervision by, only the most qualified individuals – physician anesthesiologists. I have supported that patient safety-centered care arrangement. I also worked to oppose Medicare coverage of nurse anesthetists providing interventional pain services.

Question 6 Response
Obamacare is the greatest threat to physican-led care. I'm leading efforts to replace it with solutions like the Patient OPTION Act. I also worry about Medicare payment cuts under the Sustainable Growth Rate (SGR) formula. I've signed a letter asking for repeal of SGR. Finally, I am concerned by drug shortages. Read more at www.paulbroun.com.

What we asked...

Note: GSA staff contacted all Congressional and Senate candidates who had announced as of October 1, 2013. Those not listed did not respond. Some responses edited by GSA staff for length.

Question 1 - Throughout U.S. history, physicians have been at the helm of patient health diagnosis, prescribing and care. Do you believe that a physician should continue to be the leader of a patient care team? Why or why not?

Question 2 - In what circumstances, if any, do you believe that someone other than a physician should lead patient care?

Question 3 - Do you believe that there is a correlation between physician-led health care and patient safety and medical research? Please explain.

Question 4 - If you support the role of physicians as the highly-trained and experienced leaders of the patient care team, how do you propose to ensure physicians remain at the forefront of patient care?

Question 5 - Should a physician anesthesiologist be available to every patient who undergoes surgery? Why or why not?

Question 6 - What do you believe to be the biggest threats to physician-led healthcare and how do you propose to address those threats?

David Perdue

Businessman
Candidate for
U.S. Senate (R)
Atlanta, GA

David Perdue is the former CEO of Dollar General and Reebok. With 40 years of business experience, he is uniquely qualified to help solve our nation's two critical problems: the national debt crisis and a stagnant economy. David has a firsthand understanding of the global economy from working in Europe, Asia, and throughout the United States, but the son of two educators has always relied on the values he learned growing up in Warner Robins.

Question 1 Response
Absolutely. In business, I quickly learned to rely on the knowledge experts in a particular field to guide important decisions. That is particularly true in health care where the stakes are so high. Unfortunately, federal government intervention and over-regulation is harming the nature of the physician-patient relationship.

Question 2 Response
There may conceivably be areas where patients choose someone other than a physician to lead their care. Even so, that would be the individual's personal decision, which is between the patient, their family, and the providers. It is not a decision that government should inject itself into either way.

Question 3 Response
Yes. Physicians are constantly under the microscope of either peer review or tort liability. The level of self-imposed and external scrutiny on physicians is extraordinary. That environment creates a direct correlation to enhanced patient care and medical research.

Question 4 Response
Obviously, we should reduce burdensome federal regulations that increase the cost of medical care and distract physicians from direct patient care. Also, we can help medical schools meet the increasing demand for physician care. This will ease efforts to dilute the physician's role due to a shortage in the field.

Question 5 Response
Questions like that should not be for the federal government to decide or dictate. The problem we've had is that too many politicians think their years in Washington equal a medical degree. It doesn't, and I recognize that decisions about the availability of anesthesiologists are best left to medical professionals.

Question 6 Response
Without a doubt, Obamacare is the biggest threat to the American health system. Political pressure has led to waivers and delayed implementation. Hopefully, Obamacare will become completely unviable and we can fully repeal it. Then we can focus on real reforms like reducing, not multiplying, regulatory burdens imposed on physicians.

Branko Radulovacki, MD

Psychiatrist, Candidate for
U.S. Senate (D)
Atlanta, GA

A first-generation immigrant, Branko Radulovacki (who goes by Dr. Rad) says he has lived the American dream. He earned an MBA and an MD with honors, then completed his psychiatry residency at Yale. His professional peers have repeatedly voted him a "Top Doc" -- both locally and nationally. Dr. Radulovacki states that his education and experience in finance, healthcare, business, and nonprofit/advocacy work prepare him well to tackle our nation's most pressing problems as a member of the U.S.Senate.

Question 1 Response
As a physician, I absolutely believe that a physician should be the leader of a patient care team. The training that physicians undergo, from both academic and clinic standpoints, is foundational. It provides a breadth of experience that is invaluable in providing the best possible patient care.

Question 2 Response
I believe someone other than a physician can and should lead patient care when a physician isn't available. For example, when paramedics arrive at an accident scene, or when a school nurse assesses a child's injury.

Question 3 Response
The better-educated and clinically-experienced the physician, the more likely a patient is to be safe -- and medical research to be executed successfully and appropriately.

Question 4 Response
There will always be pressure from insurers (and even patients) to reduce costs, and the temptation will be to cut the most expensive person on the team. That is short-sighted. I will be a strong voice for the importance and value of physician-led patient care.

Question 5 Response
Yes! Any patient who is going to be under anesthesia deserves to understand fully the risks involved and the action plan should something go wrong. And certainly, in the OR, patients deserve to have an expert on-hand to insure all goes well.

Question 6 Response
The biggest threats are insurers taking decision-making power away from physicians, and short-sighted cost containment. I intend to do all I can to return healthcare to a patient-doctor relationship with minimal intrusion by outside influences.

Eugene Yu

Businessman
Former Police Officer
Army Veteran
Candidate for
U.S. Senate (R)
Evans, GA

Eugene Yu immigrated to American at age 14. He served as an MP in the US Army and as a first responder in Richmond County. He is an entrepreneur who founded Continental Military Services, a business that has created thousands of jobs. Eugene's father moved his family to America with the dream of a better life, and he knows we can reclaim this dream with true leadership and a return to the values that made America great.

Question 1 Response
Yes, physicians should be the leaders of the patient care team. Although there are many important healthcare professionals involved in the care of the whole patient, decisions are best made between the physician, the patient and the patient's loved ones. We must keep government out of these decisions and allow physicians to be the drivers of patient care.

Question 2 Response
I cannot think of any reason or any time it would be appropriate for someone outside the patient and the physician, to lead patient care. After the patient and the physician have chosen a path, the medical decisions to achieve the best possible outcome should be directed by the physician and supported by the patient care team.

Question 3 Response
Yes. In your profession alone, complications due to anesthesia have plummeted over the past half century while deaths have dropped dramatically as well. This is no doubt a direct result of the research, education and advocacy of organizations such as yours that work to keep the patient squarely in the center.

Question 4 Response
We must solicit input from physicians to find ways to work together to ensure that healthcare is both cost effective and patient-centered. We can find ways to replace the stifling regulations of the Affordable Care Act and replace it with sensible, market based reforms that expand and improve coverage while allowing patients and their physicians to remain in charge of their health care.

Question 5 Response
I am not a healthcare professional, but I do believe that, when deemed medically appropriate by a patient's physician, a physician anesthesiologists should be an option for all patients undergoing surgery.

Question 6 Response
Other than the Affordable Care Act, the biggest threat to physician-led healthcare is our culture of litigation. We need serious tort reform, including medical malpractice reform, to rein in costs and let physicians do their jobs without the constant fear of lawsuits.

Meet the Candidates
U.S. Congress District 1-9

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Question 1 - Throughout U.S. history, physicians have been at the helm of patient health diagnosis, prescribing and care. Do you believe that a physician should continue to be the leader of a patient care team? Why or why not?

Question 2 - In what circumstances, if any, do you believe that someone other than a physician should lead patient care?

Question 3 - Do you believe that there is a correlation between physician-led health care and patient safety and medical research? Please explain.

Question 4 - If you support the role of physicians as the highly-trained and experienced leaders of the patient care team, how do you propose to ensure physicians remain at the forefront of patient care?

Question 5 - Should a physician anesthesiologist be available to every patient who undergoes surgery? Why or why not?

Question 6 - What do you believe to be the biggest threats to physician-led healthcare and how do you propose to address those threats?

Stefan Jarvis, MPA

Teacher, Veteran
Candidate for
U.S. House District 1 (R)
Savannah, GA

Stefan Jarvis was born in Wurzburg, Germany while his father was serving in the US Army. Raised in Savannah, Stefan graduated high school in 1992 and later enlisted in the US Army. After 5 years as an Infantry soldier, Stefan is ready to once again answer his country's call to service, not as a Republican or Democrat, but as a true and needed patriot.

Question 1 Response
Yes I believe a licensed physician should be the leader of a patient care team. It is the physician that is trained in medical care and treatment. The government does not have a place in a patient – physician team.

Question 2 Response
When it comes to patient care, I believe the only person capable of leading the diagnosis and treatment of a patient is a licensed physician.

Question 3 Response
Yes, I believe there is an established correlation. It is because of the working relationship between a physician and patient that the correlation exists. The physician and patient are able to establish a relationship that is in the best interest of the patient.

Question 4 Response
We must defund ACA. Healthcare does not belong in the hands of the government or IRS. We must allow licensed physicians to do their job and physicians and patients to establish a working health relationship. Governmental regulation of healthcare needs to be reviewed; policies that hinder the physician must be abolished.

Question 5 Response
Yes a physician anesthesiologist should be available to every patient to ensure patient health and safety during surgery.

Question 6 Response
Governmental interference and insurance companies who have crossed the boundary of insurer to medical advisor. I will fight to keep the government out of healthcare. Insurance companies need to be reminded they are insurers, not medical personnel. If a physician, after diagnosis and discussion, feels a treatment is necessary, the insurance company should comply with the physician's request.

Bob Johnnson, MD

FACS, MAJ, MC, USA (Ret.)
Physician, Veteran
Candidate for
U.S. House District 1 (R)
Savannah, GA

Robert Johnson, MD, FACS, served in the US Army as a Ranger, PA and head & neck surgeon. Upon retirement from the Army, Dr. Johnson and family moved to Savannah. Dr. Johnson's wife, Stacie, is an anesthesiologist. Both are graduates of MCG. They have two children: Alex, 20, a cadet at West Point and Emily, 18, a high school senior.

Question 1 Response
As a former PA, prior to going to medical school, I can tell you unequivocally that the knowledge and skill level that separates physicians from non-physician providers is immense. The notion of "independent" NPs, CRNAs, PAs, etc. is bankrupt and almost oxymoronic.

Question 2 Response
In field medicine, i.e., ambulance calls, paramedics understand the rescue paradigm better than any other health care providers. There is no other condition under which I would prefer to see a non-physician "lead" the team.

Question 3 Response
To my knowledge, no study reports non-physicians as providing better care than physicians. Some purport equivalency, but I believe each case has the population controlled by design or circumstance. For example, the provision of anesthesia in rural communities by unsupervised CRNAs selects less ill patients; those with advanced illness are referred to urban medical centers.

Question 4 Response
We need to aggressively work with legislators to inform them of the real facts of this matter. In my specialty, for instance. audiologists with doctorates (Au.D.) have petitioned Congress for statutory description as "physicians" under the US Code! This is outrageous, absurd and dangerous.

Question 5 Response
Always. In rural communities where there is no anesthesiologist, the surgeon legally responsible for supervision of the anesthetist should be notified in writing by the hospital employing the anesthetist. The anesthesia care-team model has provided for an unparalleled record of safety over the last several decades and should be preserved.

Question 6 Response
Activist non-physicians petition elected officials for expansion of scope of practice. We should support no such candidates unless they promise to not pursue partisan legislation that advances the interests of the few at the risk of many. We must be involved in the political process.

Sanford Bishop

U.S. Representative for
House District 2 (D)
Albany, GA

Serving for 11 terms, Congressman Bishop seeks to use the legislative process to "create a higher, better quality of life for all citizens by promoting jobs and a stronger, more diversified economy, better education, safe and secure communities, a clean environment, affordable and accessible health care, sustainable agriculture, energy independence, and a strong national defense -- all within the context of a balanced budget." Congressman Bishop is a leader among the fiscally responsible Democrats in Congress. Since 2003, Congressman Bishop has served on the House Committee on Appropriations. He has been elected by his colleagues to serve as the top Democrat on the Military Construction, Veterans Affairs and Related Agencies Appropriations Subcommittee.

Question 1 Response
Yes. Physicians should continue to be the leader of a patient care team because of their training, understanding of the health care environment, and dedication to the needs of their patients.

Question 2 Response
I am unaware of any such circumstances.

Question 3 Response
Yes, physicians are in a unique position to provide input on how best to improve patient safety and advocate for medical research based on their training and experience.

Question 4 Response
As a Member of Congress, I want to ensure that our nation's health care policies enhance the doctor-patient relationship, maintain the central role of doctors in the provision of health care, and guarantee that decisions about health care are doctor-patient driven rather than made by third-party non-medical providers.

Question 5 Response
A physician anesthesiologist should be available to every patient who undergoes surgery wherever feasible.

Question 6 Response
Physicians should be awarded for managing costs and improving the quality of patient care. We need to look at new structures like Accountable Care Organizations where all health care system participants are rewarded for improvements in quality. We also need to ensure adequate Medicare reimbursements for specialists and place the Medicare physician payment system on firmer ground so that there is no uncertainty.

Chip Flanegan

Small Business Owner
Candidate for
U.S. House District 3 (R)
Henry County, Georgia

Chip Flanegan is 56 years old. As a small business owner for 34 years he manages payroll, budgets, insurance, employees and, in spite of government caused downturns, he has managed to be successful and debt free. He is a common sense small government constitutionalist. He believes that a government that can't balance its own budget and is deeply in debt has no business taking over our healthcare and telling Americans how to live their lives.

Question 1 Response
Yes, the physician and the patient should be deciding what the best course of treatment is because with the wide range of factors that have to applied to each case no outside government formula can used to improve care or outcome.

Question 2 Response
I cannot think of any circumstance that the physician's leadership role should be subjugated by a government overseer.

Question 3 Response
The physician-led relationship has led us to the best health care in world to date and with continued advanced research done in the open market with freedom to follow that research will lead to be better patient outcomes and increased safety.

Question 4 Response
I would vote to protect the patient physician relationship at all levels of health care. That would include repeal of the "Patient Affordable Care Act". The attempt to control cost by controlling care has been used in other countries with devastating results.

Question 5 Response
Yes, The decision should be in the hands of the treating physician and the patient not a government panel or board. The many factors that have to be weighed by the treating physician such as age, complexity of procedure, patient current state of health foe example make these case by case decisions.

Question 6 Response
Third party payer brought about by current tax law that gives an economic incentive for business to provide health insurance on a pretax basis has been instrumental in causing the current state. By revising the tax law to give equal tax treatment to individuals and allowing group purchasing across state lines will help. Tort reform where the unreasonable awards for malpractice claims should be limited, government intervention by untrained bureaucrats should be eliminated.

Congressman Lynn Westmoreland

of District 3 responded that he has adopted a policy to not respond to candidate questionnaires.

John Lewis

U.S. Representative for
House District 5 (D)
Atlanta, GA

Often called "one of the most courageous persons the Civil Rights Movement ever produced," Congressman John Lewis has dedicated his life to protecting human rights, civil liberties, and building what he calls "The Beloved Community" in America. He was elected to Congress in November, 1986, and serves as the U.S. Representative of Georgia's Fifth Congressional District. He is Senior Chief Deputy Whip for the House minority, and a member of the Ways & Means Committee.

Question 1 Response
Yes, but it is important for a physician to lead in consultation with other members of a care team. I believe that the best leaders are also good listeners.

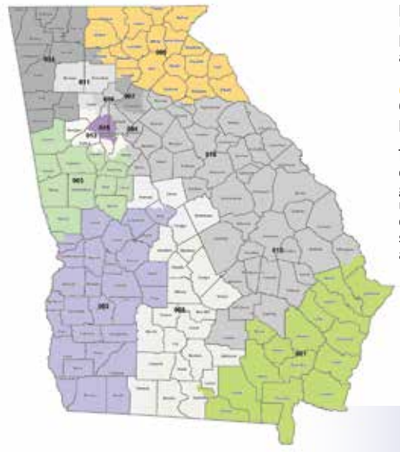
Question 2 Response
Patient care should be dictated by the needs of the patient. They are the only circumstances that matter.

Question 3 Response
Yes, doctors are always at the forefront of breakthroughs in medical science.

Question 4 Response
We need to strengthen the health care workforce pipeline. Congress must do more to ensure there are sufficient graduate medical education opportunities for every aspiring doctor.

Question 5 Response
Absolutely. It is most important that we have high levels of expertise for the most delicate kinds of care

Question 6 Response
I feel there are too few doctors caring for too many patients. Health care is changing, and we must do all we can to ensure that there are enough people to give needed care to everyone.



Map credit: Georgia General Assembly Legislative & Congressional Reappointment Office

Doug Collins

U.S. Representative for
House District 9 (R)
Former State Representative
Veteran, Attorney
Gainesville, GA

For 11 years, Doug served as Senior Pastor for Chicopee Baptist Church Since 2002, he also served as a Chaplain in the Air Force Reserves, completing one combat tour in 2008. Doug and his wife owned a number of small businesses before he began practicing law in his hometown of Gainesville, Georgia. From 2006 to 2012, Doug served in the Georgia General Assembly. In November 2012, he was elected to represent Georgia's 9th Congressional District.

Question 1 Response
Absolutely. Healthcare decisions belong in the hands of patients, their family, and their doctor. I don't believe anyone else belongs in the equation.

Question 2 Response
A patient obviously has to choose the medical professional they feel comfortable with. Patients select physician care the vast majority of the time because of their education, expertise, and commitment to excellence. I believe the patient's choice of his or her care team should always be honored.

Question 3 Response
Doctors promote both safety and research through their unique relationship with patients. Physicians understand the complex systems of the human body and can identify symptoms that may be related to that individual's medication, environment, or other factors. These observations improve the quality of life for many patients.

Question 4 Response
We have to make sure that medicine remains an attractive and viable line of work. Uncertainty surrounding the future of healthcare in this country, especially where reimbursement is concerned, is making it difficult for good doctors to keep their doors open. Physicians can't lead patient care if they're not there.

Question 5 Response
Patients should be able to select the services of medical professionals they believe will provide the best care, including the services of a physician anesthesiologist during surgery. Unfortunately, some patients do not always have that option as some areas struggle to attract or retain anesthesiologists.

Question 6 Response
Our government's attempt to over-regulate physicians.

The biggest threat has always been bureaucracy, whether in an insurance company or a government entity. Bureaucracies always end up influencing the direction of care. I'm most concerned at present with the massive expansion of the federal role in healthcare, and I have actively worked to delay and repeal Obamacare.

Meet the Candidates
U.S. Congress District 10

What we asked...

Note: GSA staff contacted all Congressional and Senate candidates who had announced as of October 1, 2013. Those not listed did not respond. Some responses edited by GSA staff for length.

Question 1 - Throughout U.S. history, physicians have been at the helm of patient health diagnosis, prescribing and care. Do you believe that a physician should continue to be the leader of a patient care team? Why or why not?

Question 2 - In what circumstances, if any, do you believe that someone other than a physician should lead patient care?

Question 3 - Do you believe that there is a correlation between physician-led health care and patient safety and medical research? Please explain.

Question 4 - If you support the role of physicians as the highly-trained and experienced leaders of the patient care team, how do you propose to ensure physicians remain at the forefront of patient care?

Question 5 - Should a physician anesthesiologist be available to every patient who undergoes surgery? Why or why not?

Question 6 - What do you believe to be the biggest threats to physician-led healthcare and how do you propose to address those threats?

Jody Hice, PhD
Baptist Pastor
Radio Talk Show Host
Non-Profit Group Founder
Candidate for
U.S. House District 10 (R)
Walton County, GA

Dr. Jody Hice is the founder of The Culture and Values Network and the host of The Jody Hice Show, a conservative talk radio program. He has been a pastor for nearly 25 years. Jody Hice is a constitutional conservative who has been endorsed by the Georgia Right to Life, Gun Owners of America, Family Research Council, Eagle Forum, and other groups. He and his wife Dee Dee have two adult daughters and three grandchildren.

Question 1 Response
Yes. The patient and doctor relationship is where all healthcare decisions should be made.

Question 2 Response
When an individual has children and or elderly parents there may be need for a family member to help with the healthcare decision making process. If a patient is of legal age and mentally competent, then they should have the power to make their own healthcare decisions.

Question 3 Response
Absolutely. Healthcare is safer and more effective when guided by a professionally trained physician.

Question 4 Response
First and foremost we must repeal Obamacare. This legislation takes the doctor out of the doctor patient relationship and replaces the doctor with a bureaucrat. We must also oppose unnecessary federal regulations that prevent doctors treating patients in the best medically sound cost effective way possible.

Question 5 Response
Absolutely.

Question 6 Response
The biggest threat to physician- led healthcare at the moment is Obamacare. I believe that we must repeal this law. It destroys the doctor patient relationship and will severely damage the entire healthcare system.

Ken Dious, JD
Attorney
Candidate for
U.S. House District 10 (D)
Athens, GA

An Athens native, Kenneth Dious is the founding partner of Kenneth Dious & Associates. Ken has spent his professional and personal career dedicated to politics and empowering individuals in the community. As a practicing attorney, he has provided legal services to the citizens of Northeast Georgia for 40 years, particularly in the area of human rights litigation and racial and sex discrimination.

Question 1 Response
In my opinion, a physician is the primary person that should lead a care team. The physician should be the individual that has final authority to make medical decisions in regards to patients' healthcare.

Question 2 Response
Under no circumstances, should anyone other than a licensed healthcare physician lead a patient care team.

Question 3 Response
Yes. The primary concern of physician led healthcare is to provide patients with access to the best healthcare available. Statistical research, ethical standards and patient consent and knowledge ensures that the safety of the patient is protected as well as healthcare providers.

Question 4 Response
This should be done by statutory laws authorizing only physicians or boards established by physicians would have such authority to do so.

Question 5 Response
No, because some surgeries are very basic. The administration of anesthesia, for certain surgeries, can be administered by nurse anesthetists' under the guidance and supervision of licensed anesthesiologists.

Question 6 Response
The biggest threat to physician-led healthcare is the health insurance industry's lobbying to have individuals, other than the treating physician, make medical decisions regarding patient healthcare, e.g. diagnosis and treatment, length of a patient hospitalization. I propose this should only be done by treating physicians, leading a patient health care team, with ethical and scientifically proven treatments with informed patient knowledge.

Donna Sheldon
State Representative
Businesswoman
Candidate for
U.S. House District 10 (R)
Monroe, GA

State Representative Donna Sheldon is a small business owner of 12 years and Chair of the House Majority Caucus. She also serves as Vice Chairman of the House Transportation Committee and a member of the Appropriations subcommittee on Health, Economic Development and Tourism, and Ethics committees.

Question 1 Response
Physicians must be leaders of the patient care team. Physicians possess the training and expertise to ensure proper and effective patient care, so that is why only the physician is best positioned to ensure the best patient care.

Question 2 Response
The only circumstance I can envision where a physician is not the lead in patient care is if the physician allows another to lead the care; however, that decision should lie solely with the physician.

Question 3 Response
Absolutely. Physicians are the best trained professionals to ensure patient safety and the best possible patient care. Physicians also must lead medical research because it is only with their insight and understanding of what is essential for patient care that medical research can be successful.

Question 4 Response
Patients must understand the importance of a physician-led care team. I do not support government inserting itself into this relationship because government has proven that once it gets a foothold, it continues to expand control. This is dangerous to both physicians and patients. I will work to remove government's impact on healthcare.

Question 5 Response
That is a decision I believe is best made by the physician leading the patient care team. I don't want to see government or elected officials inserting themselves into this decision.

Question 6 Response
The biggest threat is government interference and non-physicians practicing as though they are trained physicians. Excessive regulations increase healthcare costs and take physician focus away from patients. It is time for government to get out of the way and allow the physician to do what they have been trained to do.

Gary Gerrard, JD
Attorney
Non-Profit Group CEO
Candidate for
U.S. House District 10 (R)
Lexington, GA

Gary Gerrard is an Athens native, a double-Dawg, undergrad and Law School, and a veteran. Gary practiced law for over 30 years, and taught at UGA for 10 years. He helped Action Inc., the anti-poverty agency in northwest Georgia, get out of $2 million in debt, and donated his salary to Action. Gary is committed to a balanced budget, and has a contract to forfeit his congressional salary until Congress passes a balanced budget.

Question 1 Response
Of course. The most educated and knowledgeable person with firsthand information about the patient, with the patient's health the primary concern, should always be in charge, with the patient's consent. Bean counters and off-site managed care people whose primary concern is how much money is spent should NOT be in charge.

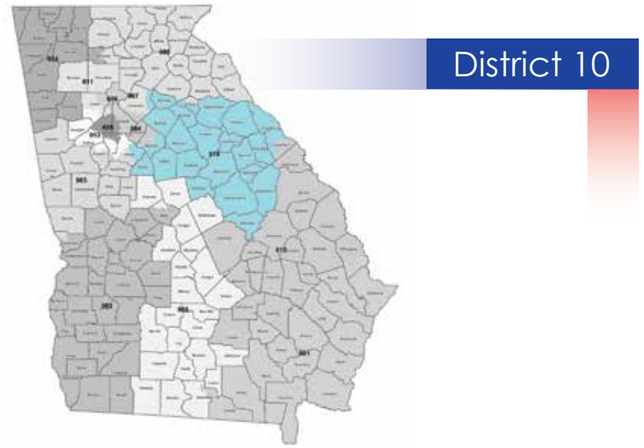
Question 2 Response
Only the patient and the physician, or non-physicians delegated the task by and with the oversight of the physician.

Question 3 Response
Patient safety, I assume, means prevention of injury or adverse reactions. If so, the answer is yes. Those providing care should be the most qualified. As for medical research, it depends on if the physicians providing care are doing research. If so, their care is restricted by managed care plans. Their ability to use innovative methods will therefore be restricted.

Question 4 Response
This is generally a scope of practice issue controlled by state legislatures, not Congress. I would support the patient's right to select his or her own doctor(s) and not let insurance companies or utilization boards or other organizations interfere with the doctor-patient relationship.

Question 5 Response
I think the surgeon and patient should decide whether an anesthesiologist or an anesthetist is appropriate. Some procedures, especially those that require a hospital admission, are likely to justify the additional experience and qualifications of an anesthesiologist. Certain procedures in ambulatory surgical centers may not.

Question 6 Response
The greatest threat is managed care and the ACA, with the people making patient care decisions more concerned with the money than the patient's health. The ACA should be replaced with a simpler system that allows individuals to pick their doctors who can treat them without having to obtain prior permission from anyone.



Map credit: Georgia General Assembly Legislative & Congressional Reappointment Office

Meet the Candidates
U.S. Congress District 11

What we asked...

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Question 1 - Throughout U.S. history, physicians have been at the helm of patient health diagnosis, prescribing and care. Do you believe that a physician should continue to be the leader of a patient care team? Why or why not?

Question 2 - In what circumstances, if any, do you believe that someone other than a physician should lead patient care?

Question 3 - Do you believe that there is a correlation between physician-led health care and patient safety and medical research? Please explain.

Question 4 - If you support the role of physicians as the highly-trained and experienced leaders of the patient care team, how do you propose to ensure physicians remain at the forefront of patient care?

Question 5 - Should a physician anesthesiologist be available to every patient who undergoes surgery? Why or why not?

Question 6 - What do you believe to be the biggest threats to physician-led healthcare and how do you propose to address those threats?

Tricia Pridemore
Businesswoman
Ex-State Workforce Development Executive Director
Candidate for
U.S. House District 11 (R)
Marietta, GA

Pridemore and her husband started a marketing automation software company in the spare bedroom of their home, growing the business into a multi-million dollar organization servicing some of the nation's leading Fortune 500 companies. A devoted conservative activist, Tricia has been an active member of the Cobb County Republican Party and a community volunteer for charities such as MUST Ministries, helping the homeless and fighting cancer. She has served on the Republican Leadership for Georgia Board of Directors and the Georgia World Congress Center Board of Governors. In 2011, Tricia was appointed Executive Director of the Governor's Office of Workforce Development where she was tasked with the overhaul of a struggling state agency. Using her private sector experience, Tricia successfully designed and implemented innovative strategies to build and improve Georgia's workforce, while driving economic growth. Tricia earned her bachelor's degree from Kennesaw State University. She and her husband, Michael, live in Marietta and are members of Mount Paran Church in Atlanta, where Tricia serves as a mentor in the Women's Ministry.

Question 1 Response
Yes, physician-led care ensures the highest quality treatment for patients.

Question 2 Response
If not the physician, then the patient should be the only one to lead in their healthcare decisions.

Question 3 Response
Yes, patient-led care would undoubtedly provide the highest quality research samples for colleges, universities and research institutions.

Question 4 Response
If elected, I would support Congressman Tom Price's Empowering Patient's First Act, and similar physician-patient centered legislation. By increasing patients' control over their health decisions, coverage will be made more affordable, accessible and responsive, while offering the highest-quality care.

Question 5 Response
Yes, this is the only way to ensure patient safety.

Question 6 Response
The greatest threat to physician-led healthcare is government- operated insurance, burdensome regulations, and the gradual move towards a single-payer system.

Barry Loudermilk
State Senator
Former State Representative
Businessman, USAF Veteran
Candidate for
U.S. House District 11 (R)
Cassville, GA

State Senator Loudermilk is a Constitutional Conservative, Georgia native, small business owner, motivational speaker, US Air Force veteran, private pilot, public servant, published author, and emerging leader in the movement to restore America to its true foundations. Barry and his wife Desiree have been married for 30 years. They have three grown children.

Question 1 Response
Yes, the relationship between the physician and the patient has been a time honored and protected throughout our nation's history. The physician, along with the patient or the parent/guardian, should be the sole decision makers regarding health care.

Question 2 Response
The only instance where the physician should not have the lead in decisions regarding the care of a patient is in the rare case where the patient chooses another option other than that recommended by the physician.

Question 3 Response
Yes. The physician has a direct relationship with the patient and, therefore, has the patient's health and welfare as their primary interest. Government directed programs are more often focused on cost of care rather than the best care available.

Question 4 Response
We must reduce unnecessary government oversight and over-regulation, which has empowered government officials to intervene in the patient/physician relationship. Over the past several years, there has been a drastic increase in government intervention, which has resulted in bureacratic oversight through policy, procedures and regulation.

Question 5 Response
Anesthesiology, as a specialty, has led the field in patient safety, which is predominately due to the extensive training, education and experience of anesthesiologists. Due to the nature of this practice, those who are properly trained, licensed and experienced should be made available to any patient undergoing surgical procedures.

Question 6 Response
The Afordable Care Act will effectively place government bureaucracy in the driver's seat of health care decisions. While there needs to be reform in health insurance, the ACA is the greatest threat to the quality and access to health care. This law needs to be replaced with patient-centered health care reforms.

Ed Lindsey, JD
Georgia House Majority Whip
Attorney
Candidate for
U.S. House District 11 (R)
Atlanta, GA

Georgia native Ed Lindsey earned a Juris Doctorate from UGA. He started his legal career in Toccoa, Ga., before moving to Atlanta, where he and three partners started a firm defending individuals, businesses, churches and private schools. Now, his firm employs 80 people in three states. A State Representative for nine years, Ed has risen to Majority Whip. He and his wife Elizabeth, have three sons - Harman, Charlie, and Zack.

Question 1 Response
Patients' health decisions are best made under the leadership of doctors, the most experienced, qualified and competent people on medical care teams. Under Obamacare (and other government programs) doctors are forced to include government regulation, defensive medical practices and liability in their medical decisions. This undermines their much needed leadership.

Question 2 Response
The only exception to the doctor/patient relationship should be an incapacitated patient, where family and doctor make decisions together. Even then, the doctor must maintain the leadership role. The Georgia Academy of Family Physicians named me their Legislator of the Year for work on advanced medical directives and portable medical orders.

Question 3 Response
Absolutely. Every human body is different and everyone reacts differently to ailments, pharmaceuticals and treatment scenarios. Guidelines on treatments from a macro, governmental level is contrary to basic science. Patients are safer when the smartest person in the room is calling the shots, not bureaucrats.

Question 4 Response
I support the alternative to Obamacare proposed by physician/Congressman Tom Price. His Act would return health care decisions to patients, families and doctors. Likewise, in rural areas, primary physicians are being replaced by nurse practitioners and physician assistants. Increased emphasis on academic science will direct more students to medical schools.

Question 5 Response
Every patient should be informed of his or her right to a physician anesthesiologist.

Question 6 Response
OObamacare violates every tenet of effective health care: choice, innovation, quality, and responsiveness. I will work to keep bureaucrats out of health care. Increased regulations create an invisible member of the health care team - one that vies for control over physicians and scientific health decisions.

Patrick Thompson
Technology Sales Executive
Former Teacher
US Park Ranger
Candidate for
U.S. House District 11 (D)
Woodstock, GA

Science Educator with 30 years of senior business management experience in hi-tech. Helps organizations harness disruptive and complex technology to improve results and operations. Continues career as entrepreneur and investor in renewable energy and sustainability, growing careers for Americans. Middle-class husband & father working hard to ensure a brighter future for Georgians. Tradition of volunteering time with youth, the poor and disadvantaged. Seeks public service for effective government, fair markets and regulated capitalism.

Question 1 Response
The physician is coach of any healthcare team. The increasing pressure to deliver healthcare quality will depend more now than ever before on the leadership of physicians and more need to move into administrative roles with hospitals and healthcare systems. Physician-led teams should define, measure and improve outcomes.

Question 2 Response
Instances where the physician can't be there - emergencies, remote and rural settings, overwhelmed inner city settings, etc – a time sliced physician may lead more effectively by building a strong team of allied health specialists and professionals that extend delivery. Divide labor to address areas like preventative or post-operative care.

Question 3 Response
Physician coach is in the best position to communicate the overall vision, plan, goals for the patient to both the patient and healthcare team – extending to safety and research. Reporting field knowledge improves safety and research. Medical research roles will extend impact on others on a broader scale.

Question 4 Response
Keep physicians focused on what they do best and direct/disseminate duties better performed by allied healthcare professionals More training in leadership and teamwork. Move from role of individual expert to team coaches. Administrators shift spending to rewarding patient outcomes, updating equipment, and providing leadership and healthcare education.

Question 5 Response
Regardless of surgery location. Vital part of any physician-led team. Communicate the plan to patient, sequence and timing, velocity and quality of their recovery. Improve patient safety and research. Cost pressures to train/let others perform duties needs balanced with risk to patient.

Question 6 Response
Increase in geography, conditions and number of patients. Move from band-aid and emergency care to managing the full healthcare spectrum of the patient with more insured. Education grants to cover training, greater reliance on team approach, consumer education, define tests per condition, telemedicine, digital education, online consumer results.

Bob Barr, JD
Former Congressman
US Attorney
Libertarian Presidential Nominee
Candidate for
U.S. House District 11 (R)
Marietta, GA

Bob Barr is a former Congressman for Georgia's 7th Congressional District. Bob was appointed as the U.S. Attorney to the Northern District of Georgia by President Reagan in 1986. Bob now practices law, and also teaches at Atlanta's John Marshall Law School. He has served as a board member of the National Rifle Association since 1997.

Question 1 Response
Yes. Physicians should continue to lead patient care teams. Physicians are uniquely trained to care for patients and help patients and their families to make health care decisions in the best interests of the patients. Bureaucrats and administrators do not have the patient's interest at heart and should not be making medical decisions.

Question 2 Response
I cannot imagine circumstances in which someone other than a physician should lead patient care. A Patient's autonomy should be respected. Individuals and their families' wishes are integral to leading patient care.

Question 3 Response
Yes. Patient safety and medical research are best advanced in a free market environment. The US has been in the forefront of health innovations in the modern era because our society focused on physician-lead health care; and until recently with minimal governmental involvement compared to the rest of the world.

Question 4 Response
The over-regulation of medicine by government and insurers has forced many physicians to become employees who answer to administrators; not independent physicians who answer to patients. Many of the best physicians in the world have become mired in a maze of regulations, trying to reach the goal of quality individual patient care.

Question 5 Response
Yes. Physician-led anesthesia has improved the safety of anesthesia with the ASA leading the way. I do not want bureaucrats compromising patient safety for a few dollar savings.

Question 6 Response
The single biggest threat to physician-led health care is the creeping nationalization and bureaucratization of healthcare. Healthcare is a personal matter between patient and physician. Regulation needs to be lessened. Patients should become more responsible for their own healthcare. We need fewer bureaucrats and administrators and more physicians leading care.

Allan Levene
Businessman
Candidate for
U.S. House District 11 (R)
Kennesaw, GA

Allan Levene moved to the United States over forty years ago. He has been self-employed for well over twenty years, focusing on the IT data center and desktop virtualization for mid-size to large businesses. A resident of metro Atlanta for about thirty years, his lifetime focus is solving problems, not talking about them. If sent to Washington, he promises to fix America's problems instead of creating more. His full bio can be found at www.allanleveneforcongress.com/bio/.

Question 1 Response
Physicians must be free to do what's best for their patients, without government interference. Obamacare regulations (30,000 pages so far, and counting) will, no doubt, start dictating what can and cannot be done. It's wrong. I've written articles about this, and other healthcare issues on my campaign website, allanleveneforcongress.com.

Question 2 Response
I can't think of any reason for a bureaucrat, or other group, agency or institution will know more about the physician-patient relationship than the attending physician. As such, the best outcomes are determined by that relationship, not third party institutions that dictate procedures based on non-healthcare priorities.

Question 3 Response
The answer is yes, if the personal physician is involved in the trials. .Obviously, new techniques are continually developed to help patients. Medical research demands clinical trials to test the efficacy of lab results. It is the physician's responsibility to determine if a patient is suitable for any particular trial.

Question 4 Response
Obamacare is a threat to the traditional, effective model. Why? Because of the financial strain it will place on the medical community. As I was born and raised in England, I am familiar with national health care so have firsthand experience as practiced in the U.K. and oppose it.

Question 5 Response
Yes. An anesthesiologist is a physician first. They are best qualified to diagnose any serious issue and resolve it quickly in the Operating Room. I prefer a physician to regulate a patient's anesthesia. An anesthesiologist may decide that some procedures can be done using an anesthesiologist-assistant; that's the anesthesiologist's decision.

Question 6 Response
Physicians are being badgered by patients asking for the latest prescription drugs, after seeing them advertised on television. Physicians are pressured to prescribe these drugs. It's wrong, and I will propose a bill, if elected, to block television advertising of prescription drugs.

Register to vote now.
General Primary Election is May 20, 2014.

Meet the Candidates
U.S. Congress District 11

What we asked...

Note: GSA staff contacted all Congressional and Senate candidates who had announced as of October 1, 2013. Those not listed did not respond. Some responses edited by GSA staff for length.

Question 1 - Throughout U.S. history, physicians have been at the helm of patient health diagnosis, prescribing and care. Do you believe that a physician should continue to be the leader of a patient care team? Why or why not?

Question 2 - In what circumstances, if any, do you believe that someone other than a physician should lead patient care?

Question 3 - Do you believe that there is a correlation between physician-led health care and patient safety and medical research? Please explain.

Question 4 - If you support the role of physicians as the highly-trained and experienced leaders of the patient care team, how do you propose to ensure physicians remain at the forefront of patient care?

Question 5 - Should a physician anesthesiologist be available to every patient who undergoes surgery? Why or why not?

Question 6 - What do you believe to be the biggest threats to physician-led healthcare and how do you propose to address those threats?

Continued from Page 13

Larry Mrozinski
Retired Army Officer
GOP Activist
Candidate for
U.S. House District 11 (R)
Woodstock, GA

Colonel Larry Mrozinski retired from the U.S. Army after nearly 3 decades of service. He and his wife of nearly twenty-eight years, Danelle, have four adult children.

Question 1 Response
Yes the physician should always be the head of the patient team. Patients and physicians must have close relationships in regards to the patient's health history and diagnosis. The patient's medical relationship is between the physician and the patient; any diagnosis and treatment which is rendered, must be approved by the patient and the physician.

Question 2 Response
Based on the confidentiality between physician and patient, the only reason I would only support this action if a medical team needed to evaluate a high risk treatment strategy for the patient, in which other physicians expertise would be needed.

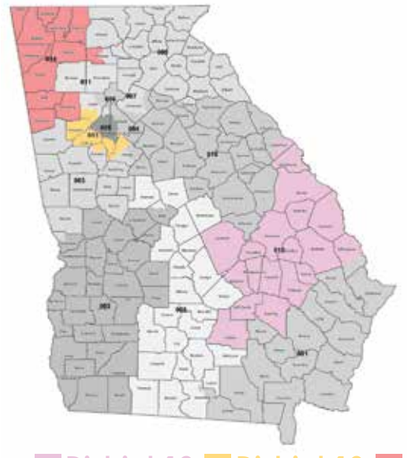
Question 3 Response
There is a direct correlation between physician-lead health care for patient safety and medical research. Forward thinking medical research teams must be able to work with the ever increasing medical issues. Without interaction between medical teams and physicians, patient safety and advance research would be at a standstill.

Question 4 Response
Physicians are the natural leaders of patient care; they have years of advanced training and experience. Hospital administrators must support the physicians and physician-led teams from outside sources, who think they have an interest in patients, but are actually looking at the bottom line. They avoid costly treatment at the patient's interest.

Question 5 Response
No, the highly trained and experience CRNA can assist the anesthesiologist in the OR, where the anesthesiologist can monitor several different case and CRNA's at the same time and reduce the patient load and cost. anesthesiologist can be the leader of the team environment in multi OR cases.

Question 6 Response
Physicians who have made the decision to forgo medical practices because of the high cost of malpractice insurance, non-qualified decision making team members, and regulations which makes physician practices difficult at best. U.S. healthcare is the world's best as long as physicians develop the patient care alliance.

District 11



District 12 District 13 District 14

Map credit: Georgia General Assembly Legislative & Congressional Reappointment Office

Districts 12-14

Meet the Candidates
U.S. Congress District 12-14

John Stone
Former Congressional Aide
Newspaper Reporter
Candidate for
U.S. House District 12 (R)
Augusta, GA

John Stone is former Chief of Staff to House Homeland Security Appropriations Subcommittee Chairman John Carter (R-TX31), Deputy Chief of Staff for U.S. Rep. Charlie Norwood, DDS (R-GA10), and former President of U.S. Freedom Foundation. Prior to politics, he was a news anchor in Augusta. He attended Augusta College, University of Georgia, and Regent University. John and Deborah Stone were married in 1977, have six daughters, three grandsons, and attend Burns United Methodist Church in Augusta.

Question 1 Response
The only two irreplaceable elements in health care delivery are the patient and a willing doctor. All else is optional, and the real problem we face in health care today is that we have let too many other factions become involved in delivery, many of which have tried to place themselves between the physician and patient. Not only do I believe physicians should lead, I think it is past time to start restoring the physician/patient relationship by cutting out the middlemen.

Question 2 Response
Only in the circumstance of health care providers such as dentists operating within their legal scope of practice guidelines under state law.

Question 3 Response
Yes. Safety and medical research should be governed under AMA oversight in order to ensure both medical safety and timely access to new treatment options.

Question 4 Response
Administration efforts to force patients into front-line treatments by unqualified healthcare providers such as physician assistants and dental hygienists must be vigorously opposed.

Question 5 Response
Yes. Patients should have the right to insist that every health care procedure be delivered by fully qualified professionals.

Question 6 Response
The biggest threat is spiraling costs. Unless that is controlled any health care reform will ultimately fail. We must reign in frivolous lawsuits, expensive government regulation, and destructive health insurance billing and treatment dictates. The best solution is for a vigorous restoration of free-market principles such as tort reform, medical savings accounts, interstate health plans, and the development of a nationwide high-risk health pool to replace Obamacare.

John Barrow responded, indicating that he follows a policy to not submit responses to candidate questionnaires.

David Scott
U.S. Representative for
House District 13 (D)
Former State
Representative & Senator
Atlanta, GA

David Scott (GA-13) represents portions of 6 counties: Cobb, Clayton, Douglas, Fayette, Fulton and Henry. Congressman Scott sits on the Financial Services Committee; the Agriculture Committee and is a member of the NATO Parliamentary Assembly. He served in the Georgia House of Representatives 1974 - 1982 and the Georgia Senate 1983 - 2002. He received his BA from Florida A&M University and MBA from the Wharton School of Finance at the University of Pennsylvania.

Question 1 Response
As we enter into a new era of healthcare, it is important that we continue to ensure that physicians play a prominent role in patient centered medical services. Throughout my time in office, I have championed the role of doctors and have fought to ensure that they are adequately reimbursed.

Question 2 Response
Studies have shown that physicians practice within sixty miles of where they are trained. This correlation leads to a lack of physicians in rural areas. We must ensure that there are medical professionals in place for those areas whether it's through tele-health, email, or video technology. Physicians can certainly be leaders in these areas.

Question 3 Response
I believe that there is a correlation between strong leadership and patient safety and medical research. Studies have shown that when we have leaders who empower their employees, are innovative, and place the patient first, we receive quality results.

Question 4 Response
I believe that the current SGR is inadequate in ensuring that physicians remain leaders in patient care. Fortunately, Chairmain Fred Upton, Congressman Alysson Schwartz , and other members of the House Committee on Energy and Commerce are proposing legislation that allows for greater reimbursement for all doctors and also creates pilot projects to ensure that physicians are adequately paid to handle a 21st Century health care system.

Question 5 Response
I believe that a physician anesthesiologist should be available to every patient. Patients should be informed before they enter surgery who their physicians are so that they can make informed decisions about their health.

Question 6 Response
In a time when the health care landscape is changing rapidly, I believe that we must focus less on threats and more on opportunities. We must continue to ensure that physicians are paid properly for their services. We also must seriously address tort reform, so that doctors can focus how best to treat their patients, and not on the fear of being sued. I will continue to fight for these issues on the federal level. You can count on me to be your voice in Washington.

Tom Graves
Congressman for
U.S. House District 14 (R)
Ranger, GA

U.S. Representative Tom Graves has served in the U.S. House of Representatives since 2010. He serves on the House Appropriations Committee, which means Tom is on the front lines of the battle to solve America's debt crisis. He works to balance the budget, cut government waste, and reform Congress so that it that focuses on saving - not spending - taxpayer dollars. In 2013, Tom was elected chairman of the Georgia Republican Congressional Delegation.

Question 1 Response
While there will always be a role for a variety of medical practitioners, with their years of training in classroom and clinical environments, physicians are uniquely qualified to provide top tier care to patients

Question 2 Response
Ultimately, a well-informed patient should be able to guide his or her own care. I believe that most patients who are informed about the qualifications, training, and expertise of their medical providers will want their care team led by a physician.

Question 3 Response
The experience a physician brings to the bedside remains invaluable to patient care. While other medical professionals may be able to provide routine bedside care, a physician's clinical skillset ensures that he or she can provide top tier care now, while responding appropriately with responsive care now and development of new treatments through research in the future when the routine becomes the unconventional.

Question 4 Response
The best way to ensure that physicians remain at the forefront of the patient care model is to ensure that decisions on care remain in the hands of patients. Should care begin to be rationed as a result of government intrusion into care decisions, the doctor-patient relationship will be the first to go.

Question 5 Response
Every patient undergoing surgery should have the opportunity to be under the care of an anesthesiologist. We should never reach the situation where government mandates, rationing, and reimbursement cuts take that choice away from patients and their doctors.

Question 6 Response
Obamacare. I believe that this law will inevitably lead to rationing by the government. Much like the SGR fight in Medicare, should Obamacare remain in place I fear that we will find ourselves in a situation where doctors cannot afford to remain in practice, and care choices are taken away from patients and their doctors and put in the hands of government bureaucrats.

Dr. Puri elected AMA delegate


Dr. Puri

Medical College of Georgia Resident Dr. Suvikram Puri has been elected by his peers to serve as the alternate delegate to the AMA in 2014 and delegate in 2015. He campaigned for and won the election during the ASA Resident House of Delegates in San Francisco, CA, in October.

"I was given the opportunity to serve as resident delegate to the American Society of Anesthesiologists and was privileged to represent the State of Georgia and MCG," Dr. Puri said. "By participating, I have developed a unique insight into the future of anesthesiology during my conversations with several current and future ASA leaders.

Dr. Puri will serve multiple roles. He will work alongside the ASA board of directors and become part of the delegation to the American Medical Association. In addition, as a member of the ASA resident governing council and in collaboration with the AMA resident leadership, he will represent over 5,500 anesthesiology residents from over 130 programs. Other responsibilities include significant involvement with the ASA-PAC, grassroots lobbying, and educating anesthesiology residents about healthcare policies.

"The ASA is a very active and powerful organization and I am extremely proud to be in a position to serve. I am grateful to both the anesthesiology department at MCG (especially Drs. Manuel Castresana, Mary Arthur, and John Blackburn) and the GSA (especially Dr. Jay Johansen and Jet Toney) in their wholehearted support and constant encouragement of my effort to be elected," he said.

Grateful, respectful, anxious

Continued from Page 2

medicine, this will require current and valid outcome studies, he said. There is a notable lack of such studies, Dr. Neeld said. He then boldly challenged the ASA to fund well-designed, scientifically-valid outcome studies to prove the value that anesthesiologists bring to patient care.


Rovenstine Lecturer Dr. John Neeld

I had the pleasure of speaking with Dr. Neeld and I asked what we can do to help win this war and continue to provide our patients with the highest quality care. His response was multi-faceted and started with appreciation of the gravity of the situation. He asserted it is imperative that we stay abreast of efforts to undermine our role in patient care. The amazing staff at GSA Headquarters and Cornerstone Communications Group makes this easy to do through relevant, informative GSA e-news updates delivered via e-mail to members.

Support candidates who recognize and embrace the physician-led model as the gold standard for patient care.

Dr. Neeld said physicians must be aware of our allies in the government arena and pledge support to these individuals. This is the theme of this edition of scOpe as we examine the candidates who are vying in the coming elections to represent our state at the federal level. It is imperative, perhaps now more than ever, that we support candidates who recognize and embrace the physician-led model as the gold standard for patient care in the perioperative period.

Finally, Dr. Neeld emphasized that we must encourage ASA's leadership to fund outcomes studies. Such studies could arm our allies with the necessary ammunition to counter the attacks on our specialty and patient quality of care. Each one of us must actively participate in these studies by providing outcomes data. The Anesthesia Quality Institute exists for the purpose. The mission of the AQI is "to develop and maintain an ongoing registry (NACOR) of case data that will become the primary resource for anesthesiologists looking to assess and improve patient care." By providing data to the AQI, we equip the ASA to prove our value and preserve our leading role in patient care.

"Although it is the heart of what we do, it is no longer sufficient that we only provide the best possible care for our patients," Dr. Neeld said. We must follow his and others' examples by tirelessly working to preserve our specialty in this new era of healthcare. We all have a role to play, and we simply cannot afford to be inactive.

Each one of us must actively participate in these studies by providing outcomes data.

Watch "Winning the War" Rovenstine Lecture at...
http://education.asahq.org/2013/Rovenstine

Anesthesiology Today

CURRENT ISSUES AND MULTIDISCIPLINARY UPDATES

January 11-12, 2014 | *GSA Winter Forum*
January 11-12, 2014
Atlanta Perimeter Center Marriott Hotel

Target Audience:

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

Activity Co-Directors:

Justin Ford, MD
Northside Anesthesiology

Jay Kher, MD
Northside Anesthesiology

Register at www.gsahq.org

Jointly sponsored by...

American Society of Anesthesiologists

Georgia Society of Anesthesiologists, Inc.

2014 GSA Winter Forum Schedule

Friday, January 10, 2014

3:00 – 6:00 p Registration - **Grand Foyer**

4:30 – 6:30 p Board of Directors Meeting - **Madison**

5:00 – 9:00 p Exhibitor Set Up - **Presidential Ballroom**

6:30 – 7:30 p Welcome Hospitality: Registrants, Exhibitors and Guests - **Roosevelt**

7:30 p Dinner on your own with family and friends

7:45 p Board of Directors and Faculty Dinner

Saturday, January 11, 2014

6:00 a Exhibitor Set Up - **Presidential Ballroom**

6:30 – 7:20 a Registration/Breakfast with Exhibitors - **Presidential Ballroom**

7:25 a *Welcome* - **Salon A, B, C & D**
Jay Johansen, MD, PhD - GSA President

Introductions -
Winter Meeting Activity Co-Directors
Justin Ford, MD
Northside Anesthesiology Consultants, LLC
Jay Kher, MD
Northside Anesthesiology Consultants, LLC

7:30-8:25 a *How Pain Mechanisms Direct Pain Management*
John Rowlingson, MD - University of Virginia
Cosmo A. DiFazio Professor of Anesthesiology

8:30-9:25 a *Mixing Sharp Needles with Thin Blood*
John Rowlingson, MD - University of Virginia
Cosmo A. DiFazio Professor of Anesthesiology

9:30-10:00 a Break with Exhibitors - **Presidential Ballroom**
Resident Section Meeting – **Salon E**

10:00-10:55 a *Non-Opiod Anesthesia*
Robert Thiele, MD
University of Virginia
Assistant Professor of Anesthesiology

9:30-12:00 p Resident Section Meeting

10:00-10:55 a *Conundrums in Ambulatory Anesthesia II*
Girish Joshi, MBBS, MD, FFARCSI

11:00a-11:55 p *Intraoperative Goal Directed Therapy (GDT)*
Robert Thiele, MD
University of Virginia
Assistant Professor of Anesthesiology

12:00-1:00 p Lunch and GSA General Business Meeting - **Foyer**

1:00-1:55 p *Basics of TEE for the Non-Cardiac Anesthesiologist*
Julie Huffmeyer, MD
University of Virginia
Assistant Professor of Anesthesiology

2:00-2:55 p *The Perioperative Surgical Home from Concept to Reality*
Arthur Boudreaux, MD
University of Alabama at Birmingham
Chief of Staff & Clinical Professor

3:00-3:30 p Break with Exhibitors - **Presidential Ballroom**

3:30-4:25 p *Utilizing Performance Improvement Techniques to Improve Clinical Practice*
Arthur Boudreaux, MD
University of Alabama at Birmingham
Chief of Staff & Clinical Professor

4:30-5:25 p *Anesthetic Considerations of the Complex Spine Case*
Jeffrey Gonzales, MD, MA
Duke University, Department of Anesthesiology
Clinical Director of Surgical Spine Services
& Assistant Professor

5:30 p Meeting Adjourns

6:00-7:00 p Mixer with Family and Friends - **Great Room**

7:00 p Dinner on your own with family and friends

Sunday, January 12, 2014

7:30 a -12:00 p *Workshop:*
Ultrasound Guided Regional Anesthesia **– Pavilion**

Ultrasound Workshop Instructors
Michael Ashmore, MD
Howard Hong, MD
Jay Kher, MD
Douglas Stewart, MD

Workshop attendees will rotate through four ultrasound stations, following the below schedule:

7:30 - 8:25 **a**	Ultrasound Session 1
8:30 - 9:25 **a**	Ultrasound Session 2
9:30 - 10:00 **a**	Break
10:00 - 10:55 **a**	Ultrasound Session 3
11:00 - 11:55 **a**	Ultrasound Session 4

8:00-10:00 a *GAAA Legislative Workshop:*
Open to all anesthesiologists & AAs -Tyler
Senator Check Hufstetler, AA-C (R-Rome)

10:00a -1:00 p GAAA Board of Directors Meeting – **Tyler**

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

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.

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 the January 11th live activity for a maximum of 8 *AMA PRA Category 1 Credits*™ and the January 12th live activity for a maximum of 4 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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, January 6, 2014, to qualify for refund. Absolutely no refunds will be issued for changes received at GSA headquarters after Monday, January 6. The cancellation policy will be strictly enforced.

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

Anesthesiology Today

CURRENT ISSUES AND MULTIDISCIPLINARY UPDATES

Arthur Boudreaux, MD
University of Alabama at Birmingham, Chief of Staff, Clinical Professor

The Perioperative Surgical Home: From Concept to Reality
At the conclusion of the presentation, the learner should be able to:
- Describe the major components of the perioperative surgical home (PHS).
- Identify gaps in current practice that have to be filled to offer a PSH service.
- Emphasize need for collaboration and teamwork and the local political obstacles of a PSH.
- Discuss the possible funding sources for PSH development.

Utilizing Performance Improvement Techniques to Improve Clinical Practice
At the conclusion of the presentation, the learner should be able to:
- Review the concept of performance improvement in improving the value of an anesthesia service.
- Utilizing PDCA, Lean and other methods to solve real clinical problems.
- Determine how to interpret data collected from PI projects.
- Show how to overcome obstacles in implementation of PI projects.

Jeffrey Gonzales, MD, MA
Duke University, Department of Anesthesiology
Clinical Director of Surgical Spine Services, Assistant Professor

Anesthetic Considerations of the Complex Spine Case
At the conclusion of the presentation, the learner should be able to:
- Describe the standard risks associated with open spine surgery.
- Discuss management of chronic pain patients presenting for spine surgery.
- Evaluate use of noninvasive techniques for blood management in spine cases.
- Discuss future goals of hospital care in spine patients with regard to CMS/healthcare changes.

Julie Huffmeyer, MD
University of Virginia, Department of Anesthesiology
Assistant Professor of Anesthesiology

Basics of Transesophageal Echocardiography for the Non-Cardiac Anesthesiologist
At the conclusion of the presentation, the learner should be able to:
- Explain indications for use of transesophageal echocardiography (TEE) and transthoracic echocardiography for patients undergoing noncardiac surgery.
- Recognize relative and absolute contraindications to the use of TEE.
- Discuss basic TEE views to obtain for use in noncardiac surgery.

John Rowlingson, MD
University of Virginia, Department of Anesthesiology
Cosmo A. DiFazio Professor of Anesthesiology

How Pain Mechanisms Direct Pain Management
At the conclusion of the presentation, the learner should be able to:
- Highlight the mechanisms by which the pain transmission system is activated.
- Present the rationale for utilizing mechanism-targeted therapy.
- Discuss contemporary advances in pain treatment.

Mixing Sharp Needles with Thin Blood
At the conclusion of the presentation, the learner should be able to:
- Review the need for anticoagulation in the perioperative period.
- Highlight recommendations from leading guidelines.
- Discuss the pharmacology of modern-day anticoagulant drugs.

Robert Thiele, MD
University of Virginia, Department of Anesthesiology
Assistant Professor of Anesthesiology

Non-Opioid Anesthesia
At the conclusion of the presentation, the learner should be able to:
- Identify the effect of intraoperative opioids on postoperative care.
- Determine alternative, non-opioid "MAC reducing" agents.
- Learn which anesthetic agents can reduce postoperative opioid utilization.

Intraoperative Goal-Directed Therapy (GDT)
At the conclusion of the presentation, the learner should be able to:
- Compare the "goal-directed" hemodynamic management to traditional strategies.
- Review the means of achieving hemodynamic goals.
- Discuss hemodynamic monitors utilized in GDT.
- Discuss GDT as a component of Enhanced Recovery after Surgery (ERAS) protocols.

Ultrasound Workshop Instructors

Michael Ashmore, MD
Northside Anesthesiology Consultants, LLC
Anesthesiologist

Howard Hong, MD
Northside Anesthesiology Consultants, LLC
Anesthesiologist

Jay Kher, MD
Northside Anesthesiology Consultants, LLC
Anesthesiologist

Douglas Stewart, MD
Northside Anesthesiology Consultants, LLC
Anesthesiologist

Workshop for Ultrasound Guided Regional Anesthesia
At the conclusion of the presentation, the learner should be able to:
- Identify the use of ultrasound for upper extremity regional nerve blocks.
- Recognize the use of ultrasound for lower extremity regional nerve blocks.
- Identify the use of ultrasound for paravertebral blocks.
- Explain the use of ultrasound for transverse abdominal plane blocks.

Accommodations

For hotel reservations, please contact the Atlanta Marriott Perimeter Center Hotel at 1-888-858-2451 and request the Georgia Society of Anesthesiologists room block.

To book online, please visit…
http://www.marriott.com/hotels/travel/atlpc-atlanta-marriott-perimeter-center/?toDate=1/12/14&groupCode=gsagsaa&stop_mobi=yes&fromDate=1/10/14&app=resvlink

The group block code is **gsagsaa**. You must use the above link and enter the group code to secure the group rate and receive a waiver from the 5 night minimum requirement. Please note that the cut-off date to receive the GSA room rate is December 24, 2013.

Register at www.gsahq.org

Questions? Contact Kristin Andris, GSA Member Services Manager: 404-249-9178 x6 | kristin.strickland@politics.org

GAAA/GSA partnership

AAs promote advocacy, safety in ACT model

By Joy Rusmisell, AA-C
GAAA President

With the Georgia Academy of Anesthesiologist Assistants (GAAA) and Georgia Society of Anesthesiologists (GSA) joint membership program up and running, we wanted to take an opportunity to share what advocacy & safety in anesthesia looks like from an Anesthesiologist Assistant (AA) perspective.

To advocate is simply defined as the act of showing support or concern for a cause or proposal. However, to an Anesthesiologist Assistant, advocacy is the cornerstone of our practice. Our practice involves a unique relationship between the AA, Anesthesiologist, and patient. We have chosen a healthcare profession that holds the belief that the interests of patient safety are best served with an anesthesiologist's involvement with the delivery of every anesthetic. Advocating for our patients' safety, interest, and well-being are paramount to our ethical standards of conduct.

The AAs in Georgia are honored to be partnered with the anesthesiologists of the GSA.

As we are facing challenges in medical service reimbursement, the demands to save money are being placed on all providers. Patient safety should not be sacrificed throughout this process. There is no increase in cost to patients when receiving an anesthetic through the Anesthesia Care Team (ACT) model, and there is a significant increase in safety over non-physician sole anesthesia providers. Along with this increase in safety, comes the inherent cost savings associated with avoiding increases in complications.

AAs are proud to be a part of the scientifically proven elevation in safety… utilizing the ACT model.

The Silber Study (Anesthesiology, 2000) clearly demonstrated that there were 2.5 times more deaths and 6.9 times more complications out of 1,000 cases when anesthesiologists were not involved in patient care. AAs are proud to be a part of the scientifically proven elevation in safety record amongst anesthetic delivery utilizing the ACT model. We advocate daily for the anesthesiologist-led team approach and are the only mid-level anesthesia providers that do so.

Georgia Academy of Anesthesiologist Assistants

Educating our patients, physicians, and fellow healthcare colleagues about the AA profession and physician-led anesthesia team is necessary for the sustainability of the ACT model of patient care. The AA profession was established at Emory University in 1969 by Anesthesiologists that were concerned with the status of the anesthesia workforce in the United States. They created a profession that is centered on patient safety in perioperative care. Again, we are the only non-physician anesthesia provider that allows for this practice model.

Through the joint membership program, the GAAA has placed advocacy and safety at the pinnacle of our partnership. We believe that the unified voice of GSA Anesthesiologists and GAAA Anesthesiologist Assistants provide a platform that can be utilized to highlight the importance of anesthetic delivery under a physician-led model which will further the growth of our professions. As a team, the Anesthesiologist and Anesthesiologist Assistant are highly efficient and provide exceptional patient care through complex environments. The AAs in Georgia are honored to be partnered with the Anesthesiologists of the GSA. We will continue to promote the Anesthesiologist as the leader of the care team, and we look forward to the continued support of the AA profession by the Anesthesiologists in Georgia.

GSA's management team to serve AAAA

Cornerstone Communications Group, Inc. has been selected by the American Academy of Anesthesiologist Assistants to manage the organizations' administrative and governance affairs. Cornerstone currently provides association management, activity planning and government affairs services to the GSA and will continue in that role. AAAA will transition its operations from Richmond, Virginia to Cornerstone's Atlanta offices on January 1, 2014.

"This firm is proud of our continued association with GSA, " James E. "Jet" Toney, founding principal, said. "GSA and Cornerstone have grown together, and the experience earned during our 22 year relationship has prepared us to offer many of the same services to the AAAA leaders and members."

Toney will serve as executive director of the AAAA while remaining executive secretary of the GSA. Kristin Andris, GSA's member services manager and associate editor of scOpe will have similar but expanded responsibilities for the AAAA. GSA's financial services manager, Leann Johnston, will manage AAAA's books and e-commerce transactions. Cornerstone will expand its personnel to better serve both organizations.

At its July 2013 meeting, the GSA Board of Directors voted unanimously to endorse Cornerstone's bid for the AAAA contract.

Judy Semo... Continued from Page 4

Based upon this investigation, the OIG decided to include the review of anesthesia in the 2013 OIG Work Plan. In particular, the auditor says that the staff "came up with an audit idea to review anesthesia services, paid by Medicare that may have been incorrectly claimed as personally performed."

3. The Changing Anesthesia Community.

a. Continued Sales of Anesthesia Groups. Sales of anesthesia groups continue to make the news, with at least thirteen sales having been announced in the first three quarters of 2013 and three more having been announced by mid-November 2013. Mednax, EmCare, Team Health, Sheridan, and NAPA, among others, have announced acquisitions.

Investment banking firms that advise anesthesia groups on such transactions report that more transactions are likely to be announced before year-end.

Is this step the right one for a private anesthesia group to take? It may still be too early to know if these sales will benefit the selling anesthesiologists long-term. The decision is an individual assessment that requires consideration, among other things, of:

1. The scope and diversity of a group's practice operations,
2. The long-term goals of the group anesthesiologists,
3. The other opportunities and challenges the group faces,
4. The likely reaction of the group's key facility customers, and
5. The financial implications of a sales transaction.

b. Goldman Sachs Enters the Anesthesia Market. So who is buying anesthesia practices? That answer continues to evolve. The "strategics" (anesthesia management companies, some of which offer multiple medical specialty service lines; some noted in Section 2.a, above) are not the only ones looking to purchase anesthesia practices; private equity companies also are bidding on anesthesia practices. (To be clear, some of the strategics (or their affiliated companies), including Sheridan, NAPA, and EmCare, are owned in part by private equity firms.)

In May 2013, Goldman Sachs entered the anesthesia market with its announcement of the recapitalization of Broad Anesthesia Associates and Mid-Florida Anesthesia Associates and the formation of Resolute Anesthesia and Pain Solutions, LLC. According to press reports, Resolute Anesthesia serves over 25 locations in Florida, Missouri, and Illinois. Resolute Anesthesia joins U.S. Anesthesia Partners, which entered the market in November 2012 (formed by Welsh Carson Anderson & Stowe) and acquired a cornerstone practice, Greater Houston Anesthesiology, in December 2012; and PhyMed Healthcare Group, among other anesthesia firms with private equity ownership. PhyMed Management, LLC was the management services company for Anesthesia Medical Group in Nashville, Tennessee; in August 2012, Excellere Partners announced its investment in PhyMed. Other private equity firms, such as MTS Health Investors LLC; Moelis Capital Partners; The Beekman Group LLC; and Triton Pacific Capital Partners, LLC, also have invested in anesthesia practices.

4. Continuing Challenges for Anesthesia Practices: Cross-Subsidization of Anesthesia Services. "But no one could afford to provide anesthesia services at this hospital for less than we do." That refrain is one that often is heard at hospitals with poor payor mixes, high levels of indigent patients, underutilized operating rooms, or a combination of those factors. Anesthesia management companies that offer a variety of medical specialties are able to compete differently with traditional anesthesia groups and anesthesia-only anesthesia management companies.

One longtime anesthesia group (not located in Georgia), with a record of service of over thirty years at a community hospital and a record of active involvement in hospital affairs, was replaced this year by an anesthesia management company. With a payor mix consisting of 77% Medicare, Medicaid, and self-pay patients, a traditional anesthesia group would be likely to need financial support from the hospital to provide the services needed. Three anesthesia management companies offered to provide anesthesia services for no compensation at all, provided that the hospital awarded them the emergency medicine contract, as well.

This story serves as a reminder to anesthesia groups of the increasingly competitive market in which they practice and must compete.

5. HIPAA on Steroids. "Of course we know that we have to keep patients' health care information private. What else is new?" Quite a bit!

In January 2013, the Office for Civil Rights ("OCR") in the Department of Health and Human Services released an omnibus rule amending the HIPAA privacy, security, and enforcement rules. The rule is available at http://www.gpo.gov/fdsys/pkg/-FR-2013-01-25/pdf/2013-01073.pdf. Among the many changes, the rule:

- Amends the definition of a data breach so that any impermissible use or disclosure of protected health information ("PHI") is presumed to be a breach unless the covered entity (the physician practice) or business associate ("BA") demonstrates that there is a low probability that the PHI has been compromised;

- Expands the definition of BAs to include entities that maintain PHI, and makes BAs and their subcontractors liable for HIPAA compliance; and

- Increases the penalties for noncompliance.

Anesthesiology groups need to have amended their notice of privacy practices and BA agreements, and they need to reevaluate who are their BAs.

Even before issuance of the omnibus final rule, OCR had been actively enforcing HIPAA, in contrast with OCR's prior emphasis on technical assistance to assist covered entities to comply. Importantly, over two-thirds of the data breaches involve lost or stolen PHI, not deliberate efforts to misuse PHI. The settlements are not just with large covered entities, but include small physician practices and nonprofit entities. For example, in April 2012, a five-physician practice agreed to pay a $100,000 fine in connection with a data breach.

The common themes of the OCR enforcement actions are:

- Failure of covered entity to have HIPAA privacy & security policies;
- Failure to conduct a risk assessment; and
- Failure to take steps to minimize risk.

The risk assessment is an assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic PHI. Additional guidance on the process is available at http://www.hhs.gov-/ocr/privacy/hipaa/administrative/securityrule/rafinalguidancepdf.pdf.

The bottom line is that HIPAA compliance will take time and cost money, but failure to comply will take even more time and cost far more money.

Judy is an attorney in private practice in Washington, D.C. As counsel to ASA and anesthesiology practices nationwide, she has had extensive experience in business and legal issues relating to the practice of anesthesiology. Judy has written or co-authored ten practice management monographs in the ASA Practice Management series, as well as other articles for anesthesiologists on practice management issues.

IN MEMORIAM

Walter Newman "Sam" McGaughey Jr., MD

Sam McGaughey Jr., MD, 52, died November 11, 2013. Dr. McGaughey was an anesthesiologist at Anesthesia Associates of Savannah and an active member of GSA for more than 10 years.

Dr. McGaughey was born in Macon, Georgia, son of Jannette Lee Edwards McGaughey and the late Walter Newman McGaughey Sr. He was a 1979 graduate of Stratford Academy and a 1983 graduate of Auburn University where he was a member of Kappa Alpha Order and Phi Beta Kappa Fraternities. He was accepted into medical school at the Medical College of Georgia, graduating in 1987. He served his residency at the Medical University of South Carolina in Charleston. He was the recipient of the Robert D. Dripps, MD, Memorial Award for outstanding Graduate Resident in Anesthesiology.

Sam's zest for life led him on many adventures around the world. He had a passion for the outdoors especially hunting, fishing and boating. He was a devoted father, husband and friend. His children were his greatest love. Sam was a highly respected physician among his peers and patients. His energy and enthusiasm was, and will continue to be, his legacy.

Surviving are his wife, Mary Margaret McGaughey of Savannah; children, Lauren Evan McGaughey and Zachary Mills McGaughey both of Savannah; mother, Janette Lee Edwards McGaughey of Savannah; step-children, David Weston Trosdal and Margaret Meriwether Trosdal both of Savannah; sister and brother-in-law, Mary Holly McGaughey Anderson and Kavan Brett Anderson, of Macon, GA; nieces, Mary Brett Anderson and Emma McKay Anderson both of Macon.

A memorial service was held on Saturday, November 16, 2013 in the Hodgson Chapel of Fox & Weeks Funeral Directors. Compiled with information from Savannah Morning News and GSA records.

G. Donald Clarke, MD

G. Donald Clarke, M.D., died on August 14, 2013 after a valiant struggle with numerous maladies. Dr. Clarke was a retired GSA member and anesthesiologist at Anesthesia Associates of Savannah.

Dr. Clarke graduated from Moorestown High School in 1958, The College of William and Mary in 1962, and Jefferson Medical College in 1966. He completed his anesthesiology residency at the University of Virginia School of Medicine. Dr. Clarke was a highly regarded and respected board certified anesthesiologist practicing in Savannah. He was a partner with Anesthesia Associates of Savannah.

Dr. Clarke and his wife, Sandy, were married for 51 years and made their home in Savannah for over 44 years. Dr. Clarke and his wife had an enduring interest and love for various forms of art, which they collected during their travels throughout the world. Dr. Clarke was a kind and generous physician who contributed to many charitable causes and supported local philanthropies.

Dr. Clarke is survived by his wife, Sandra Woodle Clarke; his sister, Marie Ward, and husband, Chuck; his brother-in-law, Buddy Woodle, and wife, Patti; and numerous nieces and nephews.

A memorial service was held on Monday, August 19, 2013, at 11:00 a.m. at the Messiah Lutheran Church in Savannah, Georgia. In lieu of flowers, remembrances may be sent to Hospice Savannah, P.O. Box 14549, Savannah, GA 31416 or Messiah Lutheran Church, One West Ridge Road, Savannah, GA 31411.

Compiled with information from Savannah Morning News and GSA records.

Joseph Augustus Mulherin, Jr. MD

Joseph Augustus Mulherin, Jr. MD, died Tuesday, January 15, 2013 after a brief illness. Dr. Mulherin was a retired GSA Member and anesthesiologist at Candler Hospital.

Dr. Mulherin was born in Augusta, Georgia on May 25, 1931. After graduating Boys Catholic High School he served in the Navy and was honorably discharged. He then went on to earn a B.S. degree from the University of Georgia in August 1955 and an MD degree from the Medical College of Georgia in June 1958. He completed an Internship at Memorial hospital in Savannah Georgia in July 1959 and finished his Residency in Anesthesiology, also at Memorial, in June 1963. During this time, he also maintained a general practice in Hinesville, GA. He was then accepted to a Clinical Fellowship in anesthesiology at Massachusetts General Hospital in Boston Massachusetts where he was also named acting chief resident. He completed his fellowship at Mass General in December 1964.

He then moved back to the Savannah, Georgia and joined Anesthesiology Associates where he practiced anesthesiology at Candler Hospital until he retired in 1993. He was active in politics, an avid golfer, Good Samaritan and a great story teller. He was a member of, the Hibernian Society of Savannah and was a communicant of St. James Catholic Church.

Dr. Mulherin is survived by his children, Kathleen Mulherin Taylor (Earl), Joseph A. Mulherin III (Lisa), Theresa Mulherin Agnew (Roger), Michael G. Mulherin, Mark E. Mulherin (Cindy), his ten grandchildren, two great-grandchildren, a niece and two nephews.

Mass of the Christian Burial was held on Saturday, January 19, 2013 at St. James Catholic Church. Remembrances may be made to St. James Catholic Church, 8412 Whitfield Ave., Savannah, GA 31406 or St. Vincent's Academy, 207 E. Liberty St., Savannah, GA 31401.

Compiled with information from Savannah Morning News and GSA records.