GSA Newsletter
GEORGIA SOCIETY OF ANESTHESIOLOGISTS OCTOBER 2006

The Key to Your Future: The ASA and the AMA

By John Neeld, M.D.

Dr. Neeld is a past president of the American Society of Anesthesiologists and is an active member of the American Medical Association. The following article was written for medical students.

This chapter outlines the over-riding importance of organized medicine, that is, the American Society of Anesthesiologists (ASA) and the American Medical Association (AMA), to your future.

Let's begin at what turned out to be my earliest statement about organized medicine:

"I have no interest in medical politics, I simply want to be a good doctor". These words were in response to a question posed by my soon-to-be-wife in 1974, and I sincerely meant every word.

I believe today's students would champion a similar idealistic view; and I interpret the statement of Benjamin D. Unger, M.D., 2006 President of the ASA Resident Council Governing Council: "I like to consider myself of the generation of doctors whose practice is evidence-based and data driven" (1) to reflect views similar to mine but couched in the language of today's medicine."

I soon learned, however, as you will, that being a good physician is necessary but not sufficient to fulfill our duty to protect and improve the health of our patients and to advance medical knowledge.

While physicians deal very effectively with the needs of their individual patients on the micro level in our practices, the future of our profession and of health care in America will be determined at the macro-level by the Federal government in Washington and in the various states by their legislators and regulators. It is only through the strength of organized medicine, the ASA and AMA, that physicians can influence the processes that will determine their future.

Consider the following:

1.) The United States spends more than any other nation on health care, some $6,300 per person annually or 15% of the Gross Domestic Product [(2)].
2.) 45 million Americans are uninsured.
3.) Some sources rank the U.S. 37th in the world in terms of value received for money spent on health care. [(3)]
4.) Voters consistently rank "affordability of health care" second only to the economy as a major concern. [(4)]
5.) Levels of reimbursement are not controlled primarily by physicians but are dominated by the Federal Government through the Medicare program which determines both the manner and amount of reimbursement for physician services.
6.) In the private sector, the consolidation of health plans into a few dominant payers who frequently reimburse a percentage of Medicare's payments for similar services (sometimes less than 100%) has severely limited the ability of physicians and physician groups to negotiate for non-government controlled payments.
7.) The hugely flawed sustainable growth rate (SGR) formula for determining physician reimbursement under Medicare has resulted in reimbursements falling behind the government's own estimates of the growth in practice costs by 12% over the last four years with further reductions projected to be 37% by 2015, a period during which practice costs are projected to rise by 22%. Clearly we cannot sustain these reductions.

Can you and I resolve these enormous issues individually? Of course not. We must come together with all of our colleagues under the leadership of the AMA working with the

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Newsletter Doubles

In an effort to satisfy the requests of our business partners for more advertising opportunities, the GSA Newsletter will be published four times annually. This decision by the GSA Executive Committee creates an advantage of increasing communications to members, especially during the months leading to the convening of the General Assembly.

Members of the Society will also be afforded more space to communicate opinions and ask questions. A new "Letters to the Editor" page will be the venue for such communication and response.

Articles on a variety of subjects relative to patient safety and the practice of Anesthesiology will be featured in future issues, and a broader authorship will be encouraged to expand the source of comment and appeal.

Please encourage vendors and exhibitors to advertise to GSA members through the quarterly *GSA Newsletter.*

The Editor

Editor's Corner

Carolyn Bannister, M.D.
Editor

Hello Colleagues,

I hope this finds all of you doing well. When you receive this edition of the newsletter, you may think that time is moving faster than the usual warp speed at which it seems to move. Is it really time for the winter edition? How many days 'til Christmas? Well, relax. It has only been three months since the last edition of the *GSA Newsletter* reached you. In the meantime, the GSA executive committee has enthusiastically approved doubling production to four editions annually; and this is the first "extra" edition.

We would hope to expand the current newsletter format to include a section for member discussion, questions, ideas, and opportunities for improvement. We may review an article that is particularly timely. We have discussed inviting guest editors for some editions. With that in mind, given the important pending legislative atmosphere, I have asked our lobbyist, Jet Toney, to be the guest editor for this edition. Mr. Toney is well known and highly respected for his thoughtful, honest representation of the issues and his diligent pursuit of legislation that protects and promotes patient safety.

As a means of introduction of our guest editor (is any really needed?) I present the following:

James E. "Jet" Toney is a cum laude graduate of the University of Georgia where he majored in Journalism and minored in Marketing and Political Science. He is President and CEO of Cornerstone Communications Group, Inc. which he formed along with partner Michael R. Holiman in 1990. This firm specializes in public and media relations, government affairs and issues management; clients include the Georgia Foundation for Independent Colleges, the Medical Association of Georgia, Choicepoint verification services, the Georgia Affordable Housing Coalition, the Georgia Council for the Hearing Impaired, and the Georgia Society of Anesthesiologists.

Mr. Toney served as Director of the Georgia House of Representatives Public Information Office from 1979 to1986 and was a staff member for 11 years. A veteran of 31 state legislative sessions, Mr. Toney has lobbied for various business, government, higher education and health care issues for the past 20 years.

It gives me great pleasure to turn this edition over to Jet Toney. I am honored to be able to work with him through our Society.

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Guest Editor

James E. "Jet" Toney
Executive Secretary

Evolution of GSA real 'reality' show

With humility I accept the opportunity to serve as "Guest Editor" of the reformatted *GSA Newsletter.* I am honored that Dr. Carolyn Bannister, communications committee chair for the Society and newsletter editor, would allow a non-physician to take the reins of the Society's primary internal communications tool for even one issue.

This guest editorial is organized in two parts: 1) a walk-through of the contents of this issue with explanation of why and how these pieces fit, and 2) personal observations on the evolution of GSA with a glimpse of the future.

Part One

The work of the Georgia Society of Anesthesiologists is one heckuva reality show. I'm not one given to watching reality shows because I cannot get past the existence of a television camera on a deserted island. What members of the GSA face on a day-to-day continuum and what the Society faces in Congress and at the State Capitol is more than enough reality for me. I'm confident that your changing practice and its financial pressures are all the reality you need as well.

With the theme of reality in mind, the Society's leadership team has fashioned an edition of the *Newsletter* that highlights the role of professional medical societies at the national level and spotlights components of the work of GSA and the Medical Association of Georgia at the state level. The reality of advocacy is that the ASA, AMA, GSA and MAG are so thoroughly intertwined that the sum of the government relations efforts of each is far greater than anything even one or two of the organizations could do alone at peak efficiency. I encourage every GSA member to join each of these professional organizations and to support their political action committees. From my viewpoint, membership in these is the "union card", the minimum level of activity for an anesthesiologist.

Dr. John Neeld's cover story places in proper perspective the value of involvement in and support of the AMA and the ASA. His article on page four summarizes one of the most potent and possibly divisive issues that can be considered by the Georgia General Assembly in January 2007. As a complementary note, the list on page five of GSA members contributing to GSA-PAC reveals which physicians are not only aware of how important electoral involvement is to public policy advocacy but also indicates their desire to participate dynamically.

On a component level, Resident President Barry Barton, M.D. describes on page 14 the learning curve he is experiencing relative to the work and value of professional medical societies. His awareness of service opportunities for resident physicians and those entering into private practice should not be lost on even the most experienced physician.

On page 12, Dr. Howard Odom, the GSA's chair for Anesthesia Care Team issues, characterizes the organizational opportunity before Anesthesiologists Assistants. The GSA Executive Committee has committed to facilitate AAs in the creation of a state-level organization if AAs so decide. The decision, however, will be made by AAs and not GSA leaders.

ASA Director Steve Sween, M.D. offers a glance at the GSA as an organization. And while his text is a requisite report of the GSA component to the mother ship (the ASA), it offers a strikingly focused snapshot of where the organization is 10 years beyond its transformation from the volunteer-led "club" model of operation to a combined volunteer-led, professionally-staffed outfit.

This brings me to my last point about the emphasis of this issue. On page 13 is an announcement about the formal presentation of the CWL Award to Dr. Robert Crumrine at the Winter Forum. One might be given to overlook both the significance of the award and the awardee. Allow me to explain…

Part Two

GSA is an evolving professional organization whose successes in providing world-class educational programs and public policy advocacy on behalf of patients and members

Continued on page 11

New Feature:
Letters to the Editor

GSA members and friends of the organization are encouraged to contribute Letters to the Editor (LTE) by emailing *GSA Newsletter* Editor Dr. Carolyn Bannister at **carolyn.bannister@emoryhealthcare.org**.

LTE submissions may include statements of fact and opinion, or both. LTEs may be stated in the manner of a question or suggestion, or both.

The GSA Executive Committee encourages members to communicate their perspectives through LTEs. The discussion which ensues will equip the Society to deal more knowledgeably with critical contemporary issues. With the Newsletter doubling to a quarterly format, maintaining timeliness is less of a concern.

Remember, submissions may be published in subsequent newsletters. Let us hear from you!

Thoughts on CON policy

By John Neeld, M.D.

A small but very vocal group of physicians, primarily members of the Georgia Society of General Surgeons (GSGS), is attempting to persuade the Medical Association of Georgia (MAG) to make radical revision, if not the total repeal, of Georgia's current Certificate of Need (CON) laws its number one legislative objective in 2007. Their effort apparently stems from the fact that current Georgia law does not consider general surgery to be a single specialty which has prevented general surgeons from benefiting from the 1991 law exempting physicians in single-specialty physician-owned ambulatory surgical centers (ASCs) from the CON review process as long as the cost of building and equipping the facility falls below a certain expenditure threshold.

The exclusion of single-specialty ASC's from the CON process means that their owners do not have to demonstrate that there is any need for the services offered, do not have to accept Medicaid patients or provide indigent or charity care and do not have to report health planning data to the state; rather, they are issued a Letter of Non-Reviewability (LNR) by the Department of Community Health (DCH). This liberal exemption of ASCs from CON review has led Georgia to be ranked #3 in the nation in the number of ASCs, trailing only California and Florida.

It is understandable that general surgeons would wish to be considered a single-specialty so that they could also develop ASCs without CON review. The CON laws do not need to be repealed in order to accomplish this goal.

As members of the GSA consider the question of the CON laws it is important to remember that quality health care for all Georgians is directly dependent upon the continued economic viability of our hospitals, especially the not-for-profit community hospitals. It is these institutions, not ACSs, that our citizens depend upon to provide care for anyone with an emergency, regardless of ability to pay. It is these institutions, not ACSs, that assure access to care for all patients, including the uninsured and underinsured and insure the availability of unprofitable services such as emergency departments, trauma service, L & D, and ICUs.

Our citizens and our legislators understand the economic viability of hospitals must be assured; a wholesale attack on the CON laws will be portrayed as a threat to hospital survivability and will likely be a costly defeat for medicine.

It seems that a logical course for MAG to pursue would be:

1.) Maintain the physician-owned single-specialty CON exemption.
2.) Obtain single-specialty designation under CON for general surgery.
3.) Increase the ASC global threshold from $1.6 million to a more reasonable amount.

While the hospital association would likely oppose the above proposals, the opposition would certainly be less spirited than medicine would face with an attempt for greater CON reform.

As the debate approaches, the GSA needs to encourage MAG to focus on what is best for the health care of all citizens, including the 1.5 million uninsured Georgians, and not spend precious political capital for the economic benefit of a very small number of MAG members.

The GSA and MAG need to concentrate upon major issues that effect all members, such as the preservation of tort reform (which was achieved by one vote), improved reimbursement under Medicaid, abusive contracting practices resulting from the concentration of market power among smaller number of payers and elimination of the SGR formula for Medicare reimbursement. These are issues for all of us; radical revision of CON laws is not.

MEDICAL ASSOCIATION OF GEORGIA

PROPOSED 2007 LEGISLATIVE PRIORITIES

Tier 1

1. Protect Tort Reform
2. Certificate of Need
   - A. General Surgery as a "Single Specialty"
   - B. Protect Single Specialty Exemption
   - C. Eliminate Capital Threshold
3. Regulate TPA: Broaden Application of Prompt Pay Statute to ERISA Plans

Tier 2

1. Stop Scope of Practice Expansions
   - A. Optometry
   - B. Psychologist
   - C. Chiropractor
   - D. Pharmacists (Therapeutic Substitution)
2. Secure Funding for Trauma Network
3. Rewrite of Medical Practice Act

OTHER ISSUES OF IMPORTANCE

Payment Issues

Medicaid Managed Care
Fair contracting/Rental Network
Economic Profiling/(Tiering Physician Networks)
Attacks on balanced Billing
Credentialing

The Uninsured:

Develop Policy and Legislation to Address the Issue of the Uninsured

Marketplace Issues:

Antitrust Reform (State Action Doctrine)
Mini-Clinics

Public Health Issues:

Advanced Directives
Obesity
Tobacco Use

2006 PAC Contributors

The following members have boosted GSA's public policy clout by contributing to the Committee for Responsible Healthcare Policy (GSA-PAC). During the 2006 election cycle, more than $75,000 in contributions will be presented to candidates who support civil justice reform and laws that promote patient safety.

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The Key to Your Future ...

(Continued from page 1)

ASA, all specialty societies and the state medical associations to exert our collective influence at the national level. If we fail, the increasing number of the uninsured and under-insured, ever rising costs for patients and their employers, and the growing perception that the quality of American health care has declined make the threat of a single-payer system very real. A decision to move to such a plan will be irrevocable and the fate of medicine's future will be sealed. Failure to actively participate in the political process is not an acceptable or realistic option for any physician in today's world.

Failure to actively participate in the political process is not an acceptable or realistic option for any physician in today's world.

Even as AMA and ASA deal with these complex and dangerous issues at the national level, we must also deal with the annual efforts of non-physician practitioner groups in state legislatures to expand their scope of practice by regulation, not education. Organized medicine does not battle these efforts to "protect our turf" or enhance income; it does so solely to protect our patients, who know virtually nothing about the education and qualifications of health care providers, from being misled about the identity and qualifications of different providers.

The AMA and ASA are responding effectively in this arena. The AMA House of Delegates at its June 2006 meeting passed the ASA's Resolution 211 "Need to Expose and Counter Nurse Doctorial Programs (NDP) Misrepresentation". The resolution was prompted by the plan of the American Association of Colleges of Nursing to convert their advanced practice nursing degrees from a Master's level to a Doctor of Nursing Practice Degree by 2015 and ASA's concern that patient safety could be jeopardized in the clinical setting by nurses and other NPP's identifying themselves as "doctors" when they have not earned a medical degree.

Additionally, in February 2005 the AMA created the Scope of Practice Partnership (SOPP), which includes ASA as a member of its executive board, to coordinate nationwide activities on the scope of practice issue with the various specialty and state medical associations.

The creation of the SOPP is clearly "on target" based on the June 2006 creation of the Coalition for Patients' Rights (CPR) which consists of some 25 organizations of NPP's including the AANA, various other nursing organizations, chiropractors, psychologists and physical therapists. The CPR attempts to counter the SOPP's efforts to clarify the true qualifications of NPP's for the public by characterizing it as an effort to "reduce provider options for patients".

Excerpts from the CPR's Joint Statement include the following:

1.) "It is inappropriate for physician organizations to advise consumers, legislators, regulators, policy makers or payors regarding the scope of practice of licensed healthcare professionals whose practice is authorized in statutes other than medical practice acts. The erroneous assumption that physician organizations should determine what is best for other licensed healthcare professions is an outdated line of thinking that does not serve today's patients. (Emphasis added).

2.) ... "With America's population aging, we are the answer to the challenge of keeping pace with the demand for quality heath care services".

3.) "Our members are not physician adjuncts, and are independently responsible for their actions, regardless of whether physicians are involved".

In your medical school education you have probably heard little, perhaps nothing, about the issues I have briefly addressed; regrettably, few anesthesiology residency programs offer much information either. Yet these are major, "real world" issues that ASA and AMA are attempting to address on behalf of every physician in our nation. The outcome of these issues will affect your practice of medicine and the care of our citizens every day of your career.

Staying on the side-lines, "above the fray", with others fighting the battles for you, is not an honorable or acceptable option. The minimum acceptable level of participation is membership in the organizations of medicine (your local and state medical associations, the AMA, your local and state anesthesia societies and the ASA) and at least the minimum contributions to all of these organizations' PACs (political action committees).

Let me close with the wise words of the 2006 President of the ASA, Dr. Orin F. Guidry:

"We must be politically active and politically astute in medical politics as well as in governmental politics. AMA is important (really important !)" [5]

REFERENCES

1.) ASA Newsletter, January 2006, Vol. 70 #1.

2.) Mark S. Williams, M.D., MBA, JD in a lecture presented at the summer meeting of the Georgia Society of Anesthesiologists at Hilton Head, South Carolina, July 29, 2006.

3.) Ibid

4.) Finkelstein, JB. Health insurance access is back on America's agenda. Am Med News, 2004; 47 (5): 1-2

5.) ASA Newsletter, February 2005, Vol. 69 #2

ASA Director's Report

Steven L. Sween, M.D.
Director (Georgia)

Annual Report to the ASA

Our component society is comprised of ASA members from the state of Georgia, geographically the largest state East of the Mississippi River. We are the Georgia Society of Anesthesiologists (GSA).

Membership and Leadership 2006

Active	601
Resident	77
Retired	81
Affiliate	23
Lifetime	1
Student	4

TOTAL 787

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ASA Delegates	Carolyn Bannister, M.D.
	Arnold Berry, M.D.
	Charles "Chip" Clifton, M.D.
	Peggy Duke, M.D.
	Jay Johansen, M.D.
	William "Bob" Lane, M.D.
	Howard Odom, M.D.

Education

Education is an important component of GSA's mission. GSA sponsors two excellent educational meetings each year.

The 2006 winter meeting, "Anesthesia, Vintage 2006" was held in January at the Chateau Elan Winery and Resort in Braselton, Georgia. Eddie Johnston, M.D., program director, compiled a world-class group of speakers for this one- day event addressing various topics related to the contemporary practice of anesthesia, including Dr. Jerry Reves, Dr. Joanne Conroy, Dr. Jim Zaidan and Congressman Dr. Tom Price.

In July, the GSA held its annual summer weekend meeting at the Sea Pines Resort on Hilton Head Island, South Carolina. An exceptional group of invited speakers discussed topics relating to "Anesthesia by The Sea," under the superb program direction of Bruce Hines, M.D. We were honored to have ASA President Dr. Fred Guidry and Nancy at our summer gathering. GSA is proud of the extraordinary quality of our semi-annual meetings, but we are discouraged with member participation (attendance). We continue to enjoy excellent vendor participation and support that is so vital to our ability to hold quality educational events. GSA is determined to remain a vibrant society with extraordinary benefits to our members. Outreach to membership must remain a priority. If meetings with excellent CME are not a productive method to effect participation, then we may entertain the idea of expanding our GSA Newsletter from twice a year to quarterly. Motivation of a broader and more active membership is an area of improvement for GSA.

Georgia is home to two fine graduate medical education programs in Anesthesiology, one at Emory University in Atlanta and the other at the Medical College of Georgia in Augusta. Each of these quality institutions of higher learning produces intelligent, well-trained and enthusiastic anesthesiologists to carry us into our next generation of caregivers and GSA leaders. GSA promotes and values the membership and participation of its resident component. The MAG Mutual Group, Georgia's largest writer of medical malpractice insurance, has been a consistent and generous source of support to our resident component. GSA greatly appreciates our close and long-standing relationship with MAG Mutual.

Governmental Affairs

Several years ago we established two important goals for GSA: First, develop an active and effective GSA PAC, and second, establish an excellent relationship with our state medical society, the Medical Association of Georgia (MAG). Under the expert and intelligent direction of our highly-respected executive secretary and lobbyist, Mr. Jet Toney, GSA has been very successful on both accounts.

So far in 2006, the GSA PAC enjoys participation by 37% of active GSA members with a total of just under $40,000 contributed. The PAC has been very active in this election cycle, and has been fundamental and invaluable in our ability to establish lasting relationships with members of the Georgia General Assembly and other state officials. We often coordinate our political efforts with those of MAG, which has fostered an outstanding relationship. We have contributed to MAG fund-raising campaigns. Within the General Assembly, MAG has arguably been more successful than any other state medical society in its opposition to scope of practice legislative proposals by non-physicians.

In 2005, MAG was highly influential in the passage of substantive and effective medical liability reform by the Georgia General Assembly. Although there is great concern that the trial lawyers may attempt to incrementally dismantle this progressive legislation, only minor and generally acceptable modifications were made in the 2006 session. GSA respects

Continued on page 9

ASA Director's Report

(Continued from page 8)

and appreciates our alliance with MAG as we contemplate future challenges in the Georgia state legislature.

There is little question in my mind that GSA enjoys a relatively privileged and stronger position because of a less dominant state nurse anesthesia organization. For those anesthesiologists who choose to practice in the ACT mode, we are extremely fortunate in Georgia to have a choice between Anesthesiologist Assistants (AAs) and CRNAs, in about equal numbers. Most practices in the Atlanta-metro area employ some of each, to varying degrees. In my practice and in my experience, there is little or no acrimony (in Atlanta) between the two groups of non-physician anesthesia providers. To my knowledge, anesthesiologists in Georgia harbor little prejudice favoring one group over another. In my opinion, the balance provided by nearly equal numbers of all three types of anesthesia providers in Georgia creates a sense of harmony and a practice model that may be the envy of many.

Atlanta, GA – GSA Executive Secretary Jet Toney (left) poses with Georgia House Speaker Glenn Richardson, R-Hiram, and House Majority Leader Jerry Keen, R-St. Simon's Island, at a 2005 political function. Toney represents the interests of GSA members at the State Capitol and before state agencies. The emphasis, he states, is promoting "patient safety...After that, everything else falls in line."

I was honored to give the commencement address at last week's AA graduation ceremony at Emory University. One of the points that I emphasized was the growing support among ASA leaders and the House of Delegates for the expansion of AA practice and training programs, and the importance of their ASA membership and participation to the continued momentum for the expansion of AA practice.

GSA will soon expand its efforts to facilitate the organization of a Georgia AA component. In so doing, we hope to promote and energize the AAs in Georgia to a higher level of interest and involvement (membership) in ASA. More AAs reside and practice in Georgia than in all of the other states combined.

I recall meeting Dr. Fred Guidry for the first time in 1993 in Atlanta for an ASA-sponsored regional workshop on how to organize a component society, with particular emphasis on strengthening state governmental affairs and lobbying. GSA had just retained Mr. James "Jet" Toney to represent us, and Jet gave one of the lobbyist presentations that Saturday morning. During a break, Dr. Guidry commented to me, "it looks like GSA is well-served in its representation." Indeed, Fred's statement was accurate, but I can state now thirteen years later that his assessment was actually a gross underestimate of what Jet would bring to the GSA. His steady hand of leadership, wise counsel, respect and integrity has contributed more to the tremendous progress and maturity of our organization than anybody could have predicted way back then.

At this year's summer meeting of the GSA, several of the vendors complimented us for our hospitality and our pleasant demeanor. I am certain that those kind words were very much influenced by their interactions with our association management (Jet's Cornerstone group) prior to and at our venue. I am fully aware that GSA was incredibly fortunate to retain Jet Toney more than a decade ago, and not every component society has had or will have the same extraordinary results. However, I would encourage every component that has not yet shared our experience to consider the tremendous benefit and advantage that high quality and high character association management has brought to the Georgia Society of Anesthesiologists.

Save the dates!

2007

Winter Meeting: Sat., January 20, 2007
Marriott Evergreen Conference Resort - Stone Mountain Park, GA

Summer Meeting: Fri., August 3 - Sun., August 5, 2007
King & Prince Resort - St. Simon's Island, GA

2008

Winter Meeting: Sat., January 26, 2008

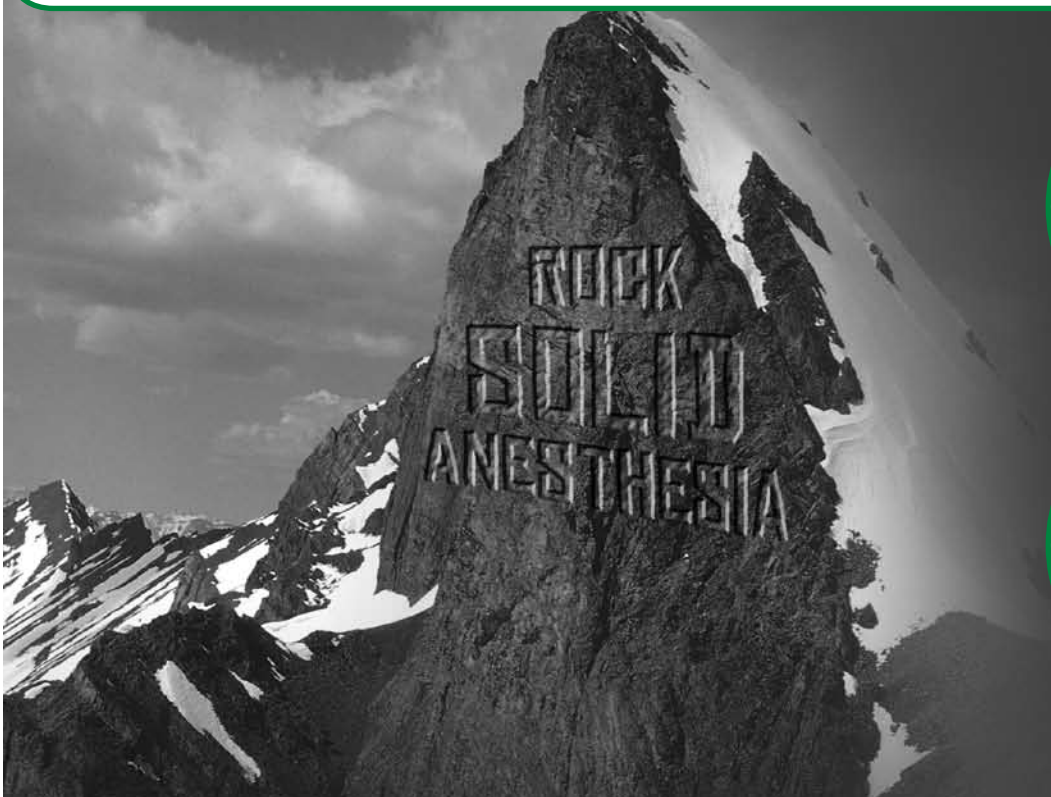
Summer Meeting: Fri., July 25 - Sun., July 27, 2008
Sea Pines Resort - Hilton Head Island, SC

2009

Winter Meeting: Sat., January 24, 2009

Summer Meeting: Fri., July 31 - Sun., August 2, 2009
King and Prince Resort - St. Simon's Island, GA

Winter Meeting 2007



January 20, 2007

Marriott Evergreen Conference Resort

Stone Mountain Park
www.evergreenresort.com
www.stonemountainpark.com

Program Director
Kathryn Stack, M.D.

Call **888-670-2250** now for reservations. Ask for the GSA room block.

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Wake Forest University School of Medicine
Winston-Salem, NC

Pediatric Anesthesia
Zeev Kain, M.D.
Yale University School of Medicine
New Haven, CT

Medical Malpractice
Anna Fretwell, Attorney
Huff, Powell, Bailey LLC
Atlanta, GA

Chronic Pain
Anne Marie McKenzie-Brown, M.D.
Emory University School of Medicine
Atlanta, GA

Crawford W. Long History Lecture
Physician's Assistants in Anesthesia
Ron Hall, M.D.
Emory University School of Medicine
Atlanta, GA

Legislative Affairs Update
Special Guest

Marriott EVERGREEN CONFERENCE RESORT

Guest Editor

(Continued from page 3)

could be chronicled over dozens of pages in this publication. The history of GSA, were it chronicled in a reality series, would be divided into two periods: BC and AC, i.e. Pre-Crumrine and Post-Crumrine.

As a reality show, the Pre-Crumrine era would be filled with episodes of the patriarchs and matriarchs of modernizing anesthesia practices creating the Society and running it as an addendum to their medical practice. In an era without pressures of managed care and waves of slow-, low- or no-payment patients, physicians were apparently able to section off larger portions of their schedules to volunteer. The model worked well. I salute the myriad of hours invested in the BC GSA by countless leaders. Your successes are many in CME and public policy.

In the post-Crumrine era, physicians across most specialties do not enjoy the flex-time choices that allow for huge amounts of time for volunteerism, even in activities as important to one's livelihood as the GSA or MAG. Therefore, a new organizational model was adopted including continued doses of volunteer participation by GSA members across the state with nutritional supplements from paid staff members.

The transitional median between these two operational models is Bob Crumrine, the 1996 GSA President who invested one day a week for nearly a year driving from the Medical College of Georgia to GSA's then midtown Atlanta offices. Crumrine, with the concurrence and direction of the Board of Directors, steered the Society through the transition. By all standards and comparisons, the move was a good one, having withstood the test of time, finances and politics.

The keys to future success remain firmly in the level of volunteerism and commitment members are willing to invest in the Society's educational and governmental production. Indicators are strong that individual members desire to participate and to lead. Recently, Dr. Chip Clifton announced that, after a decade of service, he is unable to continue as the GSA rep to the Medicare CAC. Enter Dr. David Gale (see page 15 for CAC report). A month ago, one rising member on the leadership ladder withdrew to handle practice matters. Another member is stepping forward to handle the responsibilities.

Even considering these positive indicators, however, we know the organizational dynamism of the Society will continue to be tested by the nature of medical practice generally and anesthesiology, specifically. To encourage participation, the Executive Committee has charged newly elected Secretary-Treasurer Jay Johansen, M.D. with the task of turbo-charging involvement at all components and affiliations. Among the initiatives which GSA members can undertake to help maintain the organization's dynamic volunteer leadership are the following:

- Multi-member practice groups should designate at least one physician to attend each GSA educational meeting (winter and summer events)
- Multi-member practice groups should designate and underwrite the participation of at least one physician to the eye-opening ASA Washington Legislative Conference (annually in spring)
- Practice groups in the less populated areas of Georgia can participate at a leadership level through electronic means and are encouraged to do so
- Contributions to the GSA-PAC should be a priority of every practice group regardless of size
- Contact members of the Board (see page two) or GSA headquarters to volunteer to serve on committees (see back cover) or to nominate a member for election to the responsibilities of an officer
- Every GSA member can encourage vendors to participate in the GSA through advertising, exhibits at meetings or undesignated educational gifts
- Every GSA member can encourage a non-member to join

In summary, allow me to state that from my perspective as the hired help, the future of the GSA (and the profession) depends on the investment of time and intellect by its members.

The Society's mission remains tied to the provision of top quality medical education and the delivery of effective public policy advocacy at the state level. The ingredients of success in an AC GSA remain (as it was BC) lots of continuing hard work from many different individuals and a genuine appreciation for one's patients and practice.

New Feature:

Letters to the Editor

GSA members and friends of the organization are encouraged to contribute Letters to the Editor (LTE) by emailing *GSA Newsletter* Editor Dr. Carolyn Bannister at **carolyn.bannister@emoryhealthcare.org**.

LTE submissions may include statements of fact and opinion, or both. LTEs may be stated in the manner of a question or suggestion, or both.

The GSA Executive Committee encourages members to communicate their perspectives through LTEs. The discussion which ensues will equip the Society to deal more knowledgeably with critical contemporary issues. With the Newsletter doubling to a quarterly format, maintaining timeliness is less of a concern.

Remember, submissions may be published in subsequent newsletters. Let us hear from you!

Anesthesia Care Team

An organization for Georgia AAs?

Howard Odom, M.D.
Chair, Anesthesia Care Team Committee

The *GSA Newsletter* has included updates related to anesthetist issues many times before. On this occasion it is to inform members regarding the current interest to form a state-level professional organization for Anesthesiologist Assistants (AAs). The premise is that formation of such an organization would be a natural and important step forward along a direction which leads to a more visible and constructive professional identity for AAs in Georgia. Why is this a natural step?

The Anesthesia Care Team (ACT) remains alive and well in Georgia. Without fanfare or long-winded explanations, a large portion of Georgia healthcare consumers have become dependent on the ACT. This mode of anesthesiology practice has been successfully applied across the state as groups and facilities of all sizes have established a track record of excellent care. AAs have been functioning as Care Team members in Georgia since before the concept was initially formalized in the 1982 ASA *Statement on the Anesthesia Care Team*. **Some consider that the current *Statement on the ACT* was substantially validated by experience with AAs in Georgia.**

Formation of a state-level AA organization raises several questions:

- Is such an organization needed?
- What would be the benefit of the organization to AAs?
- What would be the organization's mandate?
- How would the organization relate to GSA and GSA to it?
- What can or should anesthesiologists and practice groups do to support the launch effort?
- Is there a political role the organization can or should play?
- Isn't the need for state-level AA advocacy filled by the AAAA?

Though I won't propose answers to all of these questions, I do suggest you consider the first two questions from the perspective of your membership in GSA: "Is such an organization needed?" and "What are the benefits I gain from our state professional society?"

I need GSA because the organization and its members possess experience beyond my range of past opportunity, provide expertise outside my limited mastery, and exert influence in arenas to which I wouldn't otherwise gain access. The GSA is there for me, the individual.

Have I benefited from my state professional society? My view is that every anesthesiologist in Georgia – whether a member of GSA or not – has benefited from the influence and advocacy GSA provides. We know that our interests, within the profession and on behalf of our patients, will be spoken for with authority, conviction and compassion. These benefits are leveraged to an even greater degree by extending our involvement onto the national stage through the ASA.

Do AAs in Georgia need an organization which fulfills a similar role for the profession? I believe so. Will the organization mesh purposes with GSA for the benefit of patients and ACT practice solidarity? I hope so. Can the national organization

Some Basic Facts of AA Practice:

The Georgia View:

- AAs have been licensed as healthcare practitioners in Georgia for approximately 30 years.
- AAs are eligible to be Educational Affiliate members of GSA.
- There is presently no state-level professional society for AAs.
- Issues relevant to AA practice exist in Georgia despite their long history of participation as members of the Anesthesia Care Team.

The National View:

- AAs are a recognized health profession by:
  - Education program accreditors nationally
  - State Boards of Medicine (licensed as a type of physician assistant)
  - Third-Party payors (including CMS)
- AAs are designated members of the ASA Anesthesia Care Team Statement
- AAs are eligible to be Educational Affiliate members of ASA
- AAs have a national professional organization called the American Academy of Anesthesiologist Assistants (AAAA).
- AAAA has been the practitioner advocate in matters of AA practice into established states.
- AAAA has been the practitioner contact in efforts to extend AA practice into new states.
- AAAA participates with ASA as Member Organizations on the Accreditation

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Anesthesia Care Team

(Continued from page 12)

(AAAA) reformulate itself to capitalize on the proven model of national and component state organizations of the ASA and its Component Societies? I expect so.

Perhaps you see other questions or can draw personal parallels between your experience with GSA and the possibilities for an AA state organization. Some basic points are listed for your reference in the accompanying Fact Box. Georgia AAs should be represented when the inevitable issues related to licensure and practice arise in the future. We can only hope they will have the incredible good fortune to find an Executive Director of the caliber we enjoy in Mr. Jet Toney along with his staff at Cornerstone Communications Group.

As yet, there is no specific next step for GSA. A significant number of AAAA members and leadership are Georgia AAs. A core group will need to determine the level of AA interest and commitment to forming a Georgia AA component organization. You may be approached for your opinion and support. I hope you will see ways you can encourage the effort. Keep GSA informed of local developments. No matter how this issue progresses, I know I can count on my state Society to be at the table.

Crumrine recognized for CWL Award

Dr. Robert S. Crumrine of Augusta will receive the Crawford W. Long Award at the Society's January 20, 2007 Winter Forum at the Evergreen Conference Center at Stone Mountain Park.

Dr. Crumrine presided over the GSA in 1996 and was instrumental in establishing the Society's headquarters current structure and services. His focus advanced the organization from its strictly volunteer status to a model which today includes paid professional staff and increased outreach to members and affiliated organizations.

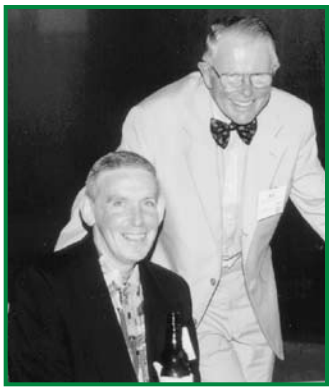
The Crawford W. Long Award is the highest honor which members of the Society can award one of their own. It is given in recognition to those physicians who have made exceptional contributions to the GSA and done so in the tradition of service as exemplified by the life and medical practice of Crawford W. Long, M.D., the originator of medical use of anesthesia and who practiced in Georgia. The Award is not an annual award but is reserved for those times when a person of special merit is identified.

The list of CWL Award recipients includes the following members:

- Dr. Perry P. Volpitto
- Dr. Evan L. Frederickson
- Dr. John E. Steinhaus
- Dr. Zachariah W. Gramling
- Dr. Joseph F. Johnston (1999)
- Dr. Julius N. "Buck" Hill (1999)
- Dr. Ronald W. Dunbar (2001)

To recommend a GSA member for consideration of this prestigious recognition, contact Dr. Peggy Duke, Chair, CWL Award Committee, at ***peggy.duke@emoryhealthcare.org***. Formal recommendations must be submitted in writing by a GSA member.

Robert S. Crumrine, 1996 GSA President, will receive the CWL Award at the 2007 Winter Forum on January 20 at Evergreen Conference Center, Stone Mtn. Park.



Daufuskie Island, SC -- Dr. Ronald W. Dunbar (standing) was recognized by GSA members in 2001 for the CWL Award. Dr. Steven Holtzman joined the celebration.

Amelia Island, FL -- Dr. Joseph F. Johnston (l) and Dr. Julius N. "Buck" Hill (r) received the CWL Award in 1999. GSA Director William Hammonds presented the award.

Resident President's Letter

Barry Barton, M.D.
President, GSA Resident Component

Completing a residency in Anesthesiology is a unique experience. As a resident you spend much of your time in the OR but you definitely aren't a surgeon. You spend much of your time with H & Ps, Pain Clinic, and running the ICU; but you are definitely not an internal medicine doc. Much of your residency is spent learning the intricacies of those aspects of medicine that are unique to anesthesiology.

But where do you find your voice? Somewhere between the pages of Miller and the practical experience of the OR and ICU you begin to understand what it means to deliver a well planned anesthetic. You begin to learn to calculate the risks, plan for the pitfalls, and obviate the obstacles. Yet through all this, sometimes what is happening in the "real world" of anesthesia is clouded over, distant. It's nice to be shielded from the real world when you are just learning to spread your wings; however, it is also vitally important to understand what is out there when you are just getting ready to soar.

This is why the Resident Component of the Georgia Society of Anesthesiology is vitally important.

It's nice to be shielded from the real world when you are just learning to spread your wings...

Truthfully, I attended my first GSA summer meeting as a first-year anesthesia resident because it was a nice weekend to get away and my department was willing to help cover some of the cost. What I experienced was eye opening. I discovered a whole new side to the world of anesthesiology that I did not know existed. I learned some of the issues that face our specialty and attended excellent educational lectures on topics at the cutting edge of anesthesiology. I wanted to find my voice, so I joined the resident component of the GSA.

The resident component of the GSA offers residents a voice; and we want to be heard. We are concerned about the future of our specialty; and we want to make a difference. This year we had 100 percent participation in GSA Political Action Committee contributions from the residents in attendance at the GSA summer meeting. This is an important step for those of us just entering the specialty and will help create habits that will preserve the interests of our patients and our own interests as well.

The resident component of the GSA also participates on the national level. We send a delegate every year to the legislative conference to understand the issues and bring back a report to the resident section. It is important for our lawmakers to hear anesthesiologists-in-training speaking up and participating at this level. It shows commitment to our specialty and impresses upon lawmakers the importance of our mission. It also provides yet another opportunity to educate residents about the political issues facing our specialty.

It is important for our lawmakers to see anesthesiologists-in-training speaking up...

In addition, Georgia maintains three delegate spots at the American Society of Anesthesiology Resident House of Delegates where we participate in making decisions that affect resident education and training quality across the nation. In this capacity we also have the opportunity to attend the ASA House of Delegates and observe the business of the ASA on a national level.

As resident anesthesiologists, our main goal is participation. The more residents that are exposed to the GSA and the ASA meetings the more anesthesiologists we will turn out who are aware of the issues and ready to step up and make a difference for the future of our specialty.

New Feature:
Letters to the Editor

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Member Benefit Profile

CAC: Not just another acronym

David Gale, M.D.
GSA Representative to the CAC

Editor's Note: Beginning this issue, the GSA Newsletter will profile a function or service that is provided by the Society on behalf of members. The purpose of these articles is to educate members about the various activities the organization conducts to meet its mission. As in most professional associations, members volunteer to perform these services or conduct such functions. It is through the sacrifice and commitment of a variety of members that GSA continues to provide value to its 700-plus members.

This may be a refresher course for many, but my gestault is that this particular acronym remains a mystery for the majority of our members. CAC stands for Carrier Advisory Committee, and I am your "CAC Rep".

The "carrier" is the health care contractor who administers each state's Medicare program. Commonly, these carriers are subsidiaries of major insurers (Wellpoint, Blue Cross Blue Shield, Anthem, etc). Each state contract is put up for bid on a recurring basis. Our contractor in Georgia is CAHABA who also holds the Alabama and Mississippi contracts. CAHABA is a subsidiary of Wellpoint, which also owns BCBS of GA, as well as many other insurers nationwide.

The "CAC" consists of representatives from each of the major specialties and subspecialties in each state. The practice of anesthesia is represented by GSA, cardiology by the Georgia Society of Cardiologists, and so on. There are currently 26 "CAC reps" who are physicians. We act as consultants to the Carrier Medical Director (CMD) who currently is Dr Earl Berman. Dr Berman is an internist who practiced in Georgia in a five-man group and became very interested in health care systems and policy through his clinical practice. He was hired as the CMD approximately three years ago.

The CAC meets three times per year in Georgia. Currently, the meetings are held at Crawford Long as the majority of the CAC reps work in the greater Atlanta area. The carrier is based in Savannah, and it brings in its administrative team for each meeting.

The purpose of the meetings is to discuss policy, utilization, new procedures/medications, etc. Local carriers have discretion to allow or disallow certain codes from being covered in the particular state or region. They also can set guidelines for utilization of a particular procedure to assure appropriate usage. For example, the CAC recently reviewed facet injections and stipulated that they must be fluoroscopically guided (or CT) to assure accurate needle placement. This prevents physicians from performing a trigger point injection near the spine and coding for a facet injection.

Another example is the clinical criteria needed prior to covering Remicaide infusions for the treatment of rheumatoid arthritis. It is important to note that actual reimbursement (payment) rates are determined at the national level by CMS (formerly HCFA), not the local carrier.

There is a move to consolidate nearby states into regions so policies can be the same for patients getting medical care in two different states. This happens commonly in the Dalton-Chattanooga region and in west Georgia with Birmingham. Cahaba currently has the state Medicare Part B contract for Georgia, Alabama, and Mississippi. It is in the process of consolidating the individual state policies to become uniform throughout the tri-state region. This is occurring in other parts of the US as well, under the direction of CMS.

Historically, GSA has had an outstanding working relationship with our carrier (CAHABA) and the Carrier Medical Director. During the mid 1990s, much confusion existed over interpretation of (then) HCFA's (now CMS's) "seven commandments" and "six allowable sins" for medical direction. Dr. Chip Clifton worked with CAHABA and the national leadership of ASA to develop reasonable interpretations of HCFA's language. The "Georgia Q and A's" were developed as a result of those efforts and have become the standard that the other CACs nationwide use for their own local policies. Chip defined the relationship of working closely with your carrier as opposed to being confrontational.

Currently, there are no significant OR anesthesia issues that the CAC is addressing. However, being visible at the CAC meetings is extremely important as issues WILL arise in the future. GSA must be ready.

Over the past several years, there has been an over-utilization of several pain management procedures. I am working closely with our CMD and the CAC to preserve patient access to pain relieving techniques. The goal is to preserve the integrity of the doctor-patient relationship in decision making while at the same time being a good steward of the finite sum of money available.

Editor's note:
To comment on GSA's involvement with the Carrier Advisory Committee or to submit a related question, email Dr. Carolyn Bannister, GSA Newsletter editor,at carolyn.bannister@emoryhealthcare.org. Submissions may be published in later editions of the GSA Newsletter.

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