GSA Newsletter
GEORGIA SOCIETY OF ANESTHESIOLOGISTS FALL 2007

The Ever-Changing World of Resident Education

By Howard Odom, M.D.
GSA President-Elect
Chair, Anesthesia Care Team Committee

I am grateful to *GSA Newsletter* Editor, Dr. Carolyn Bannister, for the opportunity to serve as guest editor for this edition of the Newsletter. The topic for this edition is "Residency Education in Georgia."

No matter what our current practice situation, we all share the experience of having trained at the elbow of our esteemed academic faculty. Conversations with colleagues often include "when I was a resident …" as the launching point of a most, or least memorable event during training. Despite sharing the singular role as an anesthesiologist, we have each arrived at that destination by a very personal path.

Think about it. How many roads could you choose to travel taking a driving trip from Atlanta to San Francisco? Many of us plan to fly there soon for the ASA 2007 Annual Meeting. There are countless possible driving routes, but the points of origin and destination are the same.

It is easy when you have been in practice for some time to think back to your residency education in much the same manner as a youthful road trip. Choosing your driving route meant deciding which residency programs possessed professional attractions just as a map shows the many possible roads to a destination. Road-side attractions, people and rare finds often defined the trip more indelibly than the eventual destination.

My medical world view was shaped by the healthcare system of the late 1980's – pre-managed care, pre-internet, pre-genome project, pre-simulators, and certainly pre-XM radio in the OR. Just think of how your life in medicine today is different from your pre-med role model's and even your residency mentor's.

Now consider the young anesthesiologists training and graduating today. Will they think back to a road trip analogy of their own? Perhaps, but just as MapQuest & Travelocity have somewhat replaced AAA as the travel guides, residency education looks quite different today than when I trained. One of the benchmarks of my vascular anesthesia experience, open abdominal aortic aneurysm repair, is becoming a rarity bowing now to endovascular stents placed under radiographic guidance.

Change is good because the new anesthesiologists that are needed will require different preparation. Healthcare and anesthesiology practice will continue to call for updated approaches to the old problems and different skills to apply to new problems. Surgical progress has been facilitated by our advances and has circled back to press us further forward. This is the professional cycle current residents will continue to fuel.

Forgive me for pressing the road trip analogy upon you, but allow me to twist it once more. Despite many shared experiences along the way, it seems to me that today's residency education points of origin and destination can no longer be assumed to be identical to ours. Significant differences exist in the diversity of life experiences before training and expectations for lifestyle after. Perhaps rather than Atlanta to San Francisco, today's trip might be one from Savannah to Orlando (site of the 2008 ASA Annual Meeting). At its origin, a well established and historic city rich with tradition, legend and the occasional coastal storm. Arriving at the destination, today's reality is one recently created from yesterday's fantasy. To the innovators at this new destination, even recreation assumes fluency in technology. Very different end points, but still an arduous journey.

I never expected, or wanted to practice the same old way forever after graduating. But I couldn't predict all the ways the world of clinical medicine would change. Patient safety and scientific leadership remain unshakable pillars of anesthesiology. If we are to justifiably claim our 'gold standard' position as anesthesia providers, we will need to develop new methodologies and management strategies to effectively deliver care in non-classical environments. Adaptability and innovation will be the key attributes of successful anesthesiologists now in the educational pathway.

This issue of the Newsletter brings you reports from the front lines of residency education in Georgia. Articles by Dr. Tom Philpot, Director of Residency Education at Emory, and Dr. Al Head, Department Chair at MCG, will give you a sense of what, and how much things are changing. What remains constant is that guided by the faculty of our two superb residency programs, trainees will be on-the-spot problem solvers and innovators. Be encouraged and reassured that your future partners will arrive well traveled.

Editor's Corner

Carolyn Bannister, M.D.
Editor, GSA Newsletter

Dr. Howard Odom, GSA President-Elect, is Guest Editor of this fall edition of the quarterly GSA *Newsletter*. The theme "Resident Education" allows GSA members an opportunity to read diverse perspectives on the current state of resident instruction and, perhaps more importantly, view prognostications on where Resident Education is going. And while the trends in education are certainly important to current and future medical students, real interest is likely to come from those GSA members who are responsible for hiring graduates turning out of Residency programs.

Thank you, Howard, for investing your time in the production of this valuable edition of the *Newsletter*.

Biographical Information

Dr. Odom is a Georgia native who received a B.S. in Physics at West Georgia College in Carrollton. Shortly after graduation he joined the Allied Health arm of the Emory University Anesthesiology Department in 1978 working for Dr. Wesley Frazier. As an instructor of basic sciences in the Anesthesiologist Assistant education program, he was a non-tenure track faculty member for the six years prior to entering medical school at Emory in 1986.

Following graduation in 1990, he completed an internship in General Surgery at Emory. The remainder of his anesthesia training was in Boston at Brigham & Women's Hospital. During his last year of residency in 1994, Dr. Odom served as Anesthesiology Chief Resident at Brigham & Women's Hospital.

Returning to Emory, Dr. Odom joined the faculty of as an Assistant Professor at Emory University Hospital. One primary educational role while at Emory was as Course Director of classes in the Anesthesiologist Assistant education program.

Dr. Odom founded North Point Anesthesia Consultants, LLC in 1999. The ongoing focus of his clinical interests has been to translate his experience in hospital-based anesthesia care into the world of office surgery.

Currently Dr. Odom is a Delegate to the American Society of Anesthesiologists (ASA) from the Georgia Society of Anesthesiologists (GSA), is the Chair of the GSA Anesthesia Care Team Committee and is the 2007 President-Elect of the GSA.

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President's Letter

Limits on Resident Duty Hours: Are the Effects Known?

By Arnold J. Berry, M.D., MPH

In July 2003, the Accreditation Council for Graduate Medical Education (ACGME) implemented duty hour regulations for all accredited residency programs. This action was taken because of concern regarding resident fatigue and sleepiness resulting from long work hours producing medical errors and adverse patient events.

The ACGME requirement limited in-hospital work to 80 hours per week and mandated that residents have one day in seven free from all educational and clinical duties. In-house call was not to exceed every third night on average and must not be longer than 24 hours. This meant that after a night of in-house call, an anesthesia resident could stay in the hospital on duty for up to 6 additional hours but only for educational sessions or to transfer care of patients or to participate in outpatient clinics, but the resident could not start a new anesthetic case on the morning after call.

Several recent observational studies, including two in the September 5, 2007 issue of JAMA, indicate that there were no changes or only small decreases in patient mortality after the ACGME duty limits were implemented. It is important to note that these studies did not specifically look at anesthesia practice.

Why is this issue important and what is the significance of these negative studies? Several years ago, the federal government, the Institute of Medicine, educators, and public policy makers became aware of a series of studies indicating that the long duty hours of trainees were associated with an increased risk of critical patient incidents such as incorrect interpretation of data and treatment errors. Consistent with the findings of this clinical research, a study in volunteers demonstrated that being continuously awake for 17 hours resulted in impairment of psychomotor function to a degree similar to that of volunteers tested with a blood alcohol level considered DUI. Research on sleep deprived anesthesiology residents performing cases using simulators to create a realistic operating room scenario demonstrated impairment on psychomotor testing but failed to show any significant clinical effects on the simulated patient care. An unexpected finding from this work was that anesthesia residents during their normal non-call periods of duty were chronically sleep deprived and functioned at a level similar to residents who were immediately post-call.

During the public debate, as ACGME was considering implementation of resident duty hour limits, many groups were concerned about the possible negative impact. Some argued that patient care might suffer since duty limits would require more transfers of clinical responsibility (i.e., shift work) from one resident team to the next. Inadequate transmission of critical information with these handoffs might have resulted in an increased incidence of clinical errors. (A tired resident who knows the patient may be better than a rested one who does not.)

Additionally, surgeons argued that duty limits might impair resident education and training since they would not be able to continuously follow a patient throughout their evaluation, surgery, and recovery into the early postoperative period. There were concerns related to the cost of hiring non-physicians to perform some of the routine functions (drawing blood, starting IVs) traditionally performed by trainees. Another consequence of resident duty hour limits is that faculty would be required to spend more time directly caring for patients when trainees were not available. When a resident "times out" (they had reached their maximum work hours for the week) during a long surgical procedure, the resident has to leave the case requiring the attending surgeon to operate without a first assistant. Therefore, as more information is being collected about the impact of the ACGME duty hour limits, the initial reports indicating no negative effects on patient care and outcomes are encouraging.

While ACGME duty hour limits are only applicable to residency training programs, there are no comparable requirements for practicing physicians. For other occupations such as truckers and airline pilots, the federal government has implemented very strict duty limits since these industries have an effect on public safety.

In 2004, the Association of Anaesthetists of Great Britain and Ireland published a monograph entitled "Fatigue and Anaesthetists" which addresses these issues for anesthesiologists in the U.K. In this document, the Association indicates that each practitioner carries a personal obligation to be aware of the problem of fatigue and notes that individuals should not practice when they believe that they are compromised by fatigue or sleep deprivation. The document also suggests that routine rest breaks should be taken during long periods of work and that group practices should assess on-call responsibility of individuals over 55 years of age. The American Society of Anesthesiologists Committee on Occupation Health has established a Task Force on Night Call and Fatigue that is beginning to consider these topics.

At the current time, when there is a shortage of anesthesiologists and anesthetists in the U.S., it is not feasible or desirable to begin a public discussion of the time that anesthesiologists are spending on duty. Any change in current practices might compromise patients' access to care provided by anesthesiologists. As we await additional information on the impact of duty hour limits for residents in training, we should be personally aware of the risks of fatigue and sleep deprivation so that we can provide the best possible care for our patients.

Resident Education

A biased and prospective view of Anesthesiology resident education for the future

C. Alvin Head, M.D.
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Is it time to change our methods of teaching residents? Possibly YES! Medicine has evolved significantly, even since my residency completion in 1993. Now more than ever, reimbursement issues influence decisions regarding drug usage and the need for speed of recovery and productivity in the operating room. Though no one likes change, this practice is not all bad.

The question I pose for educators is "How can we better equip residents for their future practice, rather than simply train them in the same manner we were trained, specifically since some of those practices are now clearly outdated?" This is not stated in disrespect towards the outstanding educators of the past, *(I have rapidly fallen into that category)* but rather to keep our minds open and directed toward endowing our residents with today's foremost excellence of knowledge, which will be required in their achievement of successful careers.

It is difficult to educate residents when the target is moving and the road ahead is not clear. Evolution of medicine combined with culture changes and attitudes toward the work environment of our medical students and residents have also significantly influenced teaching. More value is placed on time away from work. Maybe they have it right. As I grow older, it is now hard for me to determine if I had it right back then. We were not issued guidelines specifying how much time we could spend with a patient, nor were we issued specific guidelines on how much time we were allowed on an operative case. The Nike slogan, "Just Do It" still rings clearly in my mind. We had debt, but not at the level of most students and residents today.

The volume of knowledge continues to expand exponentially for almost every procedure anesthesiologists perform. Today, even the details and breadth of knowledge are greater than ever in administering basic anesthesia care. Malpractice and tort reform are now required topics of discussion with residents *(or should be)*, along with ethics and sensitivity training. Web-savvy patients have more questions and are more informed than ever before. Direct-to-consumer advertisements for medications make a significant contribution to this issue as well. Where does it end?

A call for sanity is needed! Our specialty has outgrown the ability to be all things to all patients. General Practice is not really General Practice when OB, Cardiac and Neuro-anesthesia demand such expertise. Using specialty physician knowledge to provide for the needs of the most complex and complicated patients offers not only job security for the fellowship-trained Anesthesiologist, but in the end, the real beneficiary of this knowledge is the patient. So again, this may not be all bad, but are we teaching in the right way to help the resident obtain the foremost knowledge?

Are we losing boundaries within this new medicine model? The answer is clearly a resounding "Yes"! Anesthesiologists perform the trans-esophageal echo (TEE) and take these procedures from cardiologists; while radiologists, cardiologists and surgeons are battling over invasive procedures in our modern radiology suites, which resemble operating rooms. I understand that hospitalists are developing a proceduralist track (since reimbursement is higher). Emergency Medicine residents and faculty are intubating and trying to perform general anesthesia (*excuse me, deep sedation as they call it*) in the Emergency Department.

So, is it time to have a separate Pain Residency? This would include rotations within neurology, psychiatry, rehab medicine, in addition to our standard regional and chronic pain anesthesia programs. This very issue is being discussed as I write. Should we use that new found time, formerly given to a pain rotation, to increase our Critical Care training or should that also be a distinct residency as well? Do office-based and ambulatory anesthesia practices need specialty training?

Unfortunately, I am discovering there are many more questions than answers in attempting to provide a solution of these issues. However, it is certain that our Society needs to begin aggressively defining and refining the direction of where it needs to go and precisely determine who we are! For our specialty to survive, it is imperative that we stay current with the movement of modern medicine; otherwise, we will be consumed into many other specialties that are now moving to re-invent themselves.

Food for thought!

Enjoy a GSA Committee!

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Resident Education

Resident Education, Competencies and the New Generation of Trainees

Thomas E. Philpot, M.D.
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The Residency Review Committee (RRC) for Anesthesiology, under the auspices of the Accreditation Council for Graduate Medical Education (ACGME), establishes training requirements for our specialty. Although the Outcome Project of the ACGME suggests that all training programs should show that residents have achieved a given level of expertise, our RRC continues to maintain specific minimal clinical experiences. These current minimal experiences must include anesthetics for 40 vaginal deliveries, 20 c-sections, 100 children less than 12 years old, 20 cardio-pulmonary bypass cases, 20 major vascular cases, 20 thoracic cases not involving bypass, 20 craniotomies, 50 epidurals, 10 trauma cases, 50 subarachnoid blocks, 40 peripheral nerve blocks, experience with acute and chronic pain management and pre-operative management.

The curriculum should include instruction in anesthetic considerations for geriatric and ambulatory surgery patients. Trainees must demonstrate significant airway management expertise and clinical skill with central vein cannulation techniques, and they should receive experience in transesophageal echocardiography, electroencephalography and evoked potential monitoring. Training programs must provide residents with a minimum of two weeks managing patients in the post anesthesia care unit and two months of critical care medicine. Newer requirements include instruction in signs and symptoms of substance abuse, stress and fatigue.

On July 1, 2008 residents will experience one month of specialized training in perioperative management and evaluation of surgical patients. This rotation ideally will focus on evidence-based medicine in anesthesiology practice. The critical care medicine experience will increase from two months to four months; however, residents are allowed to complete two of the required months during the clinical base year.

The ACGME, recognizing the potential for medical errors occurring when a resident is tired or fatigued, implemented duty hour standards for all 8,000 training programs. This standard requires that residents work no more that 80 hours per week averaged over four weeks. The resident must receive at least 10 hours of rest between duty periods and must not work in excess of 30 continuous hours, which includes the 24-hour call plus 6 hours of transfer of care or education. Duty hour standards guarantee one day in seven free from patient care and educational obligations. In house call can be no more frequent than one in three nights averaged over four weeks.

The RRC now requires that training programs evaluate residents in six competencies as part of the "Outcomes Project". The six areas are 1. patient care, 2. medical knowledge, 3. practice based learning and improvement, 4. interpersonal and communication skills, 5. professionalism and 6. system based practice. Residents must successfully meet the requirements of all six competencies to complete their training and be assessed by the departmental Clinical Competency Committee as having demonstrated the ability to practice the specialty competently and independently, which is the ultimate training "outcome".

The Resident Component meets annually at the GSA Summer Meeting. Residents elected a slate of officers for the 2007-08 year and organized for increased political participation.

The ACGME recommends specific assessment techniques for each of these competencies including traditional written and oral examinations, specific assessment forms, simulations, observed structure clinical examinations/evaluations. Over the 36 months of training in Anesthesiology, the program maintains

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ACT Update

The Challenge of Care Team Staffing – An Inside Track to Recruitment

By Howard Odom, M.D.
GSA President-Elect
Chair, Anesthesia Care Team Committee

This issue of the Newsletter highlights residency education in Georgia. Keeping our residency programs healthy is of prime importance to maintaining the supply of anesthesiologists. Many of us maintain contacts with our training programs as hunting grounds for new partners. In addition to physicians, the anesthesia workforce needed to meet future demands includes the practitioners who extend our care.

For a significant number of GSA members whose groups practice in the Anesthesia Care Team mode, anesthetist staffing is an ongoing challenge. Workload frequently exceeds workforce as new facilities are built and services are expanded. These changing demands are complicated by the departures of anesthetists who seek a different balance of hours and dollars. Those who remain with the group may want to transition to a more selective schedule of call or duty hours as they 'mature.'

The new challenge is to attract graduates to jobs in Georgia

So how can anesthesiology groups possibly manage their anesthetist needs? There are perhaps as many variations as there are groups, but in fact the actual range of methodologies is limited. One end of the spectrum is defined by the groups who maintain an ongoing recruitment effort in anticipation of the eventual need. The other extreme is to require the group partners to cover the unmet Care Team workload then begin looking when the need becomes critical. Wherever a groups lies on the spectrum, there is an obligatory investment of time and money to build and maintain a Care Team anesthetist workforce.

There is similar demand pressure on the supply of anesthetists just as there is for anesthesiologists. What are the supply prospects from the Anesthesiologist Assistant (AA) education programs? Nationally, the number of programs has more than doubled in the last four years. Two legacy institutions at Emory and Case Western were joined by South University in Savannah (second class graduated August, 2007) and Nova Southeastern in Fort Lauderdale, Florida (first class to graduate May 2008). The newest program opened this past summer at the University of Missouri-Kansas City School of Medicine. Though there are now 'only' five programs, a significant increase in output will contribute to the anesthetist supply in the coming years. Approximately 100 AAs will graduate from the current programs in 2008.

A well proven method to identify potential hires is to strategically and consistently invite students for rotations in your hospital. This plan contributes a key resource – clinical rotation sites – to the educational programs and also provides valuable experience for the students. The days of limited geographic options for AA practice are gone forcing us out of our "they all stay in Georgia" dream state. Demand for graduates outside of Georgia is high and already attracts many in-state students to jobs far from our needs. The new challenge is to attract graduates to jobs in Georgia during their formative period of training.

Demand for graduates outside of Georgia is high

Getting cases done puts everyone under pressure. Anesthesiologists who have been in practice a while may feel they have little to offer a student in today's production oriented OR. Having AA students on rotation does not increase your supply of licensed providers who can ramp up the caseload. But consider for a moment that an AA student working and being taught by you in the OR is a selfish luxury you can indulge in for the future payback of proven graduates for your practice.

How better to support AA practice than to partner with the education programs

How better to support AA practice than to partner with the education programs to produce

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ACT Update

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the graduates you are very likely to need soon? No matter the size of the group, "auditioning" candidates provides a distinct advantage in recruiting anesthetists who fit smoothly into the work and the practice.

What's the next step? An email or phone call to the program offices is all it takes to start the process. A central resource for contact information for the AA education programs is the website for the American Academy for Anesthesiologist Assistants (know as "quad-A"). Point your web browser to **www.anesthetist.org** and find the listing of each program phone numbers, websites, etc. It just may be the most productive internet surfing your group's recruiter has done in a long time. Start building your own 'inside track' to recruiting the anesthetists you need now and in the future.

"auditioning" candidates provides a distinct advantage in recruiting anesthetists

2007 Summer Meeting Review

Recreation on St. Simon's Island.

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Doctor/Vendor golf at Hampton Club.

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Resident Education

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in the resident's portfolio documentation of the resident's assessments in the competencies, case logs, CME activities, conferences and journal clubs attended. This portfolio is a permanent part of the resident's file and must be available at the time of an RRC site visit.

Of the six competencies, training programs seem to have the most difficulty with defining, teaching and assessing professionalism. Frequently difficult to describe, it is obvious when it is missing. In general the resident must demonstrate accountability, selflessness, altruism and sensitivity to cultural, religious, racial, sexual and nationality differences in patients and colleagues. Generational issues and misunderstandings sometimes interfere with assessments of professionalism. Each generation has different perspectives of professionalism, and conflict may arise when one generation assesses or evaluates a different generation.

Baby boomers were born between 1946 and 1962. In general they are workaholic, optimistic, team players that are loyal to an organization or group. They are willing to "pay their dues" and accept delayed gratification.

Generation X was born between 1965 and 1977. These are the latch key kids who fend for themselves and show loyalty to themselves and their profession; not to groups or organizations. They want immediate gratification, can be perceived as being disrespectful and perform better with feedback and credit. They work hard; however they maintain a healthy work and life balance. This generation expects state of the art technology at their fingertips. They tend to want more breaks at work and are willing to work less for less pay to insure more time for leisure activities.

Generation Y was born between 1978 and 1985. Generation Y tends to be very similar to Generation X but are more demanding, have a sense of entitlement and are extremely technically savvy. They also tend to be resistant to traditional hierarchies, and older adults must prove themselves before gaining the respect of Generation Y.

In an academic department, it is certainly clear that one cannot change Baby Boomer behavior into Generation Y's behavior or vise versa. And open and understanding environment of the differences between the generations' behavior must be established in order to have an effective evaluation of a particular individual's professionalism.

The behaviors of each generation can be found in the psychological profiles in any current textbook of Psychology. In daily life the most clear behavioral differences are that generation X and Y residents will expect flexible working conditions, quality time off, cutting edge technology, frequent performance feedback, fixed work hours and equitable compensation. Because their loyalty is to themselves and the profession, they frequently may move from group to group.

Of interest is the Millennium generation, born between 1986 and 2000, who is showing early behaviors more similar to Baby Boomers than to Generation Y. However, since this generation is still developing, the behavioral profile is a work in progress.

The specialty of Anesthesiology has found renewed interest with medical students. Emory's School of Medicine 2007 graduating class includes ten percent of its students matched in Anesthesiology training programs. The Emory Department of Anesthesiology received over 750 applications for residency positions, interviewed 100 applicants and fortunately filled its 14 positions. In addition, the academic quality of our applicants has improved significantly over the past five years. The applicants USMLE Step one scores are at an all time high ranging from 230 to 250 with a national average of approximately 210. Many graduates are members of AOA and at the top of their graduating class, and have publications of research. Not only are they intelligent, but they also have their feet on the ground evidenced by volunteerism and their work in jobs to finance their education.

The Emory University Anesthesiology training program had an RRC accreditation review in 2006. The training program received a full five-year accreditation without citation.

GSA Education Needs Assessment

The Program and Education Committee regularly solicits information and responses from members on the conduct of future educational meetings. Member response equips members of the Program and Education and Executive committees to offer topics and presenters that will empower the meeting participant to provide more effective health care treatment to patients. Thus, your response enables GSA to meet its educational mission. Thank you for your support and participation.

1. When did you last attend a GSA educational meeting? _____
2. Was this meeting a winter or summer meeting? _____ Winter _____ Summer
3. Did your family attend the meeting with you? Y N
4. If attended a recent GSA meeting did you/your family attend the social functions? Y N
5. What determines your decision to attend one of the educational meetings of the GSA? (*rank in order of importance, 1 being most important*) ___curriculum and speakers ___location ___dates ___ time off from work ___cost of the meeting/hotel ___family/social attractions ___need for CME hours ___other (please elaborate) _____
6. How do you currently acquire CME hours? (*mark all that apply*) ___local meetings ___regional/national meetings ___online courses ___self assessment courses ___hospital ___other (please elaborate) _____
7. How many days should educational content be offered? 1 day 2 days 3 days 4 days
8. What do you consider a reasonable registration fee for a single meeting providing at least 8 CME hours? _____ _____ For a 3-day meeting with 12 CME hours? _____
9. How easy/difficult is it for you to be away from work to attend an educational conference? ____Very Easy ____ Somewhat Easy _____Somewhat Difficult ___ Difficult _____Impossible
10. Do you prefer a general curriculum with varied topics or prefer a focused meeting, i.e., cardiac anesthesia, OB anesthesia, regional anesthesia, etc? ___ General Curriculum ____Focused
11. What topics would you like to see presented at future meetings? _____ _____ _____
12. Name speakers you would like to hear or list the type of speaker or credential/experience that you consider valuable to your practice and to improving your mode of practice/treatment. _____ _____ _____
13. To what summer locations would you travel for an educational conference? _____ _____
14. To what winter locations would you travel for an education conference? _____ _____
15. What is your preferred email address? _____
16. Your name: _____
17. Your practice location (facility): _____
18. General comments regarding educational meetings: _____ _____

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Cornerstone adds two VPs to GSA team

Cornerstone Communications Group has added two experienced government affairs personnel to the team that serves GSA's public policy initiatives. Michael McPherson and Rufus Montgomery joined Cornerstone late in 2006 and are completing their first year of participation. Cornerstone provides association management, government affairs and communication services to GSA.

"We are pleased to make available to GSA members the knowledge and experience of these two energetic professionals," said Jet Toney, President of Cornerstone and GSA Executive Secretary. "With the incredible expansion of public policy impacting the delivery of health care, GSA needs additional resources to monitor, consider and impact public policy to protect patient safety. Rufus and Michael certainly ramp up the horsepower in this regard at GSA headquarters."

Michael McPherson

Michael McPherson Biographical

A former chief of staff and campaign consultant to two state senate leaders, Michael brings government and business experience to Cornerstone's government affairs and association management team.

Michael attended Georgia Perimeter College, where he received numerous leadership awards and departmental awards. He graduated from GPC as a History and Political Science double-major. At Georgia State University he was accepted as a McNair Scholar, which afforded him the opportunity to participate in two graduate level summer study programs with professors from both fields of his chosen course of study, Anthropology and Political Science. In 2006, Michael was honored by the Georgia Association of Special Programs Personnel as an exemplary McNair scholar.

As a life-long athlete and enthusiast, Michael became a successful community advocate for action sports. By 1996, Michael was working with the City of Roswell's Parks and Recreation Department to assess community involvement in specific sports, so as to determine the need for a permanent action sports facility. Asked to lead a sports camp, he developed a week-long lesson plan that has been in use for the past ten years, which provides for every level of expertise from the beginner to the advanced. Roswell's permanent facility opened in 1998 and is still one of the city's unique attractions. Following an advocacy campaign in Gwinnett County in the late 1990s, the County Parks and Recreation Department decided to add an action sports facility to a park in the community of Berkley Lake. Since the beginning of his advocacy, Michael has been a consultant in the realm of public and private action sports parks.

Michael.mcpherson@politics.org

Rufus Montgomery

Rufus Montgomery Biographical

Rufus Montgomery is a decorated U.S. Army veteran whose civilian experience covers the disciplines of business, higher education and public policy. With more than 15 years practical knowledge of urban, state and federal politics, Rufus provides Cornerstone's clients the ability to influence public opinion and government decisions.

In the field of higher education, Rufus has served as an executive in institutional advancement and external affairs. His business acumen has been shaped as a director of operations and business development for several automotive sales organizations and as an analyst in the areas of education, health care administration and urban renewal.

A member of the Executive Committee of the Georgia Republican Party and chairman of the Georgia Black Republican Council, Rufus is both well-known and well-regarded among Republican officeholders and officials. He has coordinated political campaign activity at the state and federal levels in Georgia and Florida.

Rufus earned his Bachelor of Science degree from Florida Agricultural and Mechanical University in 1995 and completed his Master of Applied Social Science in Public Administration at FAMU in 1996.

His numerous civic affiliations include membership in the Veterans of Foreign Wars (Life Member), Association of the U.S. Army, American Legion and the Air Force Association.

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The GSA Newsletter is published quarterly by
The Georgia Society of Anesthesiologists, Inc.
1231 Collier Road, NW, Suite J, Atlanta, Georgia 30318,
Phone 404-249-9178, Fax 404-249-8831.
All items for publication should be submitted to the editor.
The financial support of advertisers is greatly appreciated.

Editor, Carolyn Bannister, M.D.
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Update your e-mail address

E-mail GSA Member Services Manager Cynthia Thomas at ***cynthia.thomas@politics.org*** with your preferred e-mail address. Include other personal contact information as appropriate to help GSA complete its database rebuild.

Winter Meeting 2008

January 19, 2008

Marriott Evergreen Conference Resort
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www.evergreenresort.com
www.stonemountainpark.com

Program Co-Directors

Carolyn Bannister, M.D.
Children's Healthcare of Atlanta, Emory University Healthcare
Atlanta, Georgia

Thomas M. Fuhrman, M.D.
Medical College of Georgia
Augusta, Georgia

Anesthesiology:
Our Past to the Present

Agenda

6:30 a.m. **Breakfast with Exhibitors**

7:20 a.m. **Welcome**
Arnold Berry, MD, GSA President
Carolyn Bannister, MD Program Co-Director
Tom Fuhrman, MD, Program Co-Director

7:30 a.m. **Resident/Fellow Research Presentations**
(Speakers TBD)

8:30 a.m. **Neuromonitoring in Anesthesia – What's the Latest?**
Eugene Fu, MD
Chief of Neuroanesthesia
Miami University

9:30 a.m. **Break with Exhibitors**

10:00 a.m. **History of Anesthesia – Our Midlevel Providers: What have we learned?**
William Hammonds, MD, MPH
Professor, Department of Anesthesiology and Perioperative Medicine
Medical College of Georgia, Augusta, GA

11:00 a.m. **OSA – What Do Sleep Studies Tell Us?**
Brian Carlin, MD
Chief of Pulmonology
University of Pennsylvania

12:00 p.m. **Lunch and General Business Meeting**

1:30 p.m. **Airway Management for Trauma**
Robert Johnstone, MD
Professor of Anesthesiology
Department of Anesthesiology
West Virginia School of Medicine

2:30 p.m. **Medicolegal Issues in Neuroanesthesia**
Eugene Fu, MD
Chief of Neuroanesthesia
Miami University

3:30 p.m. **Break with Exhibitors**

4:00 p.m. **CPAP and other Treatment for Sleep Apnea**
Brian Carlin, MD

5:00 p.m. **Medicare in the Future**
Robert Johnstone, MD

6:00 p.m **Adourn**

www.gsahq.org

Resident Section

Rony Atiyeh, D.O.
President, GSA Resident Component

Dear colleagues,

I write to you today while my wife and I await our first child to be born any hour now. I could be reading the many journal articles of which I keep promising myself to extract every ounce of knowledge, or I could be tackling the colossal Miller that gives me shivers down my spine as I approach the bookshelf; but yet, I have decided to write to you for two reasons.

First of all, I do not seem to be able to concentrate on complex anesthetic theories while my wife's contractions wax and wane. Secondly, I want to share with you why I ran for this office. As physicians, we endure a long and hard road before we finish medical school, in order to attain that noble status, where honor, duty, and altruism become our daily bread. Yet somewhere along the road, many of us find ourselves questioning the very reason why we chose to be physicians, given the hostile environment that currently exists in the world of medicine: insurance companies dictating how we should treat our patients, politicians telling us how to run our hospitals while decreasing reimbursements, and malpractice lawyers forcing us to practice defensive medicine. All the while malpractice premiums have skyrocketed to the stratosphere.

I do sound a bit depressing, alas, this is the unfortunate state of medicine in general, and anesthesiology is no exception. However, we can make a difference.

As residents, for the most part, we live in a bubble; call it post-graduate kindergarten. We are swaddled by the GME department, spoon-fed by our attendings, and constantly watched over to ensure we are not making mistakes. The truth is that most of us have no idea about the real world of medicine until we graduate and get "real jobs". We hear attendings complaining here and there about the economical state of anesthesia, lecturers at conferences reminiscing about the glory days while painting a gloom and doom picture for the future if things do not change as we ourselves engage in endless discussions on blog sites while our identities remain hidden. Yet, until we are practicing physicians, we do not get real-world experience regarding the politics of medicine.

We live in a bubble

How can we get out of this bubble

How can we get out of this bubble and get ready to face our future without fear, prepared to tackle obstacles without losing faith in the very noble profession that we worked so hard to attain?

The answer is to get involved in our federal, state and local medical societies, not only in anesthesiology but organizations such as the American Medical Association /American Osteopathic Association. We also need to get involved in our communities, where we have the opportunity to educate the common public and work to regain sound, trusting relationships between patients and physicians. As our professors and attendings continue to educate and prepare us to become the best possible physicians, we owe it to ourselves and the field of anesthesiology to learn the intricacies of politically- and legally-influenced medicine.

On a lighter note, a new position was recently added to the GSA resident component, resident liaison to the government affair committee. Dr. Matthew Klopman has been elected to this office this past summer. As resident component president, I will be working with my fellow officers to send updates to all anesthesiology residents in the state of Georgia regarding new laws, changes, and urgent actions need to be taken in order to get our voices heard. As many past presidents have done before, I encourage every resident to send contributions to the GSA political action committee.

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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 $60,000 in contributions was presented to candidates who support civil justice reform and laws that promote patient safety.

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Continued on page 15

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(Continued from page14)

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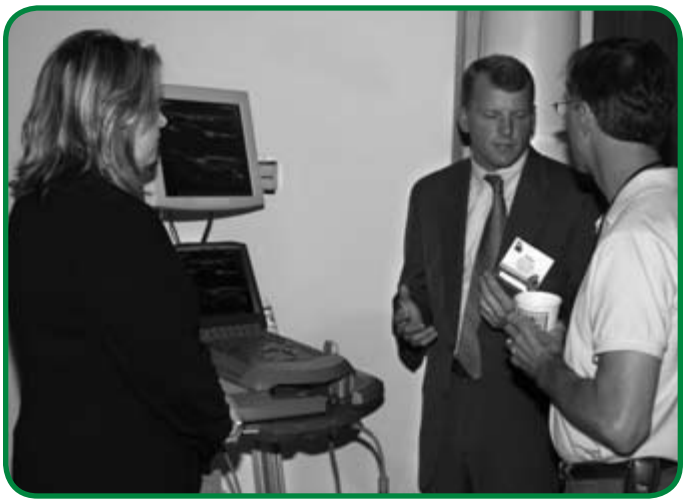
Attend the 2008 GSA Winter Meeting
January 19, 2008
Details and Registration coming
at www.gsahq.org

Scenes from Summer Meeting

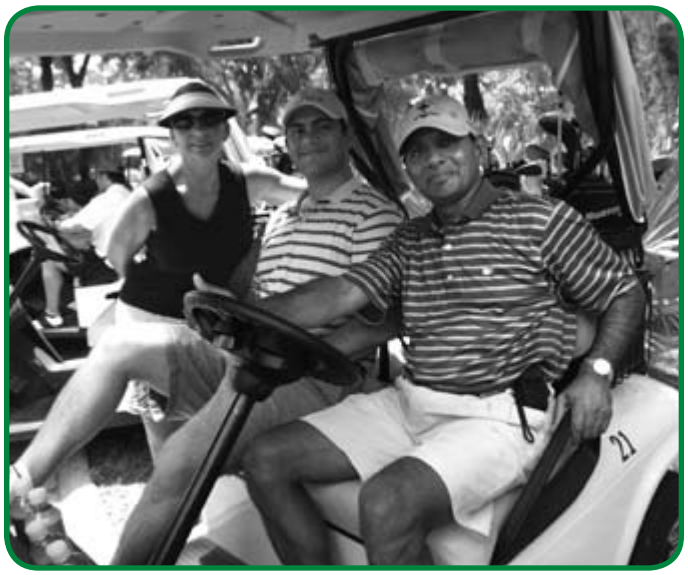
The 2007 Summer Meeting was the most well-attended educational conference of the Society in more than a decade. Including exhibitors, physicians, other attendees and guests, the GSA family on sunny St. Simon's Island was greater than 180 participants.

From an educational perspective, Program Co-Directors Stan Plavin, M.D. and Mark Norris, M.D. presented nationally regarded experts in areas of practice that are high priority of GSA members, according to recent education needs assessments completed by members and previous meeting attendees.

Presenters were awarded very high scores by attendees in the post-meeting evaluations. Such strong positive response from attendees has become a trend for GSA educational conferences where program organizers have secured top quality speakers who address issues of importance and relevance to members' practices.



Vendor support for the 2007 meeting was extremely large. More than 18 exhibitors provided valuable information about their products and services. Vendors are encouraged to utilize the annual educational conferences as a mechanism for outreach to decision makers at practice groups throughout the state.



Post-meeting fun with family and friends at the beautiful Hampton Club Golf Course on St. Simon's Island.

Dr. Admir Hadzic presented two highly-rated, high-tech lectures on "Lower Extremity Nerve Blocks" and "Preventing Complications from Peripheral Nerve Blocks". Dr. Hadzic is Director of Regional Anesthesia, St. Luke's-Roosevelt Hospital Center, Associate Professor of Anesthesiology, College of Physicians and Surgeons, Columbia University.

Mark Norris, M.D.
Summer Program Co-Director

Stan Plavin, M.D.
Summer Program Co-Director

Government Affairs

Special House Panel

GSA members selected for pain management study

Members of the Georgia Society of Anesthesiologists have been selected to participate in a special state House study committee on pain management.

Georgia House Speaker Glenn Richardson, R-Hiram, has appointed GSA member Michael Byas-Smith, M.D., to the House Pain Management Study Committee. GSA members David Gale, M.D., and Carlos Giron, M.D., will present to the committee as representatives of the medical profession with expertise in the treatment of pain. State Rep. Buddy Carter, R-Savannah, a pharmacist and pharmacy owner, chairs the select committee.

Michael Byas-Smith, M.D.
Emory University School of Medicine
Atlanta, GA

The panel will study and report to the Governor and the General Assembly on medical, pharmaceutical, and patient care issues involving the treatment of pain including, but not limited to, the use of Schedule II controlled substances. In addition, the panel will facilitate a discussion among the appropriate regulatory boards, and other interested persons that focuses on identifying appropriate procedures and techniques for the management of pain.

The committee will also review the adverse impact on patient recovery caused by the under treatment of pain as well as the consequences and costs of under treatment.

David Gale, M.D.
Pain Solutions Treatment Center
Atlanta, GA

"The committee wants to make certain people in pain are treated as they need to be without opening the flood gates for abuse of the system," Rep. Carter said. "Balance is the key."

The first meetings was held in Atlanta on September 27. Future meetings are scheduled in Savannah (10/18) and Augusta (date TBD). Members of the study committee include Rep. Katie Dempsey (R-Rome); Rep. Richard Smith (R-Columbus); and Rep. Pat Gardner (D-Atlanta).

State Rep. Buddy Carter, R-Pooler, chairs the House Study Committee on Pain Management. Carter is a pharmacist and pharmacy owner.

According to James E. "Jet" Toney, GSA Executive Secretary and lead lobbyist, the study committee represents the first opportunity for the medical community and health care consumers to publicly discuss issues surrounding the treatment of pain. Toney said the committee, though limited to meeting only through the balance of 2007, is slated to look at various types of pain and the treatment of those including chronic pain, pain associated with end of life, pain associated with treatment of cancer and post-treatment and pain caused by work-related injuries.

"The legislature has gotten close in recent years to committing to begin looking at whether or not Georgia law prohibits physicians from adequately treating painful indications associated with serious injuries or courses of care for serious illnesses," Toney said. "This time, however, a study is actually going to occur. This is an important first step in looking at medico-legal issues of pain management."

Carlos Giron, M.D.
Pain Institute of Georgia
Macon, Georgia

Formation of the study committee followed passage of House Resolution 663 in the 2007 Session of the Georgia General Assembly. For more legislative information, go to **www.legis.state.ga.us/**.

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