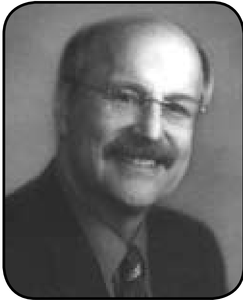
GSA Newsletter
GEORGIA SOCIETY OF ANESTHESIOLOGISTS WINTER 2007

Steven L. Sween, M.D.
ASA Director

Dr. Carl Hug earns ASA's highest honor



The 2006 ASA House of Delegates affirmed the selection committee's decision, and our GSA colleague, Carl C. Hug, Jr., MD, PhD, will receive the ASA Distinguished Service Award (DSA) at the 2007 ASA Annual Meeting in San Francisco next October. The DSA represents ASA's highest honor and is awarded to only one individual each year.

At Dr. Hug's invitation twenty years ago, I came to Georgia (Emory) for a fellowship year in Cardiothoracic Anesthesia. It became immediately apparent to me that this highly productive and prestigious physician was/is a very special person. Representing you, the GSA, as ASA District Director, it was my great pleasure to have nominated Dr. Hug for this highest honor. What follows are excerpts from my letter of nomination:

"*As the ASA Director from Georgia and with the unanimous support and encouragement of the Executive Committee of the Georgia Society of Anesthesiologists (GSA), it is my great privilege to again place in nomination our friend and mentor, Dr. Carl C. Hug, Jr., for the ASA Distinguished Service Award. To comply with the requirements of the nomination process, I have completed the enclosed nomination form. I have also enclosed a complete copy of Dr. Hug's extensive CV. Due to the expansive and extraordinary scope of Dr. Hug's participation and academic achievement in our specialty, I would urge the committee to look beyond the necessarily brief nomination form to his exceptional curriculum vitae. It is truly indisputable that Dr. Hug has been one of anesthesiology's most valuable players for many years. He has retired from the practice of medicine, but continues with his active participation within the Emory University Center for Ethics. It is our strongest belief that he is worthy and deserved of recognition in ASA's Hall of Fame, the ASA Distinguished Service Award.*

As one reviews Dr. Hug's career, there is one quality that is obvious. He is a <u>*leader*</u>*. As you will see, he has served in many leadership positions at Emory, including chief of cardiothoracic anesthesia for sixteen years. The respect that he has earned throughout the entire institution at Emory is obvious and commendable. However, no one has any higher regard for Dr. Hug than the surgeons with whom he has worked for over twenty-five years. I recall their incredible remarks of admiration at his retirement party. He has been the president of numerous national anesthesia organizations, including the AUA, ABA, and FAER. He has chaired several ASA committees, subcommittees and task forces, and participated on many more. A past editor of* Anesthesiology*, he was a perennial fixture as an ASA Refresher Course lecturer.*

Carl C. Hug, Jr. M.D., Ph.D.

To say that Carl has been active in scholarly activity is, indeed, an extreme understatement. His contributions to the field of anesthesia/pharmacology research have been extraordinary, and recognized throughout the world. He has lectured extensively, both nationally and internationally. He has been honored by membership in numerous anesthesia societies throughout the world. Thousands of medical students, pharmacology students, residents, and fellows have benefited from his persistent and insistent teaching, myself included. In spite of his academic and scholarly achievement, Dr. Hug never allowed those endeavors to interfere with the assurance of great patient care.

One of the traits that can only indirectly be concluded from evaluation of Dr. Hug's resume is the quality of his character. In spite of his nearly unparalleled academic, administrative and clinical achievement, it is quite likely that his impeccable character is what sets him apart from the field, and establishes him as our most valuable player. His sense of integrity and moral values are highly respected, and without compromise. He is deeply dedicated to his family, his beautiful wife Marilyn, and their children and grandchildren. Even when on the road, he has rarely missed the opportunity and honored his commitment to weekend worship. In recent years, Dr. Hug has recognized the obligation to be more personally involved with patients and their families as they contemplate the risks and benefits of proceeding with very high-risk surgical procedures. Consequent to that, he is currently focusing his efforts on issues related to medical ethics. His passion for doing the right thing has culminated in numerous recent publications and lectures regarding clinical decision-making

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Editor's Corner

Carolyn Bannister, M.D.
Editor

Happy Holidays to all,

I hope this finds all of you doing well.

I hope to see you all in January at Evergreen Conference Center for the GSA Winter educational meeting.

Please note the first Letter to the Editor in this edition of the newsletter. Dr. Chip Clifton's e-chat room has aired a number of important issues for anesthesiologists across the state. One of these issues is addressed for your information in the letter from Dr. Jason Williams regarding criteria for certification as a regional perinatal center. I would like to welcome more members to submit letters to the editor for publication as this is one section we are hoping to develop in the newsletter.

Many thanks to Jet Toney and the Cornerstone staff for all their assistance in 2006.

Here's wishing all of you a safe healthy happy holiday season and a wonderful New Year! See you in January at Stone Mountain Park.

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Update
your e-mail address

E-mail GSA Membership 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.

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Anesthesia Care Team

ASA adopts updated *Statement*

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

The past several years have seen a great deal of attention by ASA to issues related to the Anesthesia Care Team (ACT). I have discussed many of these issues in previous Newsletter articles. During this year's Annual Meeting in Chicago, the ASA House of Delegates adopted an updated Statement on the Anesthesia Care Team. Since many of our members practice in the Care Team mode, this article is meant to inform members of the basis for the existence of the ACT and the manner in which ASA serves as our professional advocate for this important mode of practice.

The Statement on the Anesthesia Care Team dates back to 1982 and was last amended in 1992. The purpose of the Statement was first to define the concept of a Care Team that includes nonphysician anesthetists led by an anesthesiologist. This original definition has steered anesthesiology practice in a variety of ways. One significant result was inclusion of language by HCFA – now CMS – related to directing care by nonphysician anesthetists. These are the Medicare "Conditions of Participation" that dictate the reimbursement for anesthesiology professional fees when using the ACT mode of practice.

Healthcare and anesthesiology practice has changed drastically since the original Statement. It comes as no surprise that the language and structure of the Statement had become outdated. The Statement needed revision of the existing wording, addition of new text relevant to present concerns and restructuring to reflect the changes in the intended application of the document. Dr. Art Boudreaux (Birmingham, AL) started the process of revision in 2004 during his final year as Chair of the ASA Anesthesia Care Team Committee. During the relocated ASA Annual Meeting in Atlanta last year, the Statement was considered and referred back to the ACT Committee for additional work. The current ACT Committee Chair, Dr. Jeff Plagenhoef (Dothan, AL), led the effort this past year to refine and update the Statement.

The philosophy of the revised Statement is the same in that the ACT has an anesthesiologist at the helm. But the text, tone and structure of the document are now much clearer. The changes in the Statement address points that are relevant to both current and anticipated pressures on anesthesiology practice.

1. Accurate identification of Care Team personnel – It should be clear to patients and their families who the personnel are and what role each plays. The Statement outlines appropriate terminology for physicians (anesthesiologist, fellow, resident) and nonphysicians (nurse anesthetist, anesthesiologist assistant, students - both nurse and AA). The goal of this portion of the Statement is to prevent misrepresentation by nonphysician providers and to minimize misunderstanding by patients of who is ultimately responsible for their care.
2. Supervision of Nurse Anesthetists by Surgeons – This is a new section that is certainly a timely addition. The Statement does not attempt to proscribe surgeon supervision but does clearly frame the risk potential in such situations. Also, surgeons – as the only physician involved with perioperative management – are called upon to be actively involved in assuring safe, quality care by nonphysician anesthetists when an anesthesiologist is not involved. The Statement identifies this medical oversight as the ethical duty and reasonable expectation in accordance with the surgeon's training and ability.
3. Relocation of Billing Terminology from the Statement body to an Addendum – The former Statement contained various billing / reimbursement terms as substantive inclusions within the anesthesiology practice definitions. Mixing terms in this way did nothing to clarify how the Care Team was a modality of anesthesiology professional practice. Required functions for billing are subject to payer rules that may change or be different between payers. However, appropriate medical and anesthesiology care cannot be defined based on a reimbursement checklist. Relocation of billing terms to an addendum acknowledges that there may be a relationship between medical care and reimbursement but does not depict any such checklist as an appropriate measure of complete and/or appropriate medical care.
4. Other personnel involved in perianesthetic care – The list of personnel who contribute to patient care during the period of anesthesiologist care was expanded to include perioperative nurses, obstetric nurses, and neonatal nurses. Though not specifically a designated part of the Anesthesia Care Team, these personnel could be called upon to extend the anesthesiologist's care in their respective care environments and therefore fall under the umbrella of anesthesiologist responsibility.

Dr. Plagenhoef and the ASA Anesthesia Care Team Committee spent an immense amount of time and energy to provide our profession with an informative, workable and much needed update. Our medical and professional interests have been well considered. I would encourage every GSA member to read the revised Statement. Whether you presently work with anesthetists in the Care Team mode or not, this updated ASA Statement is important to Georgia and could influence your practice in the future.

The Statement on the Anesthesia Care Team is available for download from the ASA website at the following address: **http://www.asahq.org/publicationsAndServices/standards/16.pdf**

Government Affairs Report

Richard Muench, M.D.
Chair, Government Affairs Committee

CON, Scope and Tort top legislative issues

To our members I wish a Happy New Year 2007. It has been an honor to be the legislative chair of our society for the last two years. During this time, I have learned much of the political process and of our society and specialty. I feel my position has the responsibility to report to our society members the current legislative issues and their possible impact on our specialty and patients. I also feel that I must champion the cause of our local and national PACS.

With the New Year, we say good-bye to the scandals of the 2006 election cycle. Awaiting us are the issues of the upcoming legislative session of the 2007 Georgia General Assembly. The Medical Association of Georgia has issued its 2007 legislative priorities. Working with MAG we are able to coordinate our strategies. These strategies are composed of two tiers of importance:

Tier I

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 II

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

Please see complete list at **www.mag.org**

Protecting medical liability reform for Georgians and its physicians must be the top priority. Medical liability reform will continue to be in the sights of those who are not our allies and put their goals ahead of Georgians and their ability to obtain health care. The cost of rising premiums for physicians has compromised access to care for many across the country. By maintaining medical liability reform we hope to contain the rising costs we experience in providing care to our patients. Let us not forget the hard fought battle to obtain medical liability reform for Georgia.

The majority of our membership is hospital-based physicians and practices. Any proposed revision or repeal of the Certificate of Need law could have potential catastrophic effects on these hospitals and these practices. These effects will cause a reduction in health access and care for all Georgians. As a hospital-based physician my view may be considered bias. However, as a Georgian, I depend on the continued health of our hospitals to provide top level all encompassing care. Repealing the Certificate of Need law would jeopardize the financial viability of our already vulnerable hospital system.

As a specialist, I support the supposition that general surgery is a single specialty. This revision to the law may also jeopardize hospital survivability. However, I think one should define what is rightly a specialty. If single-specialty ambulatory surgical centers affect our health system to the extent that care to patients is in question, then that will have to be addressed as a separate issue.

Scope of practice continues to present itself on almost a yearly basis. Time and time again those that do not have the educational training and skills attempt to gain privileges in the legislative process. The Medical Association of Georgia has done an exemplary job at protecting the citizens of Georgia from this potential legislation. We as a society will continue to support the Medical Association of Georgia and politicians who recognize the importance of education and training in providing the best care possible to the citizens of Georgia.

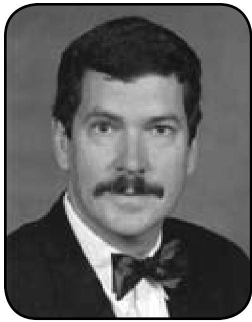
I had the privilege of being a delegate at this years American Society of Anesthesiologists House of Delegates meeting in Chicago. I would like to express to our membership the effect of this experience. First, we are extremely fortunate as a Society to have had the generations of leadership that has brought us to this point and to continue to have dedicated leaders in our field continue to lead us. Second, these members work tirelessly in what I felt was an exhaustive venture. My hat goes off to those that on a yearly basis make this pilgrimage to meeting after meeting. They discuss issues that have a direct and lasting impact on our specialty and patients. Prior to my involvement in GSA, my past interest in politics could be described as reactionary. After being involved in GSA, I can tell you my view has changed to that of proactive.

Our national political action committe (ASAPAC) continues to be a top 100 PAC. This is despite the fact that only 5% of our membership contributes. Think of what our organization could do if we just doubled that number to 10%. Our political system is most likely to remain unchanged. This means that politics runs on financial backing. Contributors get recognized and their issues get heard. Locally, we need to fund our state committee (GSA-PAC). Our neighbors in Alabama continue to win the PAC cup named in their honor for having the most dollars, highest %, and highest amount given per member. We as a state society must set the goal to take ownership of that cup.

President's Letter

By Edwin Johnston, M.D.

Pre-trial prep a must in litigation



It's probably fair to say that there are two kinds of anesthesiologists – those who have been sued and those who will be sued. Yours truly fits into the first category. The statistics – the average anesthesiologist in Georgia will be sued every eight years – seem painfully high. Counting a minor settlement fifteen years ago and two other cases against me, I'm not far out of the norm.

The second case began with an adverse outcome, which occurred ten years ago. As of this writing it is still pending. A young woman, my wife's age at the time, underwent a routine GYN procedure and a routine recovery room stay. She was discharged to the floor with appropriate discharge criteria having been met, only to suffer a cardio-respiratory arrest forty-five minutes later, which resulted in a severe anoxic brain injury. A suit was filed over a year and a half later against the hospital. Then the depositions began. They deposed everybody but the chief cook and bottle washer. If you haven't been deposed, you will be.

A word of advice: prepare. The plaintiff's attorneys will use every trick in the book to get you to incriminate yourself and others. They will use your testimony to try to impeach your testimony at trial, even years later. So you had better get your story right the first time because they will make you stick to it at trial.

In my case, I managed to not point fingers at others but gave plaintiffs enough ammunition to add me to the suit. And of course they waited until the day before the statute of limitation would have expired.

In my recovery room at the time, anesthesiologists worked closely with recovery room nurses, overseeing and directing and signing off on the administration of narcotics and other medications. I unfortunately painted the picture that recovery room nurses gave whatever they wanted to give, and I later approved of their actions by signing the chart.

Plaintiffs drooled! They were convinced that what I had done was negligent by violating an existing law – so I should write a check. My attorney and the Judge took a different interpretation. The case went to trial after the plaintiffs refused to settle with the hospital for a very large sum. Plaintiffs were convinced they would win the lottery with an eight-to-ten million-dollar jury verdict.

Prior to the trial, there were all sorts of depositions, experts for my side, experts for the plaintiffs, experts for the hospital, out of town trips to hear their experts give depositions, etc., etc. There was a mock trial to test our case before a representative jury pool. A team of experts with video cameras and bright lights prepared me to be on the witness stand.

On the day of the trial I was in my Sunday best with my lovely wife sitting behind me. At my attorney's insistence, we sat at a different table than the Hospital's counsel. He wanted the jury to disconnect me from the Hospital. Also in the courtroom was a shadow jury that had been hired by the hospital to give them feedback. The shadow jury members were to be demographically similar (e.g., age, sex, education) to the real jury. They had a facilitator who made sure that the shadow jury heard the same testimony as the real jury and did not hear less or more of the court's proceedings. The facilitator would poll the mock jury for information on how they thought the trial was progressing. The hospital attorneys had hired the shadow jury, and they shared very little information with my attorney.

It took all of the first day in court to pick a jury of twelve men and women plus six alternates. The plaintiffs use their strikes to try and remove as many educated people and as many men as they could. The result – a jury of one's peers!

Next came opening arguments. The Lord had blessed me with a stellar defense attorney. His opening remarks summarized by "the evidence will show that Dr. Johnston took excellent care of his patient and operated within the standard of care in discharging his patient to the care of others." My attorney was in command from the beginning. The usually smooth, if not *slick*, Atlanta plaintiff's attorney was ill at ease.

The trial went on into a second week. During the weekend my twelve-year-old daughter had to have an emergency appendectomy. What's the saying? When it rains it pours! On Tuesday of week two, the plaintiffs counsel sensed they weren't going to win their lottery after all, deciding to settle with the hospital, possibly misled by their shadow jury. The award was not much more than they had discussed before the trial.

Plaintiffs dismissed me "without prejudices," which meant they could still pursue a case against me within a six month window. A new trial against me would require a jury verdict in excess of the settlement. We felt pretty secure at this point. The actual jurors confided that they believed me to be innocent. The judge confided that he, based on the evidence, had been prepared to give a directed verdict, dismissing because plaintiffs had not proved causation. Plaintiffs must prove in court that there was not only an act of negligence, but also that the act caused the resultant injury.

Six months went by quickly. On the last possible day, plaintiffs re-filed the case. After another six months or so, attorneys for both sides appeared before the judge. The judge, after hearing all of the testimony, stuck with his pre-trial rules of evidence. The plaintiffs later appealed the judge's ruling. The appeals count took months to rule in favor of the plaintiffs. This had been their desire from the beginning, to show I was

Continued on page 8

Resident Section

Barry Barton, M.D.
President, Resident Section

Resident involvement determines future

At the recent ASA Conference in Chicago, the resident component of the ASA made it clear that we, as residents, are taking a stand, wading into the thick of medical politics, and making our voices heard. More than 4,000 anesthesiology residents and fellows train in 42 states nation wide. Although we are spread across the country, there are ways that we can be unified and find a voice to protect our patients and our futures.

Through involvement in organized medicine and medical politics we can effect change and be better advocates for our patients. There are opportunities to become involved on the national level at the ASA, the state level at the GSA, or at the grass roots level at your individual training program. The key is involvement. The days of sitting by, passively, and hoping things will get better in the "real world" before you finish residency, are over.

Most health care policies made at the state and national levels are developed by non-anesthesiologists. Unfortunately, their interests do not always reflect our own. Despite the strong efforts of ASA and organized medicine to achieve positive Medicare updates in 2006, the year-end congressional session did not solve the major problems facing our specialty. These problems continue to include the flawed Sustainable Growth Rate (SGR) formula and the Medicare Anesthesiology Teaching Rule. Congress did pass a short-term, inadequate "patch" to the flawed Sustainable Growth Rate (SGR) formula. The bill includes a provision to allow only a 0% update in physician payments for 2007, along with possible 1.5% bonus payments in the second half of the year for participation in a controversial pay-for-performance program. The scheduled 5.0% cut in payments for 2007 was avoided. While ASA had pushed for a positive update in 2007, a payment freeze is more desirable than the originally scheduled payment cuts.

In 2006, Congress did not pass the Medicare Anesthesiology Teaching Rule reform legislation. For 12 years now, hospitals and programs have suffered an unfair 50% payment penalty for multiple resident supervision, a rule unique to anesthesiology. Hospitals and programs must continue subsidizing care for Medicare patients, rather than receiving fair payment for the services of teaching anesthesiologists. This rule continues to hinder our ability to train new anesthesiologists, and to provide expert medical anesthesiology care to our nation's patients.

Our legislators must make decisions on these issues. Our role, even as residents, is to help them make informed decisions. Involvement in the legislative process through meetings with and letters to the U.S. House of Representatives and the U.S. Senate does make a difference. At the same time, active participation at the state level is critically important and offers a tremendous learning opportunity. Local grass roots participation provides a training ground for residents to learn about organized

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Amendments to GSA Bylaws proposed

The Executive Committee has proposed two amendments to the GSA Bylaws. The vote to enact the amendments will be taken on January 20, 2007 during the mid-day General Business meeting at the Winter Forum (Evergreen Conference Center, Stone Mountain Park). The green and underlined text below is the new language proposed to be added to the existing Bylaws.

Proposed Amendment No. 1
Article VIII, <u>8.02 Number and Election</u>
b) Vice-President: The Vice-President shall be elected at the annual meeting of the members and shall serve as Vice-President for a term of (1) one year, beginning from the date of his/her election as Vice-President, or until his/her successor is elected, whichever is applicable, or until his/her earlier resignation, death removal or the termination of the office of Vice-President. The Vice-President shall, in the absence or disability, or at the direction of the President, perform the duties and exercise the powers of the President. The Vice-President shall perform such duties as are generally performed by vice-presidents and shall perform such other duties and exercise such other powers as the Board of Directors or the President shall request or delegate. <u>The Vice President shall be responsible to the Board of Directors for assuring that committees submit reports regarding their activities to the Secretary as specified in Section 9.02.</u> The Vice President shall also serve as a member of the Board of Directors.

Proposed Amendment No. 2
Article IX, <u>9.03 Standing Committees</u>:
g) Judicial Committee: ~~The Judicial Committee shall be composed of five (5) members, all of whom shall be active members in good standing and shall have been a Past-President.~~ <u>The Judicial Committee shall be composed of the President and the four Immediate Past-Presidents. The Immediate Past-President shall serve as chair.</u> This Committee shall hear and determine disciplinary questions brought before it according to the provisions of these Bylaws. ~~Each member shall serve on the Judicial Committee for a period of five (5) years. The Chairman shall be the member serving the first year on the Committee. The Immediate Past-President shall assume a seat on the Judicial Committee immediately upon the close of his term of office as Immediate Past-President. Vacancies are filled by appointment by the President and such appointment is confirmed by approval of the Board of Directors by a majority vote; such appointee shall have been a Past-President and the appointment is for the unexpired terms.~~

HAVE YOU HAD YOUR FISCAL CHECK-UP YET?

Maybe now is the time to review your financial situation. Here are a few questions to consider:

- Do your investments work well together toward your goals?
- Is your retirement planning on track?
- Do you have written short- and long-term goals? How often do you review them?
- Do you use a CPA, financial advisor or tax advisor? Why not?

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Resident President's Letter

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medicine and builds the foundation for leadership roles throughout your career.

It is also critically important to recognize that your involvement as an anesthesiology resident or fellow need not be limited to anesthesiology-specific organizations. In fact one of the most important contributions you can make is to raise the profile of anesthesiologists in the Georgia Medical Association and the American Medical Association. These organizations work in concert with the ASA and the GSA to effect change.

Ultimately, we are responsible for our future. We must be involved in order to have a voice. Contribute to the Political Action Committee on the ASA and the GSA level. Write letters to your congressman and senators expressing your concerns. The ASA website has links to formatted letters that can easily be sent to your political representatives at the click of a button.

President's Letter

(Continued from page 6)

guilty by statutory law breaking, and therefore negligent.

The case was then appealed to the Georgia Supreme Court, which then waited until nearly the end of its session to decide to leave the Appeals Court decision in force. Nearly another year has passed with next to nothing happening. It's like the movie Casablanca. The refugees trying to get to America: they wait, and they wait, and they wait.

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Program Director
Kathryn Stack, M.D.

Enjoy a one-day GSA meeting by participating in **Winter Forum 2007**. The theme, *Rock Solid Anesthesia*, describes the 8 CME hours of medical, management and legislative updates offered. Take advantage of the opportunity to attend this meeting in a beautiful setting close to home! Stone Mountain Parks is an excellent venue for a couple's getaway, family weekend or a few hours with old friends and colleagues. The educational portion is presented on Saturday, January 20, 2007, but you and your guest can stay for a long weekend!

EDUCATIONAL OBJECTIVES (PARTIAL)

- Review the underlying pathophysiology of problems in children admitted to the post-anesthesia care unit (PACU)
- Develop strategies to manage conditions such as emergence delirium and pain in the PACU
- Learn how to manage problems such as postoperative nausea and vomiting and hypothermia in the pediatric PACU
- Review the medical literature that is relevant to the perioperative management of medical conditions such as upper respiratory infection and the 'innocent' heart murmur in children
- Critically review available data regarding fasting guidelines in children before surgery
- Develop evidence based approach to controversial conditions such as the management of postoperative apnea in children, parents in the operating room and NPO status in children
- Discuss the latest information on the clinical use of PCEA and CSE
- Discuss management strategies that reduce risk in the morbidly obese parturient
- Learn which current state legislative issues will impact your practice and how you can join others influencing those outcomes

Agenda

FRIDAY, JAN 19, 2007

6:30-8:00 pm	**Welcome Reception**
7:00 pm	**Board of Directors Dinner**
8:00 pm	**Dinner on your own**

SATURDAY, JAN 20, 2007

6:45-8:00 am	**Registration and Breakfast with Exhibitors**
8:00-8:10 am	**Welcome and Announcements** *Edwin Johnston, MD, GSA President* *Kathryn Stack, MD, Program Director*
8:10-9:00 am	**Chronic Pain** *Anne Marie McKenzie-Brown, MD*
9:00-9:50 am	**Common Problems in the Pediatric PACU** *Zeev Kain, MD*
9:50-10:20 am	**Break with Exhibitors** **Resident Section Meeting**
10:20-11:10 am	**Medical Malpractice** *Anne Fretwell, Attorney*
11:10-12 noon	**Myths in Pediatric Anesthesia** *Zeev Kain, MD*
12N-12:15 pm	**Question and Answers**
12:15-1:45 pm	**Lunch and General Business Meeting** **Presentation of CWL Award**
1:50-2:40 pm	**PCEA and CSE** *Robert D'Angelo, MD*
2:40-3:30 pm	**Physician's Assistants in Anesthesia** *Ron Hall, MD*
3:30-4:00 pm	**Break with Exhibitors**
4:00-4:50 pm	**Legislative Affairs Update** *Special Guest Speaker*
4:50-5:40 pm	**The Morbidly Obese Parturient** *Robert D'Angelo, MD*
5:40-6:00 pm	**Question and Answers**
6:00-7:30 pm	**Evening Reception honoring Dr. Crumrine**
7:30 pm	**Dinner on your own**

Registration Card

Please complete both sides and submit with payment

Pre-Registration

(Received with check or credit card by 1/12/2007)

GSA Member $300 ○

Non-Member $400 ○

GSA Resident $100 ○

Non-Member Resident $150 ○

GSA AA Member $150 ○

Non-Member AA $225 ○ $ ______

CWL Award Reception Only $25/person

(paid registrants admitted without this fee) $ ______

Late Registration/On-site Registration Fee $100

(Faxed to 404-249-8831 or otherwise received after 1/12/2007) $ ______

TOTAL $ ______

Please make your check payable to "GSA." Include this form with your check and mail to 1231 Collier Road, NW Suite J Atlanta, GA - 30318

For VISA/MasterCard payments please complete the following: (**Note:** by signing below you authorize payment for the amount written above for "Total"):

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This form is for Meeting Registration ONLY.
Make your hotel reservations
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SAVE MONEY, Ask for GSA conference rate.

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Please complete both sides and submit with payment

Registrant Name & Title: ______

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(for name badge) ______

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Home Phone: ______

Fax: ______

e-mail: ______

______

Guest #1: Name & Title (as it will appear on name tag*)
Adult ○ Child ○

______

Guest #2: Name & Title (as it will appear on name tag*)
Adult ○ Child ○

______

Guest #3: Name & Title (as it will appear on name tag*)
Adult ○ Child ○

______

Guest #4: Name & Title (as it will appear on name tag*)
Adult ○ Child ○

*Each person attending any function must wear a name badge. The badge serves as an admission ticket to events.

The Georgia Society of Anesthesiologists
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www.gsahq.org

Secretary-Treasurer's Report

Jay Johansen, M.D.
Secretary-Treasurer

Minutes of General Business Meeting - July 30, 2006

Sea Pines Resort, Hilton Head Island, S.C.

1. **Welcome -** Dr. Johnston opened the meeting by welcoming attendees. A quorum was declared present.

2. **Review -** January General Business Meeting Minutes (printed in summer 2006 Newsletter) A motion was made, seconded and approved to accept the minutes. Motion passed.

3. **Secretary-Treasurer's Report -** Dr. Johansen presented financial statements for 2006. The first six months P & L showed Net Income of $94,343.83 compared to $95,567.52 same period in 2005. The June 30, 2006 Balance sheet reported a Total Liabilities and Equity of $178,982.13. Dr. Johansen reported that the January 2006 Winter Forum produced $6,441.24 profit. For the record, Dr. Johansen reported that the following charitable contributions had been made: Medical Association of Georgia for the Good Medicine Campaign ($10,000); the Anesthesia Patient Safety Foundation ($2,000); FAER ($2,000); and GAPAN ($1,000).

   Dr. Johansen stated that he will be reaching out to practice groups to encourage full membership and participation in the GSA-PAC. He stated that GSA will also more aggressively pursue vendor/exhibitor participation in annual meetings and in the GSA Newsletter.

4. **Government Affairs Report**
   - Elections Report – Jet Toney stated that few changes will expected in the General Assembly in 2007 due to a relatively few challenges to incumbents. He stated this is counter to an eight-year trend of significant turnover caused by the recent wave of Republican advancement in Georgia.
   - Issues (CON, MC contracts/balance billing, Scope of practice) – Jet Toney presented a summary of legislative and regulatory issues which will likely carry over to the 2007 General Assembly. In a straw poll, members voted overwhelmingly to support existing CON laws and to oppose legislation proposed to repeal all or portions of the current Certificate of Need statute which protect the economic vitality of hospitals.
   - GSA-PAC Report – Jet Toney presented a brief financial report on GSA-PAC activity including the following chart:

GSA PAC Report as of 06/30/2006

	1999	2000	2001	2002	2003	2004	2005	2006 YTD
Contributions to PAC	$30,720	$37,850	$35,480	$53,215	$42,150	$42,125	$29,250	$36,920
Number of Contributions	180	220	209	206	247	253	215	222
Interest Income	$3,014	$4,946	$2,532	$282	$694	$1,458	$764	$1,850
Political Contributions	$5,650	$42,000	$33,100	$78,600	$24,500	$47,250	$5,850	$43,000
Fund Balance Year End	$50,239	50,444	$55,246	$23,144	$52,227	$45,845	$58,295	$50,965

5. **ASA Director Report –** Dr. Sween stated appreciation for Dr. Bruce Hines' leadership in directing the education portion of the 2006 Summer Meeting and congratulated him on the outstanding faculty. Dr. Sween thanked headquarters staff (Cornerstone Communications Group) for their work preparing for the conference. Dr. Sween stated his support and endorsement of Dr. Johansen's outreach to practice groups throughout the state to encourage GSA membership and participation in the GSA-PAC and ASA-PAC. Dr. Sween said, "medicine is under a microscope, it is front page news. It is important to have a seat at the table of discussion. We should have political representation and activity out of every practice group. Everyone should participate in ASA-PAC to aid ASA's federal efforts."

6. **Program and Education –** Dr. Bruce Hines reported on registration and vendor support for the current Summer Meeting. Dr. Bannister provided the following calendar of future events:
   - January 20, 2007 Winter Meeting, Dr. Kathy Stack, Program Director, Evergreen Conference Center, Stone Mountain Park, Georgia
   - August 3-5, 2007 Summer Meeting, Dr. Stan Plavin, Program Director, August 3-5, King and Prince Resort, St. Simons Island, Georgia
   - Summer 2008, Sea Pines, Hilton Head, (contract in negotiation)
   - Summer 2009, King and Prince, St. Simons Island (contract in negotiation)

7. **Membership Committee Report/Approval of Applications -** Dr. Johansen presented the following membership report for information:

Continued on page 13

ASA Update

A Delegate's Report from the 2006 ASA Annual Meeting

By Arnold J. Berry, M.D., MPH
President-Elect

Several weeks ago I attended the ASA Annual Meeting held in Chicago. It was a very successful meeting for our Society with a record attendance of over 18,000. The educational sessions were again outstanding. A new track format for eight subspecialties has now been fully implemented, and this has permitted the use of innovative formats for many of the presentations.

The Rovenstine Memorial Lecture was presented by Jerry Reves, MD, Vice-President for Medical Affairs and Dean, College of Medicine of the Medical University of South Carolina. Dr. Reves provided his recommendations for goals for academic anesthesia departments to foster scholarly research and the growth of our specialty.

The Plenary Session on Translational Research was given by John B. West, MD, the distinguished researcher on pulmonary physiology. He gave a fascinating presentation covering his years of work on the structure and function of alveoli during pulmonary hypertension and when stressed by high inflating pressures. A new educational initiative by the ASA will provide members the opportunity to view these two plenary sessions as well as ten of the other major presentations from the Annual Meeting via a web-based presentation. These should be available on the ASA website in early 2007. There will also be a mechanism whereby members can apply for CME credit for viewing these educational sessions.

The two meetings of the House of Delegates (HOD) constitute a critical portion of the Annual Meeting. Although the work of the HOD is important to all ASA members, only a small number of members ever observe this political process. The GSA is fortunate to have seven Delegates as well as our Director, Steve Sween, MD, represent us at these meetings.

At the first session of the House, it was announced that Carl C. Hug, Jr, MD, PhD was nominated to receive the Distinguished Service Award, the highest honor given by the ASA. Dr. Hug's nomination was approved by vote of the HOD, and he will be presented with the Award at the 2007 Annual Meeting in San Francisco. Dr. Hug is currently Emeritus Professor of Anesthesiology at Emory University School of Medicine. The ASA Distinguished Service Award is a wonderful tribute to the years of service that Dr. Hug has devoted to the specialty of Anesthesiology.

The business of the ASA is transacted by the HOD, and it is this body that creates the official policy for the organization. This year, there were 810 pages of reports and action items to be considered by Delegates to the HOD. Although only Delegates and Officers can vote on actions considered by the HOD, any ASA member can have input into the deliberations on all issues through their testimony at the Reference Committees. It is through this process and the vote of the Delegates at the HOD that policies, practice guidelines, and statements become the official position of the ASA, the organization that represents over 39,000 anesthesiologists in the United States. Government agencies, accrediting organizations, and healthcare payers routinely base their policies and standards on published ASA documents. All of ASA's Standards, Guidelines, and Statements can be found under the Clinical Information section of the ASA website **www.asahq.org**.

There were three issues that received a great deal of attention at the most recent HOD. The first was a revision of the Anesthesiology Care Team (ACT) Statement that was written to reflect the current Care Team mode of practice. The Statement identifies the members of the Care Team and describes the safe conduct of the ACT. Included in this document is a section devoted to "Supervision of Nurse Anesthetists by Surgeons". The portion of the proposed new ACT Statement that received considerable debate, but without resolution, was the definition of individuals who could be considered "Qualified Anesthesia Personnel". This is significant because the ASA Basic Monitoring Standard requires that a Qualified Anesthesia Personnel be present throughout every anesthetic, but no ASA document defines "Qualified Anesthesia Personnel". It was acknowledged that anesthesiologists, anesthesia residents and fellows, Certified Registered Nurse Anesthetists, and Anesthesiologist Assistants are Qualified Anesthesia Personnel, but the discussion focused on whether a Student Nurse Anesthetist would qualify. Some anesthesia practices permit Student Nurse Anesthetists to be left in the operating room without a CRNA or anesthesiologist physically present. Medicare regulations permit billing for cases performed by a Student Nurse Anesthetist directed by an anesthesiologist, but this federal payment rule cannot be construed to mean that this is a position that the ASA should endorse. The HOD chose to let the Committee on Anesthesia Care Team reconsider the issue of who is a Qualified Anesthesia Personnel and report back at the 2007 meeting. The remainder of the Statement on Anesthesiology Care Team was approved.

Another major debate within the HOD related to the issue of administration of sedation by non-anesthesia professionals. The HOD approved the "Statement on Granting Privileges for Administration of Moderate Sedation to Practitioners Who Are Not Anesthesia Professionals". This Statement is designed to assist healthcare organizations develop a program

Continued on page 13

Secretary-Treasurer's Report

(Continued from page 11)

Dr. Johansen presented the list of proposed membership applications. A motion was made and seconded to approve membership applications. The motion passed.

Membership Report for 2006
(As of 07/24/2006)

Current Members

Active	601
Affiliate	23
Life	1
Disabled	0
Resident	77
Retired	81
Student Members	0
Total	**783**

Pending Members

Active	12
Affiliate	0
Resident	21
Retired	4
Student Members	0
Total	**37**

Details

Paid	**658**
PAC Contributors	221
Museum Donation	64

Educational Affiliate Members

Educational Affiliate Members Total 2006	50
Educational Affiliate Members Paid	21
Educational Affiliate Members Pending	0

8. Committee Reports

- Newsletter/Communication-- Dr. Bannister encouraged greater participation in the production of articles for the newsletter.
- Anesthesia Care Team – Dr. Odom presented.
- Nominating – Dr. Berry reported that Dr. Howard Odom has been selected to serve the remainder of the 2006 VP term for Dr. Marvin Palmore.
- Resident Section – Dr. McCurdy, immediate past-president of the Resident Section, stated that Dr. Barry Barton (MCG) has been elected to serve as 2006-2007 President, Dr. John Hackett (Emory)as President-elect, and Dr. David Nusz (Emory) as Secretary. He stated that the section is seeking to experience full participation by all residents in the GSA-PAC.

9. Adjourn

ASA Update...

(Continued from page 12)

for formulating clinical privileges for practitioners who are not anesthesia professionals to administer drugs to establish a level of moderate sedation. This Statement is particularly important as more non-anesthesiologists are choosing to administer sedation for diagnostic and therapeutic procedures.

A more difficult issue was how ASA should handle a statement for formulating clinical privileges for non-anesthesia professionals who want to administer deep sedation. Existing ASA statements indicate that individuals who administer sedation should be able to rescue patients should they enter a level of sedation deeper than intended. Especially with the use of propofol, patients may quickly go from deep sedation to general anesthesia, and the skills required by the practitioner must therefore be greater than for use of lighter levels of sedation.

After considerable discussion, the HOD passed the "Statement on Granting Privileges to Nonanesthesiologist Practitioners for Personally Administering Deep Sedation or Supervising Deep Sedation by Individuals Who Are Not Anesthesia Professionals". The following is the exact text of that statement:

"*Because of the significant risk that patients who receive deep sedation may enter a state of general anesthesia, privileges to administer deep sedation should be granted only to practitioners who are qualified to administer general anesthesia or to appropriately supervised anesthesia professionals.*"

Some of the other significant actions of the HOD included approval of a new document, "Guidelines for Obstetric Anesthesia", funding for the establishment of a Perioperative Awareness Registry, and formation of a new Committee on Simulation Education. A White Paper on Simulation, posted on the ASA website **www.asahq.org/SIM/whitepaper.htm**, describes a proposal for ASA to develop a system to accredit simulation centers to provide CME credit. Simulation is being recognized as an important training tool, and the current actions by the ASA acknowledge an interest in developing centers for use by members.

The work of the ASA HOD and its committees has a significant impact on all anesthesiologists. The process used to conduct the business of the ASA should be as transparent as possible so that all members are aware of these activities. I hope that any GSA member interested in learning more about the activities of the ASA would contact any of the Delegates from the GSA for more information.

2006 GSA-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 $60,000 in contributions was presented to candidates who support civil justice reform and laws that promote patient safety.

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Daud Azizi, M.D.
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Patricia L. Baumann, M.D.
Robert C. Baumann, M.D.
Timothy N. Beeson, M.D.
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Robert Charles Wilson, M.D.
Jung Kim Wirsing, M.D.
Frederick P. Yilling, M.D.
Lily Young, M.D. (R)
Ginger E Zarse, M.D. (R)
Andrew Ziemann, AA

(R) denotes Resident member,
(AA) denotes Educational member

From the President-Elect

Committee Membership: A Chance to Serve

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

One of the remarkable aspects of the Georgia Society of Anesthesiologists is that so much of what is accomplished is done through the voluntary efforts of our members, working with the wonderful staff at Cornerstone. Anesthesiologists in GA benefit from the information presented at the semiannual scientific meetings and published in the expanded GSA Newsletter. The GSA website contains useful information regarding all of GSA's activities as well as links to other pertinent organizations. GSA has worked with the Medical Association of Georgia to have meaningful tort reform legislation enacted in our state. All of these have happened through the hard work of many volunteers.

Each of you now has the opportunity to serve on a GSA Committee to help accomplish the missions of our Society. As President-Elect, I am seeking members to serve on the committees listed below. These are the committees and their duties as defined by our Bylaws. It is my hope that members from all areas of the state will consider volunteering for one of these committees so that GSA can have input that is truly representative of all of the membership. Please call (404-778-3937) or e-mail (arnold.berry@emoryhealthcare.org) to let me know your committee preference.

GSA Committees

1) **Program and Education Committee**: This Committee shall plan, prepare, and secure a scientific or educational program for interim and annual meetings of the members, shall plan meetings and general arrangements and shall be responsible for maintaining the CME Accreditation of the biannual meetings.
2) **Committee on Membership**: The duties of this Committee shall be: 1) publishing the names of applicants for membership; 2) conducting investigations and making decisions on applications for all classes of membership; 3) confirming locations of principal professional activity; 4) considering endorsement of applications for membership upon due investigation, if the applicant cannot provide two active members to endorse him/her; 5) conducting investigations for all other categories of membership and submitting recommendations on such applications to the Board of Directors, except as otherwise provided for in these Bylaws; 6) formulating and revising, as necessary, membership application forms; 7) notifying the Secretary of decisions on membership and encouraging qualified persons to apply for membership in this corporation; 8) formulating and maintaining a procedural manual on committee functions; and 9) acting as an investigating body as specified in Section 4.07 of these Bylaws.
3) **Governmental Affairs Committee**: This Committee shall investigate matters and develop guides relative to the economic status and government interaction of anesthesiology, and shall disseminate such information to the membership. It shall also act as a liaison, when requested, between the members of the corporation and other parties and shall represent the corporation, under the direction of the Board of Directors, in aiding the membership to review, secure and enforce legislation and rulings in the interest of the specialty of anesthesiology.
4) **The Practice Management Committee**: The committee membership shall reflect the diversity of practice modes and represent the subspecialties of Anesthesiology as they may be affected by practice management. The Committee shall 1) solicit professionals in the areas of Practice Management to present related information to the membership via GSA sponsored publications and meetings; 2) act as a liaison between the membership and the ASA Committee on Practice Management; and 3) generally, facilitate the practice management of Anesthesiology as allowable by Federal, State, and Local regulations.
5) **Committee on Long Range Planning**: The Committee shall review the Society's general objectives, strategic directions and establish plan guidelines. The Committee shall report these guidelines annually to the Board of Directors.
6) **Committee on Communications**: The Committee shall plan, organize and publish a Newsletter, which shall be the official publication of the Society. The Chair shall be the Editor of the Newsletter. The Editor shall edit and oversee the compilation, publication and distribution of the Newsletter. A member of the committee or the President shall review any and all official GSA information distributed via the website.
7) **Electronic Media and Information Technology (EMIT) Committee:** The EMIT Committee shall have oversight of the GSA website and other duties as designated by the President.

Enjoy a GSA Committee!

contact Arnold Berry, MD, GSA President-elect

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ASAPAC GIVING FY 2006 (Final)

*ASAPAC Fiscal Year runs from October 1-September 30.

STATE	STATE COMP MEMBERS	2005 DONORS	2005 % DONORS TO MEMBERS	2005 CONTRIB.	CONTRIB GOAL	2005 AVG CONTRIB PER DONOR	2006 STATE COMP MEMBERS	2006 DONORS	2006 % DONORS TO MEMBERS	2006 CONTRIB.	CONTRIB GOAL MET TO DATE	2006 AVG CONTRIB PER DONOR
AK		6	10%	$1,870		$312	59	8	14%	$2,350		$294
AL		203	47%	$86,686		$427	428	213	50%	$81,540		$383
AR		37	15%	$9,620		$260	242	35	14%	$7,870		$225
AZ		63	9%	$14,280		$227	693	89	13%	$22,970		$258
CA		284	8%	$51,425		$181	3711	318	9%	$58,635		$184
CO		60	11%	$13,100		$218	563	80	14%	$17,060		$213
CT		47	8%	$9,250		$197	572	56	10%	$10,460		$187
DC		13	5%	$2,560		$197	288	17	6%	$2,530		$149
DE		9	10%	$2,125		$236	87	17	20%	$3,500		$206
FL		158	14%	$41,750		$264	1162	154	13%	$43,660		$284
GA		94	11%	$26,710		$284	824	135	16%	$37,965		$281
HI		8	7%	$1,450		$181	122	9	7%	$1,500		$167
IA		62	18%	$15,130		$244	348	94	27%	$22,590		$240
ID		9	12%	$1,500		$167	77	11	14%	$1,840		$167

Letters to the Editor

Letters to the Editor will be published in the GSA Newsletter as space allows. All letters must be signed. A digital headshot photograph of the letter writer is appreciated; please submit with letter. The Editor reserves the right to refuse to publish any letter and reserves the right to delete portions of letters due to space limitations. Letters may be submitted by any person regardless of membership or affiliation with the Georgia Society of Anesthesiologists. Submit letters to Dr. Carolyn Bannister, newsletter editor, at carolyn.bannister@emoryhealthcare.org. The *GSA Newsletter* is published four times annually.

24/7 guideline for CRPCs alarming

Dear Editor,

A number of concerned GSA members have recently traded emails on the emerging issue of 24/7 on site anesthesia coverage for Georgia's Regional Perinatal Centers. It has come to my attention that in the upcoming year, an anesthesiologist will be required to be in house 24/7 for criteria to be a "Certified Regional Perinatal Center." This has been changed from a "readily available" guideline without any apparent input from an anesthesiologist. We believe it is important that GSA members be aware of the issue and have an active role in developing the guidelines.

The Guideline to which I am referring is the "Core Requirements and Guidelines for Designated Regional Perinatal Centers" (revised July 2006). The state of Georgia's Council on Maternal and Fetal Health under the Division of Public Health has formed and set guidelines for patient care and center accountability. It created exhaustive criteria for being a Regional Perinatal Center and has set protocols for patient care. It has also created an organizational structure for our perinatal centers in Georgia. They subdivided the hospitals into 3 categories: Basic, Specialty, and Subspecialty Perinatal Hospital Services with their own separate criteria. There are 6 of the subspecialty perinatal centers in each region of Georgia: Memorial Hospital in Savannah, The Medical Center in Columbus, Phoebe Putney in Albany, Grady, the Medical Center of Central Georgia in Macon, the Medical College of Georgia in Augusta and the Emory Regional Perinatal Center, which includes Crawford Long Hospital, Children's Healthcare of Atlanta and Grady Memorial Hospital. Last, they have mandated what type of services should be provided in a perinatal center. As to the Anesthesia Services, the guidelines from the 1999 2nd edition have been, up to this year, as such--

"Anesthesia personnel should be present in the hospital at all times or immediately available by telephone and able to arrive within 30 minutes of being summoned, under normal traffic conditions." The 2006 edition has been changed to "Twenty-four hour anesthesia on site".

Except for a few in our practice that live just a few minutes away, our practice is "in house" 24/7. But, that is not the real issue here. What is alarming is that apparently no anesthesiologist has participated in the formation of these guidelines. In the extensive acknowledgments and list of thanked groups, there was no mention of the GSA or ASA. The American College of Obstetricians and Gynecologist and the American Academy of Pediatrics Guidelines were used. The other resource used to develop the criteria was the "Guidelines for Perinatal Care in Georgia 1999" 2nd edition. The latter also did not include any acknowledgments to any Anesthesia organization. This serves as a wake up call to folks like myself, who, if not actively participating, will have someone else… obstetricians, pediatricians, surgeons, hospital administrators or government bureaucrats dictate to us not only how we should care for our patients, but where we should be and when. These impositions might come under the auspices of standardization for better patient care. But, for a government panel to draw such detailed guidelines without the opinion of the specialist physician to whom it is dictating, is simply irresponsible. Allowing any group to set mandates or parameters for our own specialty should not be tolerated. It is obvious that someone will take advantage of us if given the chance, even if it is not intended to do so. This should serve as a huge alarm to us all…if we don't participate, others will do so for us.

By Jason Williams, MD,
Albany Anesthesia Associates

ASA Director's Report

(Continued from page1)

and end of life choices. Please see the enclosed CV specific to his participation in the field of medical ethics. From the perspective of the anesthesiologist who often enjoys too little control in patients' decisions regarding surgery or other medical interventions, Dr. Hug is a very valuable resource.

Each of you on the committee is undoubtedly aware of Dr. Hug's extraordinary contributions to our specialty and our society, even without this refresher. It is the sincere hope and conviction of the GSA to convince ASA's Committee on DSA to select Dr. Carl C. Hug, Jr. as its nominee to the 2006 ASA House of Delegates. We fully realize that the competition is keen. However, we are confident in our candidate, and consistent with his character, we will persist in our effort to be successful. Dr. Hug is our Most Valuable Player, and now in his retirement a leading candidate for induction into ASA's Hall of Fame.

Thank you, Dr. Litwiller and members of the committee, for your time and your selection of this great person, extraordinary physician and incomparable role model."

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