GSA Newsletter
GEORGIA SOCIETY OF ANESTHESIOLOGISTS INC. WINTER 2009

Status of Trauma Care: Critical Condition

By Steve Walsh, M.D.
Chair, Government Affairs Committee

I live in Roswell, Georgia. This October, I was taking one of my routine bicycle rides along the Chattahoochee River. This particular ride ended up not being routine at all. While riding in a bicycle lane at about 22 mph a car in the approaching lane turned left in front me. This caused my bike to instantly stop its forward momentum, while I continued on. Of course the physics of friction prevailed and I came to a stop shortly thereafter. My injury was minor and my feelings of good fortune great.

... the geographic location of traumatic injury can potentially increase mortality.

I could not help but think about the "what-if" scenarios had I sustained serious injury. As physicians, the more important question is what we can learn from those who have had serious injury? And, how can we be prepared to treat those who will sustain serious injury? In September, I attended a meeting "Trauma in Crisis" made possible in part by the Healthcare Georgia Foundation. Information was presented to address these very questions.

The lifestyle sacrifice and demands for the physician required to be available and ready for the trauma patient are burdensome.

As anesthesiologists, our residency training prepares us to be major participants in the trauma care team. Those of us who trained in large metropolitan hospitals provided care to patients injured by the urban "knife and gun club." This leaves us with a potentially skewed trauma perspective. Actually, the fact is about one out of every three Georgians will need trauma care. There are about 40,000 cases of major trauma in Georgia each year. Gunshot wounds and assaults account for 12% of trauma, while the majority of trauma mechanism is motor vehicle (37.7%) and falls (22.2%).

One of the most alarming facts shows that the geographic location of traumatic injury can potentially increase mortality. The Georgia Department of Transportation statistics show Georgians are four times more likely to die if involved in a vehicular crash in a rural area. These locations cover square mileage much greater than the remote depths of Cloudland Canyon or Tallulah Gorge, an area where one might anticipate a challenge to a rapid response time.

The Georgia Statewide Trauma Action Team released a map called the Golden Hour Map (see map). Upon inspection, one can draw a slanted east-west line across the map about 50 miles south of Macon. This line is known as the "deadline." In much of the area south of the "deadline" the trauma victim is greater than 50 miles from a trauma center. This places the victim at risk of failing to receive treatment in the most critical first hour. This is the "Golden Hour". This geographic area includes major sections of Interstate 75 and 16 as well as miles upon miles of major state arteries. There are millions of citizens that live and work in these higher risk areas. In fact, if you live north of Macon should you consider flying for your next family trip to Disney World? In reality, very few Georgians can escape these geographic areas of added risk within our current state trauma coverage.

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Editor's Corner

Launching Pediatric Certification Debate

Kathryn Stack, M.D.
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Sometimes professional and personal experiences align to make a notable impression. Such was my situation recently in regards to the administration of pediatric anesthesia.

Until recently, I administered pediatric anesthesia on a consistent and regular basis without having advanced training in pediatric anesthesia. Many would agree that "routine" pediatric anesthesia can and is performed safely by many non-pediatric anesthesiologists. However, the importance of the policies, procedures, and systems of the institution that supports pediatric care cannot be overemphasized. A pediatric anesthesiologist providing pediatric anesthesia in an institution lacking the system to support pediatric care cannot be perceived as superior to a non-pediatric anesthesiologist providing consistent and routine pediatric anesthesia in an institution with a commitment to pediatric care. Therefore, the conversation and debate over training and experience in pediatrics is an important one, and healthcare institutions should listen up and take responsibility for their role in the safe care of the pediatric patient.

Recently, my healthy 20 kg, 5-year-old son broke his arm (the dreaded trampoline!!). It took a couple of weeks and a couple of rounds of x-rays to find what was labeled an "unusual" fracture by our orthopedic surgeon. (Not sure whether DFACS will be contacting us soon or not). We then ended up at a pediatric satellite MRI scanner for further imaging. After being informed that

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President's Report

The Pace of Change

By Howard Odom, M.D.
President

Thinking back to the Winter Meeting in January at Evergreen, the year of 2008 has evaporated in a flash since Dr. Arnold Berry passed the duties of President to me. Our GSA 60th anniversary year is soon to be behind us. This year will go down as a very eventful one for our Society, healthcare advocacy efforts and the political landscape of our country and the world. It is a fantastic understatement to predict that 2009 will bring significant changes. The old saying about the 'winds of change' will perhaps require an update to 'typhoon of change.'

I will not waste words to rehash old problems or what shape the future solutions might take. Instead I prefer to list some of the shared successes attained through the focused efforts of GSA members. Changes for GSA have been underway throughout 2008 and are on track to continue in 2009.

Major elements of the Society Administration mission of GSA have progressed well and will continue under the leadership of Dr. Bruce Hines next year. Our relationship with Cornerstone Communication Group is solid and working very effectively. Executive Secretary Jet Toney and the CCG staff continue to provide best-of-breed association management services to keep the gears of everyday GSA operations turning smoothly.

Second is our Education & Member Services mission. What used to be a simplistic concept to me of CME credit for meetings never truly was that simple and is in fact, becoming ever more complex. To afford our members this fundamental benefit, the Cornerstone staff is skillfully guiding us through the CME requirements to assure continued value for our membership dollar. The transition to quarterly Newsletters has raised the bar of communication and is the first of several changes still in development. Finally, a new process for approving membership applications has greatly streamlined the entry pathway for new members.

Those of us who are MAG members encourage all others in GSA to join MAG

The Advocacy mission has been a major focus this year. The Medicare victories of the summer set a high-water mark for national efforts. Our state efforts have been led by a reinvented and reinvigorated Governmental Affairs Committee. The GSA-PAC achieved a record level of members involved. Your influence was meaningful in strategic campaigns across the state. Coming years will require even greater efforts and contributions. I encourage you to initiate and invest in working relationships with policy makers as we anticipate the challenges to come in the legislative session which begins this month.

The State Medical Relations mission began a new phase with participation in the 2008 MAG House of Delegates. Working within the 'house of medicine' to stand for patient's access to care, patient safety in all care environments and guarding the hard-won tort reforms will be priorities for GSA. Those of us who are MAG members encourage all others in GSA to join MAG to speak for the specialty of anesthesiology on state healthcare issues including sustainable funding for the trauma network.

Our ASA Component Society mission is another bright spot of 2008. You may not be aware of the number of your colleagues who serve on ASA Committees. Although GSA is strongly represented at the national level, there is always a need for fresh talent and perspective. I encourage you to browse the ASA website for a listing of committees then consider nominating yourself for service. The ASA Annual Meeting in Orlando saw Dr. Steve Sween run unopposed to election as Vice Speaker of the House of Delegates. We are delighted to have one of our own elected as one of the twelve officers of ASA. Solid leadership talent in the GSA has once again been recognized at the national level.

... healthcare was in the crosshairs – and we are healthcare.

Though I have listed only a few of the many changes this year, there is one major thing that hasn't changed. Volunteer service by members is the spine of our Society that maintains its posture, keeps it in touch with the environment of policy & practice and transmits the crucial information to keep everything in balance. It has been my great pleasure

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Pediatric Subspecialty Certification

Where Are We Now?

Arnold J. Berry, M.D., MPH
Past President, GSA
Chair, ASA Section on Society Subspecialties

In her editorial, Dr. Stack mentions the debate regarding pediatric anesthesiology subspecialty certification that has occurred over the past several months. A brief summary of the events surrounding this debate may be of interest.

The American Board of Anesthesiology (ABA) currently provides subpecialty certification for anesthesiologists in Critical Care Medicine, Pain Medicine, and Hospice and Palliative Medicine, although the Accreditation Council on Graduate Medical Education (ACGME) accredits fellowships for other anesthesia subspecialties including pediatric anesthesiology. In 2007, the Society for Pediatric Anesthesia (SPA) sent a letter to the ABA requesting that they develop a process for subspecialty certification in pediatric anesthesia for graduates of accredited pediatric fellowships.

In order to assess the impact of pediatric subspecialty certification on the practice of anesthesiology and the delivery of anesthetic care to pediatric patients, the ABA asked for input on the proposal from several anesthesia organizations including the ASA. The ASA's Administrative Council referred the issue to their Board of Directors (BOD) for their recommendation. At the February and August 2008 meetings, the BOD voted that ASA should oppose the SPA proposal for ABA subspecialty certification in pediatric anesthesia. At the October 2008 meeting, the House of Delegates approved BOD action, i.e. opposition to pediatric certification. Following this, Dr. Roger Moore, ASA President, wrote to the ABA indicating ASA's opposition to SPA's proposal. Dr. Moore's letter can be found on the ASA's website at: http://www.asahq.org/news/ASAtoABALtr102808.pdf

The ABA must still take action on SPA's request to offer pediatric subspecialty certification. The input from ASA and other anesthesia organizations will enter into the ABA's decision process. An editorial on the SPA website provides an insight into some of the issues that have arisen in this debate. <http://www.pedsanesthesia.org/newsletters/2008spring/subspec_cert_page.pdf>

Editor's Corner

(Continued from page 2)

either an ER physician or intensivist would administer propofol sedation, I deferred to my son just plain old holding still and watching a movie in the scanner. He had been well prepared for holding very still in the big, loud, knocking donut machine.

At our next office visit, our orthopedic surgeon promptly announced that my son needed surgery…the next day. He worried that it had been long enough since the fracture occurred that bone remodeling would make the ORIF more difficult if we waited any longer. None of the Children's Healthcare facilities where our surgeon was privileged had time the next day, so he opted for another outpatient surgery center that "did peds." After a quick phone call to the anesthesia office at the outpatient surgery center, I was told that, in fact, particular anesthesia providers preferentially administered pediatric anesthesia and a special notation would be made on the schedule, highlighting my son as a pediatric patient.

None of the anesthesiologists were pediatric fellowship-trained. My son went on to have an uneventful, complication-free surgery and was well cared for (Special thanks to those who cared for him!!). However, there were multiple indicators along the way that this facility was, in no way, prepared for routine care of the pediatric patient. I'll detail *some* of my experience and let you decide how comfortable you would be with your child or grandchild there.

As my son and I arrived at the receptionist desk, my son was asked how he got a day off from school to be with his mom while she had surgery (strike 1). Shortly after checking in we sat in the waiting room and were greeted by a staff member in scrubs who very nicely offered my son some juice (strike 2). We politely deferred. He had short sleeves and his plastic ID bracelet on. Once we arrived in the pre-op area, it was time for vital signs. A small adult BP cuff and an adult clothespin pulse ox probe were all that was available (strike 3). My son had to wear a scrub top, because there were no child size gowns, and his powder blue non-slip socks were adult XXL (strike 4). My son is psyched, because he can wear the ankle-high adult socks as knee-high soccer socks next season. After meeting our anesthetist, anesthesiologist, and OR circulator, I heard the staff discussing amongst themselves – what was the policy about

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Editor's Corner

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moms going back to the OR for induction (strike 5)?

It really didn't matter, as I had no intention of disturbing the "karma" by accompanying my son to the OR. He had been well rehearsed by his older brother. I met my son in the PACU as he awoke from an uneventful surgery. In his own little puny way, he got into the car and rolled onto the couch at home and slept it off. He later re-awoke unscathed and proud that he now joined the ranks of his older brother and sister – "operated on" (with a black Spiderman cast to prove it).

The same week at work I was assigned a one-year-old's burn case (not a big burn, thank goodness). Pediatrics recently abandoned our institution, with the exception of the occasional and random pediatric OR case. The one-year-old child's mother had no idea the struggles it took to accumulate all the necessary and yet invariably, hard to find pediatric equipment (or did she get an idea from looking around to see only adults in the pre-op area and ambulatory PACU around her). I really don't know if our whole operative experience was reassuring to her or not – There was a lot of, "Do we have pediatric…??(oral midazolam, BP cuffs, pulse ox probes, monitor cables, fluid warmers, heat lamps, diapers, buretrols, etc, etc). But, thankfully, like my son, her child appeared to do very well despite the fact there was no pediatric anesthesiologist providing care.

I do worry about the whole pediatric experience, though. Within a facility, it takes but one slight misstep along the way to make the story's ending very different. Neither my son nor my patient suffered any complication from the annoyance and extra work required to adapt to the random pediatric case. However, in a hurried, time-pressured OR environment, an anesthesiologist, no matter how well trained and experienced, must be supported by an institution and a system committed to the safe care of all its patients all the time.

I do worry about the whole pediatric experience, though.

Pediatric patients are different – there is no doubt about it. I've got no definitive opinion regarding the debate over pediatric anesthesia subspecialty certification, but I think I'll stick to pediatric *institutions* for my own children. And at work…well, until I'm no longer qualified to perform pediatric anesthesia (which might be ok with me), I'll do my best to treat them like my children and hope (insist) my institution has the same commitment.

GSA
Winter Forum 2009

One-Day Meeting
January 31, 2009

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Atlanta, GA

Legacy Lodge and Conference Center
Lake Lanier Islands, GA
www.lakelanierislands.com

From OR to ICU:
Critical Issues in **Anesthesiology**

Objective:
To present solutions to treat medical conditions which crossover from the OR to the ICU.

Anesthesiologists are, in effect, intensivists in the operating room. As healthcare changes there will be more emphasis on critically ill patients. There is little argument that our population is getting older and therefore sicker. We are performing anesthesia on more patients with multiple end organ disease and, due to advances in medicine, they are surviving. Whether you are a board certified critical care physician or not you will take care of the critically ill.

The GSA Winter Forum will meet its objectives through lectures from internationally known critical care experts in the fields of transfusion medicine, cardiac resuscitation, and solid organ transplant. The lectures will cover the following educational objectives:

1) **Review the history of critical care medicine.**
2) **Understand the advances in bloodless surgery.**
3) **Study the newest evidence based guidelines of cardiac resuscitation.**
4) **Learn about peri-operative management of patients with end stage liver disease, and**
5) **Update knowledge of surgical blood management.**

Register now at www.gsahq.org

Faculty:

1. Fresh Frozen Plasma: Fact or Fantasy
2. Blood Management for Surgical Patients in the ICU

Aryeh Shander, M.D.
Chief of the Department of Anesthesiology, Critical Care Medicine, Pain Management and Hyperbaric Medicine
Englewood Hospital and Medical Center
Englewood, NJ

Dr. Shander was one of Time Magazine's "Heroes in Medicine" and serves on the board of the American Society of Critical Care Anesthesiologists.

3. Medical Ethics: History and Current Issues in the OR and ICU

Carl C Hug, M.D., Ph.D.
Emory University Hospital
Atlanta, GA

Recipient, ASA Distinguished Service Award

4. Recent Advances in Multi-Organ Transplantation
5. Current Status of Liver Transplantation in Georgia

Parasiva Satish, M.D.
Assistant Professor of Anesthesiology
The Emory Clinic
Atlanta, GA

Dr. Satish has practiced anesthesiology worldwide focusing in the past on critical care medicine and, in more recent years, solid organ transplant.

6. Resident and Fellow Scientific Presentations

State Issues Forum

Louisiana Court of Appeals upholds ruling prohibiting CRNAs pain practice

Lisa Albany

Editor's note: The following information is compiled from published reports by Lisa Percy Albany, JD, Manager, ASA State Legislative and Regulatory Affairs. For more information, see the February 2008 (Volume 72, Number 2) edition of the ASA Newsletter at www.asahq.org.

In a unanimous decision, the Louisiana First Circuit Court of Appeals has upheld a trial court ruling which effectively prohibits nurse anesthetists from performing interventional pain management procedures. The case arose when the Louisiana State Board of Nursing issued a statement expanding nurse anesthetist practice into areas of treatment for chronic pain. Plaintiff sought and received a favorable injunction against the action of the LSBN.

The court favorably noted and extensively referenced the expert testimony of the plaintiffs. In contrast, the court compared the "experts" submitted by the CRNAs and noted their acknowledgment that no credentialing system is in place to regulate CRNAs with respect to interventional pain management procedures. The appellate court issued a strong opinion (paraphrased):

The statement issued by the LSBN expanded the scope of practice for CRNAs into an area where they have not traditionally practiced and that the practice of interventional pain management is not within the scope of practice of a CRNA, but rather is solely the practice of medicine.

The ruling of the Court of Appeal affirms the trial court ruling in two respects: 1. Issuing a permanent injunction barring CRNAs from performing interventional pain management procedures, and 2. Declaring that interventional pain management constitutes the practice of medicine and may only be performed by a duly licensed medical physician.

Finding that the argument asserted by the LSBN and Louisiana Association of Nurse Anesthetists regarding whether the statement was a "rule" and should have been adopted in accordance with the Louisiana Administrative Procedures Act, the court held that appellate was precluded by Louisiana's law of the case doctrine; therefore, the Court focuses on whether or not interventional pain management is within the traditional scope of practice of CRNAs. The Court noted that this issue is res nova, i.e., never before decided by a Louisiana Appellate Court.

In the final analysis, the Court found that, after a three (3) day trial on the merits, the trial court ruling is "reasonable, supported by the record, and not manifestly erroneous."

Background

Parties to the Louisiana lawsuit *Spine Diagnostics Center of Baton Rouge, Inc., versus Louisiana State Board of Nursing* returned to court in November 2007 to address several unresolved issues. Plaintiffs sought a declaratory judgment that the nursing board's 2005 advisory opinion, which is the subject of the lawsuit, substantively expanded the scope of practice of a nurse anesthetist into an area where they have not traditionally practiced (i.e., chronic or interventional pain management). Additionally, the court had been asked to declare that the practice of interventional pain management is solely the practice of medicine. Lastly, Spine Diagnostics returned to court in order to seek a permanent injunction prohibiting the nursing board from enforcing the advisory opinion. The appellate court had previously ordered a preliminary injunction prohibiting the nursing board from enforcing the advisory opinion and prohibiting the nurse anesthetist who sought the opinion from performing such procedures. In connection with the permanent injunction, the nursing board would be required to remove the advisory opinion from the nursing board's Web site and publish the trial court's opinion on the Web site.

On January 10, 2008, the trial court issued its ruling, which provides the following, among other things:

- The practice of interventional pain management is not within the scope of practice of a nurse anesthetist.
- The practice of interventional pain management is solely the practice of medicine.
- The advisory opinion issued by the nursing board is an effort to substantively expand nurse anesthetist scope of practice and is an improper attempt at rule making.
- A permanent injunction prohibiting the nursing board from enforcing the statement.

FOR MORE

state and federal issues, go to www.asahq.org/government.htm

GSA-PAC Year-in-Review

Catherine Meredith, M.D.
Chair, Committee for Responsible Health Care Policy

As the 2008 political calendar comes to a close, the members of the Georgia Society of Anesthesiologists have many reasons to be proud. This year we had record numbers of PAC contributions, exceeding expectations in three categories:

- in the raw number of GSA members contributing,
- in percentage of active members contributing, and
- in overall contribution dollars.

This has helped us enjoy an active and successful political agenda this year.

Earlier this year, members of GSA joined with anesthesiologists representing other state societies to lobby U.S Congressional leaders during the ASA legislative conference. As you know, members of Congress voted both to prevent the 10.6% Medicare pay cut and to overturn the unfair Medicare Anesthesiology Teaching Rule.

Back home we successfully distributed our pooled resources to state-level officials who have demonstrated support for pro-patient, physician-led healthcare. Over $60,000 was contributed to 84 candidates seeking office or re-election to the Georgia General Assembly. More than 90% of the recipients of GSA-PAC funds won their respective races.

The balance of power in the State Senate remains the same at 34 Republicans and 22 Democrats. In the State House, several incumbents were defeated ultimately resulting in a gain of two seats for the Democrats bringing their numbers to 75 versus the 105 Republicans. We continue to enjoy good standing in the state political arena, and we plan to continue re-earning this standing every two years as state lawmakers run for re-election. Thanks again to Executive Secretary Jet Toney and the members of our Governmental Affairs Committee for continuing to successfully deliver our message.

For more information email me at katiemeredith@yahoo.com or visit www.gsahq.org.

Each year we face new and different issues that affect the way we practice medicine, and the GSA-PAC will continue to be important throughout our careers. To join the GSA's critical grassroots advocacy effort, go online to the "Members" section of www.gsahq.org. Or mail your contribution to GSA-PAC, 1231 Collier Road Suite J, and Atlanta, GA 30318.

Please feel free to contact me if you wish to discuss participation in GSA-PAC or to propose a political contribution for a state level candidate.

GSA-PAC 2008 General & Primary Elections Contributions Summary

$61,500 total contributions *personally* delivered.

Primary Election

15 contested open seats (2 Senate/13 House)
41 incumbents faced primary opposition (14 Senate/27 House)
$13,500.00 Total Contributions to Candidates with Opposition
11 Senate Candidates received funds (8 Dem./3 Rep.)
9 House Candidates received funds (4 Dem./5 Rep.)
1 House incumbent chair lost his re-election bid

General Support

$13,750 in Total Contributions in support of 15 unopposed incumbent leaders
3 Senators (All Republican) and 12 Representatives (2 Democrats and 10 Republicans)
$2,500 of which went to the Republican Party of Georgia

General Election

53 incumbents faced general opposition (19 Senate/34 House)
$34,250 in Total Contributions to Candidates with Opposition
49 Candidates received funds:

16 State Senate (22 Dem/34 Rep)
5 Democrats and 11 Republicans
All recipients elected

33 State House (75 Dem/105 Rep)
10 Democrats and 23 Republicans
1 Democrat recipient defeated
3 Republican recipient defeated

- In the general election, the GOP realized 2 pick-ups both in Northeast Georgia—House Districts 8 and 28
- In the general election, the Democrats realized 4 pick-ups, one in the Central Piedmont the other 3 in the Metro-Atlanta suburbs.—House Districts 38, 95, 104, and 140

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Continued on page 13

To join GSA's political action campaign, go to www.gsahq.org and enter the "Members" only section. Or, mail your check made payable to "GSA-PAC" to 1231-J Collier Rd. NW, Atlanta, GA, 30318.

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To join a committee or learn more about the work of GSA, contact GSA President Howard Odom at npac@mindspring.com.

President's Report
(Continued from page 3)

to work with all the members who volunteer their time and ability in service of GSA. I have an enhanced and expanded appreciation for the commitment demonstrated by the Officers, Board members, Committee chairs & members and the Delegates to ASA and MAG. These esteemed anesthesiologist colleagues provide an immense service to the Society and their peers across the state. To each of you, "Thank You!"

During the recent national elections I was most impressed by the 'it's up to me' attitude evidenced by record voter turnouts and accounts of individual activism. Among other issues, healthcare was in the crosshairs – and we are healthcare. Considering the number and types of healthcare system issues we will face beginning in 2009, I contend that each GSA member must adopt the same 'it's up to me' attitude to meet the challenges and accomplish our objectives. My column in the last issue described 'GSA at Work.' Don't accept the idea that one person doesn't contribute very much since you will prove yourself to be correct. It's up to you! Keep GSA at Work in 2009! See you at the Winter Meeting on January 31st.

In Service

GSA VP exports skills, service to Africa

MONROVIA, Liberia – GSA Vice-President Rick Hawkins, M.D. recently joined an international team of exporters; in this case, a team of professional health care providers from 32 nations coalescing skills to provide medical care in one of the planet's most underserved locations – West Africa.

Dr. Hawkins provided anesthesia and peri-operative care on a *Mercy Ship* docked in Monrovia where 80 percent unemployment and a lack of electrical power brutally complement a lack of resources and prospects for improvement. The country is only two years removed from the culmination of a 15-year Civil War. He served from October 24 through November 4, 2008.

The following is Dr. Hawkins' report from the mission work:

Mercy Ships is a global charity based in Houston, Texas that has operated hospital ships in developing nations since 1978. Mercy Ships brings hope and healing to the forgotten poor by mobilizing people and resources worldwide, and serving all people without regard for race, gender, or religion. They promote health and well-being by serving the urgent surgical needs of the forgotten poor and empowering developing communities.

Their present ship is called the Africa Mercy *and is the fourth in the fleet. The 499-foot 16, 572 GRT* Africa Mercy *is the world's largest charity hospital ship. The hospital includes six state of the art operating rooms, intensive care and ward bed space for up to 78 patients. The equipment, supplies and monitors meet US standards and in some cases were better than that used in some of our facilities. The Africa Mercy has a berth capacity for 484.*

While I was on board there were about 400 volunteers representing 32 nations. The anesthesia providers who I worked with were from The United Kingdom, South Africa, Germany, Australia and Canada.

The crew is made up of long term volunteers (1 year or more) as well as short term. Several entire families (adults and children) live onboard and the maxillofacial surgeon has been with Mercy Ships for over 20 years. Most of the volunteers find churches, groups or companies to sponsor their time on ship."

The ship is a floating community with a post office, bank, school for the kids through 12th grade and even a "Starbuck's Café." Mercy Ships has a plan to build at least two and maybe three new hospital ships and have them in service within the next 5-7 years.

The following are facts posted on the *Mercy Ships* website:

- Since 1978, *Mercy Ships* has performed more than 1.7 million services valued at over $670 million and impacting more than 1.9 million people as direct beneficiaries.
- Performed more than 32,500 surgeries such as cleft lip and palate, cataract removal, straightening of crossed eyes, orthopaedic and facial reconstruction.
- Treated more than 212,000 people in village medical clinics. Performed more than 183,000 dental treatments.
- Taught over 14,500 local health care and professional workers, who have in turn trained many others in primary health care.
- Taught 95,000 local people in primary health care.
- Trained local medical professionals in modern health care techniques.
- Delivered more than $60 million worth of medical equipment, hospital supplies and medicines.
- Completed more than 900 community development projects including construction of schools, clinics, orphanages, water wells and agriculture programs.
- Demonstrated the love of God to people in over 550 port visits in 70 different nations.
- More than 850 career crew from over 40 nations serve today either on-board or in some of their land based missions
- More than 1,600 short-term volunteers serve with Mercy Ships each year.

Before

After

Status of Trauma Care:

(Continued from page1)

Should you live north of the "deadline" what will be the long term trends for trauma care preparedness? What is the stability of trauma centers in this area and across the state?

I work at North Fulton Regional Hospital Level II trauma center. I recall reading the "status board" of trauma diversions throughout the area. I saw various reasons for diversion. These reasons include ORs not available, ICU beds full, and unavailable medical sub-specialty trauma coverage. I have seen two Atlanta metro hospitals drop out of the system. I have seen emergency medicine physicians spending precious patient survival time on a telephone attempting to arrange for patient transfers. The table below shows the physician rate per 100,000 of Georgia population from 1996 to 2006.

Specialty	1996	1998	2000	2002	2004	2006
Anesthesiology	10.22	9.84	9.56	8.93	9.52	9.06
Emergency Medicine	7.8	8.4	8.9	8.8	9.6	9.6
General Surgery	9.6	9.3	9.4	8.5	8.4	7.7
Neurological Surgery	1.5	1.5	1.3	1.4	1.5	1.5
Orthopedic Surgery	7.6	7.2	6.8	6.9	7.0	7.5

Source: Georgia Board for Physician Workforce

In anesthesiology and general surgery there has been an 11.3% and 19.79% drop from 1996 to 2006. This suggests that for these specialties there are increasing demands within the trauma care component of their practice. For general surgery and neurosurgery specialists 45.7% and 41.1% are over 50 years old. The lifestyle sacrifice and demands for the physician required to be available and ready for the trauma patient are burdensome. The cost of lost elective surgery revenue is rarely recaptured through the care of the trauma victim, because 29% of trauma patients are uninsured. Doctors on medical staffs of trauma hospitals have left and many of those who remain are assessing their practice options. Recruiting new members to these medical staffs is becoming more difficult.

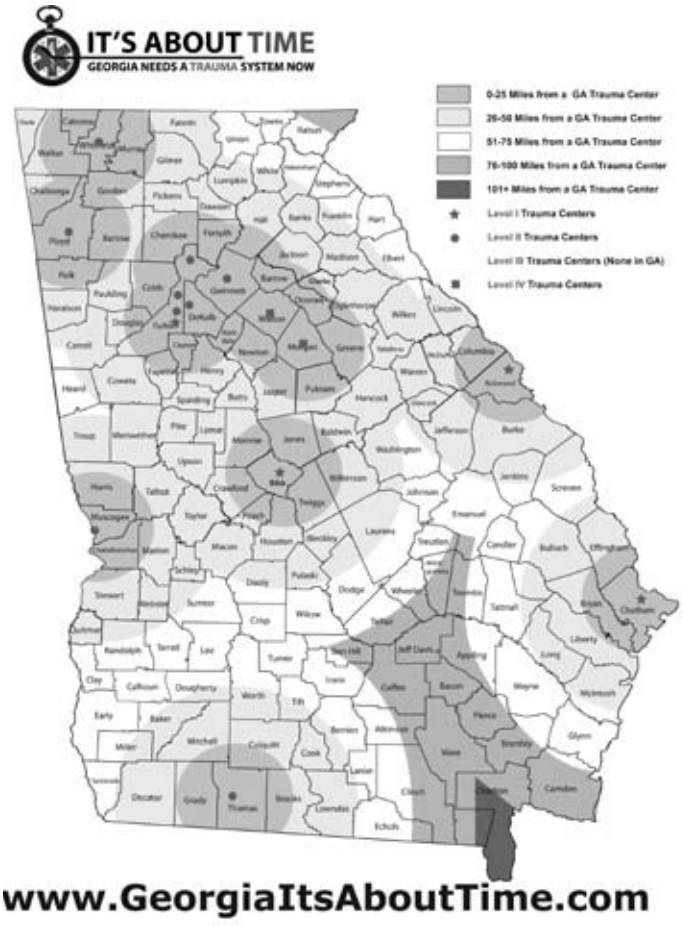
Trauma coverage across the state is at risk.

Trauma coverage across the state is at risk. Its success requires much more than hospitals seeking a "voluntary designation" as a trauma center or the hope of relying solely on doctors with a passion to provide care to the trauma victim. Last year Gov. Sonny Perdue and our legislators provided an initial step to help stabilize our current state trauma coverage. An allocation of $58.9 million was made for 2008 trauma care hospitals and physicians. S.B. 60 was passed creating the Georgia Trauma Commission.

The time for a sustainable trauma system is NOW.

Our state requires a long term solution through an organized statewide trauma system. This system must be able to rely on a sustainable funding source for 911 service, effective EMS resources, trauma hospitals, physician trauma care teams and physician consultants and rehabilitation service.

The time for a sustainable trauma system is NOW. An estimated 700 lives a year could be saved with a statewide trauma system. As anesthesiologists we need to support efforts that will provide this lifesaving care to injured patients. We need to support our physician colleagues, health professionals, and hospitals that provide that care. For more information on how you can help go to **www.GeorgiaItsAboutTime.org**.



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(Continued from page 9)

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ASA Update

Peggy G. Duke, M.D.
ASA Alternate Director

Intellect, hard work, dedication and grace

Congratulations to Dr. Steve Sween, who was elected ASA Vice-Speaker at the October 2008 ASA Annual Meeting at the HOD. Anesthesiologists in Georgia are fortunate to have Steve in this important position. As a member of the ASA Executive Committee, he will continue his strong advocacy for the specialty of Anesthesiology.

Steve, very early in his career, understood the importance of having a strong GSA and a strong GSAPAC to represent anesthesiologists in Georgia and the medical specialty of Anesthesiology. He was one of the leaders who, with foresight, dedication and hard work helped move the GSA from, primarily, a social organization to a strong politically astute organization. He, with other like-minded GSA leaders, helped bring into our organization, Jet Toney, who is the Executive Secretary and lead lobbyist for the GSA. Jet Toney, highly respected by Georgia legislators, other lobbyists, and the officers and committee chairs of the GSA, is an effective advocate for all Georgia anesthesiologists.

Steve, we are happy for you and appreciate all you have accomplished for the GSA, for serving in an exemplary fashion as the ASA Director, and your strong advocacy for the medical specialty of anesthesiology.

Federal Victory

If the following is old news to most of you, that is great. For those who may not yet be aware, the US Congress on July 15, 2008 voted to override President Bush's veto of the Medicare Improvements for Patients and Providers Act (MIPPA). This law retroactively reversed the Sustainable Growth Rate (SGR) that would have mandated a 10.6% cut in Medicare payments to physicians that had gone into effect July 1, 2008. This was a hard-fought battle by organized physician medical specialty societies, including the ASA. That victory translates to a significant retention of income for all anesthesiologists. Give a small part of that back in the form of ASA-PAC and GSA-PAC contributions.

A major victory from the July 15 MIPPA was the correction of the onerous anesthesia teaching rule which has been in effect since 1994. That rule mandated a 50% reduction in payment from CMS to academic anesthesiologists simultaneously teaching two residents. As most anesthesiologists are aware, anesthesiology is the only specialty penalized for simultaneous teaching two residents. This change goes into effect in 2010 and will add income to the bottom line of all academic anesthesiology programs.

The victories won are due in large part to those anesthesiologists who actively participate in their component societies and the ASA, and who give, for the benefit of all anesthesiologists, their time and money to their component society and PAC and to the ASA and ASA-PAC. All academic anesthesiologists can show their enthusiastic thanks for the hard work of the members of the ASA and the GSA by becoming active in organized medicine and contributing to the ASAPAC and the GSAPAC.

If you are not active in the GSA and/or do not contribute to the GSA-PAC, please become active. You will be welcomed with open arms. However, if your practice simply does not allow you to give your time, please consider contributing your money to help with continued advocacy for our specialty. Scope of practice and other issues will continue to come before the Georgia legislature. If anesthesiology is not at the capitol educating our legislators, they will not know that an anesthesiologist is a physician engaged in the medical practice of anesthesiology. They will not know that anesthesiologists have been the physician leaders in patient safety.

A very special thank you to our current GSA President, Howard Odom, who has done a yeoman's job updating the GSA Bylaws and codifying the GSA rules and regulations, that, until he undertook the onerous and laborious task, has been dependent upon "corporate memory." He has been an outstanding example of a GSA President leader who has served our society with intellect, hard work, dedication and grace.

The Winter Forum, January 31, 2009 at Lake Lanier Islands, offers a great program under the direction of Cinnamon Sullivan, MD, titled, "From the OR to the ICU, Critical Issues in Anesthesiology." You can learn, earn CME, see old friends, and make new ones. Meet the GSA officers and committee chairs and let them know you appreciate their advocacy for Georgia anesthesiologists.

Check out the GSA website: **www.gsahq.org**. There you can find information for upcoming GSA meetings as well as information on legislative and other pertinent issues related to anesthesiology. Also on the website are the profiles of the GSA officers and committee chairs with phone numbers and email addresses.

FYI, the ASA has posted the Strategic Vision and Plan to move the ASA forward during these complicated, difficult times and has also adopted a new logo.

Go to **http://www.asawebapps.org/docs/ViewDoc.asp?File=2007-2009ASAStrategicPlan.pdf** or go to the ASA website **www.asahq.org** and follow the link.

I look forward to seeing you at the Winter Meeting January 31, 2009

Happy New Year to all.

Save The Date!

GSA
Summer Meeting 2009
July 31 – August 2

Activity Director
Mary E. Arthur, M.D.
marthur@mcg.edu
Medical College of Georgia
Augusta, GA

The King & Prince Beach & Golf Resort
St. Simons Island, GA
www.kingandprince.com

Emerging Roads in Anesthesia:
Reaching Beyond the OR

Objective:

Prepare anesthesiologists to better lead critical care, pain management and treatment of chemical terrorism.

The demand for anesthesia services is increasing due to more complex procedures being performed outside the operating room. Non-operating room anesthesia claims are reported to have had a higher severity of injury and more substandard care than operating room claims. The theme of the 2009 summer GSA meeting "Emerging roads in Anesthesia: Reaching beyond the OR" will help us focus on these challenges as well as other areas such as critical care, pain management and chemical terrorism where anesthesiologists are beginning to play an ever increasing role.

Faculty:

1. **Fredric I. Weitz, M.D.**
   Emory University School of Medicine, Atlanta, GA
   - Off-Site Anesthesia: The Emory experience
2. **Ted Weatherred, M.D.**
   Medical College of Georgia, Augusta, GA
   - Off-Site Pediatric Anesthesia: The MCG experience
3. **Adam E. Berman, M.D.**
   Medical College of Georgia, Augusta, GA
   - Introduction to Electrophysiology Studies and Catheter Ablation
   - Cardiac Rhythm Device Management for the Anesthesiologist
4. **Allen N. Gustin, Jr., M.D., F.C.C.P.**
   University of Washington School of Medicine, Seattle, WA
   - New Trends in Mechanical Ventilation
   - Heparin-induced thrombocytopenia
5. **William Hammonds, M.D., M.P.H.**
   Medical College of Georgia, Augusta, GA
   - "A Life in Pain"
6. **Mark Dershwitz, M.D.**
   University of Massachusetts Medical School, Worcester, MA
   - Total Intravenous Anesthesia (TIVA) Pearls
   - Managing Chemical Weapons Exposure
7. **Manuel R. Castresana, M.D., F.C.C.M.**
   Medical College of Georgia, Augusta, GA
   - Anesthetic Implications For Endovascular Procedures Including Carotid Artery Stenting
8. **Jeffrey L. Apfelbaum, M.D.**
   ASA President, Northbrook, IL
   - ASA Update

Look for Details Soon at www.gsahq.org

Register now at www.gsahq.org

GSA
Winter Forum 2009

One-Day Meeting
January 31, 2009

Activity Director
Cinnamon L. Sullivan, M.D.
clsulli@emory.edu
Emory University Healthcare
Atlanta, GA

Legacy Lodge and Conference Center
Lake Lanier Islands, GA
www.lakelanierislands.com

From OR to ICU:
Critical Issues in **Anesthesiology**

Don't Wait!

Objective:

To present solutions to treat medical conditions which crossover from the OR to the ICU.

Anesthesiologists are, in effect, intensivists in the operating room. As healthcare changes there will be more emphasis on critically ill patients. There is little argument that our population is getting older and therefore sicker. We are performing anesthesia on more patients with multiple end organ disease and, due to advances in medicine, they are surviving. Whether you are a board certified critical care physician or not you will take care of the critically ill.

The GSA Winter Forum will meet its objectives through lectures from internationally known critical care experts in the fields of transfusion medicine, cardiac resuscitation, and solid organ transplant. The lectures will cover the following educational objectives:

1) **Review the history of critical care medicine.**
2) **Understand the advances in bloodless surgery.**
3) **Study the newest evidence based guidelines of cardiac resuscitation.**
4) **Learn about peri-operative management of patients with end stage liver disease, and**
5) **Update knowledge of surgical blood management.**

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