Georgia Society of Anesthesiologists, Inc.

scope Newsletter

Fall 2010

Academic Anesthesia: Fueling the Future of Quality Care

James R. Zaidan, MD, MBA

Professor & Chair - Department of Anesthesiology
Emory University - School of Medicine

I am very happy to say to everyone again this year that the training program at Emory remains very healthy. Our CA1 residents were at the top of their graduating classes, and the CA1s who entered outside the match are superb. All of our programs are filled. We are off to a great start, and all of us will continue to work hard to assure that the education that we provide our residents continues with the highest standards.

As everyone knows, the ACGME training program is required to teach residents the elements of Systems Based Practice, Professionalism and other core issues. Last year, residents completed team projects in Professionalism and tackled a number of very sensitive issues that dealt with religion, consents and behavior management. The end products of these team projects were wonderful, and a number of them were presented at the School of Medicine during the "Science of GME Day" where the Dean personally reviewed the projects and talked with our residents. I look forward to discovering what our residents will do this year.

Our School of Allied Health is also doing very well. For those of you who have worked with our Physicians' Assistants in Anesthesiology, you understand the very high quality of our graduates and realize how much they help us to provide excellent care to our patients.

Research continues on a positive path with new R01 grants and AGA grants entering the labs even in these difficult times, and we continue our multifaceted research pathways in the areas of pain, stroke, cell signaling, membrane receptor and coagulation. We lost one outstanding researcher, Chantal Kerssens, PhD, to the corporate world. She was working in the area of CNS connectivity, and we will certainly miss her in the department. We were fortunate to have recruited Paul Garcia, MD, PhD, who will split his time between the VAMC and EUH. Paul will study GABA receptors, and we welcome Paul to the faculty.

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C. Alvin Head, MD

Chair - Anesthesiology & Perioperative Medicine
Medical College of Georgia

Each year, our residents become more involved in the ASA. I have encouraged active participation in organized medicine to complement a well-rounded academic program. We will have resident representation at the Resident component of the ASA to address resident concerns and resident-driven issues and solutions that will enhance our future practice in anesthesia. At the Medical College of Georgia, **we want to develop** not only Board-certified anesthesiologists, but **future leaders of our profession**.

This year, our department will present four abstracts, six medically challenging cases, an educational exhibit and a lecture on academic practice. Eight residents are primary or secondary authors and will present their work at our national meeting in San Diego this October. The diversity of the presentation topics is a testament to the dedication to higher level learning, higher level thinking and innovation here at MCG. Such topics as anesthesia for hybrid convergent ablation procedures, video laryngoscope in awake intubations and thrombolytic therapy in a patient with an epidural catheter highlight our strong clinical practice.

Education comes in many forms and our residents today learn in a much different manner than many of our faculty. Our technological world has put loads of informational access in our hands for rapid answers to difficult questions. No longer do residents carry the 3x5 hand written note cards in their scrubs (as I used to). Now I carry an iTouch with more information than I could ever write down on those cards or could the residents.

With that, our residency director Dr. James Mayfield and I are working with our campus Information Technology Department to bring our program more solidly into the 21st century with iPhone 4 anesthesia training applications and tech-based digital upgrades to our

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Fall 2010

Editor's Corner

Kathryn Stack, MD, Chair, Communications Committee, Editor, GSA *scope*

I hope the arrival of fall and cooler weather finds you all well, settled back into another school year, and of course ready for the fall election season. To all you procrastinators (like me), make your GSA-PAC contributions now. We, the procrastinators, have the ability this fall to provide significant additional support to candidates who value, and will work to champion, the missions of the GSA. Contact Dr. Katie Meredith with questions, but make your contribution soon. Additionally, please contact Dr. Carolyn Bannister if you have questions about the ASAPAC.

Those of you visiting the GSA website recently may have noticed another updated look to the site. After a period of unresolved and ongoing problems with website management, Jet Toney and Cornerstone Communications Group have secured a new vendor. Visit www.gsahq.org soon and check all there is to offer. E-commerce functions will offer convenient dues, PAC and meeting registration payment.

A special welcome and thanks to Heather Atha in her new position at Cornerstone. Heather has been instrumental in the transition of website management.

The GSA 2010 annual Summer Meeting, "Meeting Current Challenges in the OR and Beyond", was held July 16-18, 2010 at the Ritz-Carlton Lodge, Reynolds Plantation in Greensboro, GA. The new location of this meeting was an overwhelming success. Program Director Dr. Colin Brinkmann assembled an

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Navigating the MedMal Maze

Kenneth Anthony - Agency Sales Manager | Medical Protective

There are a variety of decisions physicians will make over the course of a career. One of the most difficult could be selecting a professional liability carrier. After all, not only do physicians have to wade through unfamiliar terms, but also must make a decision that will affect one's career years later. While it might seem like a daunting task, sometimes just asking the right questions can make all the difference.

Medical liability insurance can be confusing. What questions should you ask? What do you need to know about your policy?

First, read the policy carefully. Ask the insurer if there are any other documents (such as an association's by-laws) that might impact your rights and obligations. Review this information with an attorney experienced in insurance and contract law and ask more questions.

Is consent to settle required? How much control does the policy allow an individual physician when making decisions regarding the settlement of a claim? Settlement of a claim involves more than money – it can impact your reputation, your practice and even future insurability. Who decides if the claim will be presented to a jury: the insured, the carrier or arbitration panel? If you object to settlement and the trial verdict is higher than what you could have settled for, will you be personally liable?

Does the physician have a voice in the defense? Know what rights, if any, the policy gives you if settlement is considered.

Ken Anthony is a regular exhibitor at GSA meetings.

Occurrence or Claims-Made? Your policy will will most likely provide professional liability coverage on either an occurrence or claims-made basis. Occurrence coverage responds to claims based on when the medical incident occurred, regardless of when the claim is actually made against you. As long as the medical incident occurred during the policy period, your occurrence policy will respond -- even if the claim is made after the policy period expires.

Claims-Made coverage, by contrast, responds to claims based on when the claim is first made against an insured. Given the length of time that can pass between a medical incident and a resulting claim, claims-made policies contain a retroactive (or "prior acts") date. This retroactive date allows the policy to look back in time and consider prior medical incidents. As long as the medical incident took place after the policy's retroactive date (or "prior acts date"), and the claim is first made during the policy period, your claims-made policy will respond.

If you renew your claims-made policy with the current carrier, your coverage will continue uninterrupted. However, if you move to another professional liability carrier, your claims-made coverage ends and you will have to either obtain a reporting endorsement from the prior carrier (often referred to as "tail" coverage), or purchase prior acts coverage from the new carrier. A reporting endorsement allows you to report claims based on medical incidents that took place between the retroactive date and policy termination date, but

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Ask questions.
Compare offerings.
Information is Power.

CME Review

'Current Challenges' fills member needs

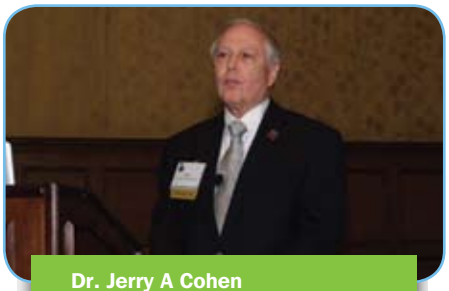
Colin S. Brinkmann, MD
Activity Director, Summer Meeting 2010

On July 16-18, the Georgia Society of Anesthesiologists held its semiannual meeting at a new location, the Ritz Carlton Reynolds Plantation on the banks of Lake Oconee. The venue was different as was the approach to the meeting. In the past, topics ranged from ICU care, outpatient anesthesia, and novel concepts in research impacting the field of anesthesia, usually revolving around a single discipline.

"Current Challenges in the OR and Beyond" focused on many of the topics or funds of knowledge that our members had requested. Namely, the meeting explored some of the common and upcoming clinical challenges as well as the ever expanding role of government regulation, its impact on healthcare, and the absolute importance of GSA members participating in the political process.

GSA President Rickard S. Hawkins, M.D. greeted GSA members before introducing ASA President **Alexander Hannenberg, M.D.** We were very fortunate to have Dr. Hannenberg give the ASA update. He presented an overview of the ASA's organizational improvement and how our parent organization partners with other national associations to create alliances and help forge policies. Members also gained information on how to access growing educational opportunities. Perhaps most importantly, Dr. Hannenberg recognized the legislative and regulatory components of the ASA Advocacy Agenda and how we as anesthesiologists need greater involvement in the political process.

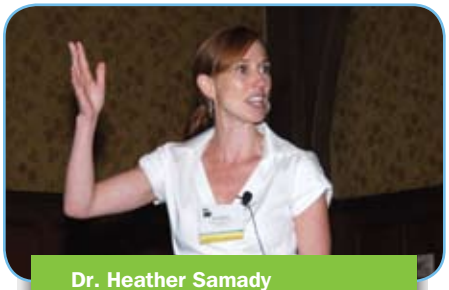
Dr. Alexander Hannenberg



Dr. Jerry A Cohen

Along with the ASA president, ASA 1st Vice President **Jerry A Cohen, M.D.** lectured on Medication Management and the Joint Commission. GSA members learned to appreciate and understand the requirements mandated by the Joint Commission for regulated anesthesia practice and to realize that the elements required for accreditation may differ from actual safe clinical practice.

Dr. Jirish Joshi, Director of Perioperative Medicine and Ambulatory Anesthesia at UT Soutwestern in Dallas, lectured on obstructive sleep apnea and on implantable cardiac defibrillators (ICD) in the ambulatory setting. GSA members learned the numerous ways to reduce risk of apnea in the perioperative setting by employing different anesthetic techniques or combinations of anesthetics and to closely monitor the patient in the postoperative period. In discussing the increased presence of ICD's in the ambulatory setting, members learned that magnet application to an ICD may have different actions and not all devices are identical. The question is not always whether or not to apply the magnet or how to minimize risk surgically, rather, what will happen when the magnet is applied.



Dr. Heather Samady

Heather Samady, M.D gave two lectures on ultrasound guided regional anesthesia involving basic ultrasound principles, imaging and the increasingly popular continuous indwelling regional catheters. Attendees gained a greater understanding of how the ultrasound works and a basic approach to image acquisition. The lecture on indwelling catheters

"Anesthesiologists need greater involvement in the political process."

ASA officers En Masse! **Six ASA officers attended the GSA Summer Meeting**

Pictured from Left to Right

Dr. Steve Sween
Vice-Speaker

Dr. Arnold Berry
VP-Scientific Affairs

Dr. Alex Hannenberg
President

Dr. Jerry Cohen
First Vice-President

Dr. John Neeld
Past-President, 1999

Dr. Robert Johnstone
VP-Professional Affairs

Three of the six are GSA members.

described the various insertion techniques as well as basic catheter management, including a review of potential complications as well as contraindications to catheter placement.

Dr. Andy Harris

Sunday morning, attendees heard **Dr. Andy Harris**, a Maryland anesthesiologist and congressional candidate who lectured on federal and state health policy affecting anesthesiologists. Topics included the role of state and federal legislatures in dictating health policy such as the requirement or lack thereof of anesthesia supervision and the effort to implement standards for office based surgery. An overwhelming message of Dr. Harris echoed that of Dr. Hannenberg: the greater need for involvement of GSA/ASA members in the political process.

Dr. Manuel Vallejo, M.D.

Manuel Vallejo, M.D. presented on both days of the meeting informing GSA members on postdural puncture headaches (PDPH) and the use of obstetric anesthesia. He gave a very thorough explanation of the differential diagnosis of PDPH and the available treatment options. In addition, he described how to use the ultrasound for labor epidural placement, something many attendees were not familiar with.

Last but not least, GSA attendees were fortunate to hear from **Dr. Jamie Ramsay**, a GSA member, Emory faculty and former president of the Society of Cardiovascular Anesthesiologists, who lectured on the adequacy of perfusion and the perioperative management of the patient with cardiac disease. He outlined a great approach to optimizing cardiac patients for non-cardiac surgery as well as explaining novel approaches to assessing volume status and responsiveness.

Dr. Jamie Ramsay

Overall, the 2010 Summer GSA meeting was a great success with the largest member turnout in 10 years amidst a beautiful new location. Members and attendees left with a better appreciation of how the political process affects the practice of anesthesia as well the need to participate.

Save the date: Winter Forum, January 22, 2011

Resident Perspective

75 years of MCG Anesthesiology: Celebrating the past, looking to the future

Vikas Kumar, MD | CA-2

The history of MCG anesthesiology dates back to 1937 when Dr. Perry Volpitto started the first residency program in the South. He is long remembered as a pioneer in academic anesthesiology at MCG and also co-founder of the Southern Society of Anesthesiologists. Since then, the department has continued to grow under Drs. Zachariah W. Gramling, Robert S. Crumrine and the present chairman, Dr. Alvin Head.

As chair, Dr. Head has largely fulfilled his diverse roles as clinician, researcher, teacher, mentor and administrator by setting an example, listening and mentoring. The residency program has come a long way under his mentorship. Walking along the road from the initial years of our residency program, we are now leading up to the exciting celebration of our 75th anniversary in 2012.

My start as a CA-1 resident was an exciting transition from internship. Scrubs replaced necktie, operating rooms took over the medicine floors and managing anesthetized patients became a routine. Preparing the room for the day's cases, you strap on your roller skates and cautiously take off for a smooth ride. The ability to make the patients smile and allay their fears in a five to ten minute conversation before taking them to the OR is incredibly satisfying. At the end of the day, my patient's smooth recovery after a long procedure makes my heart smile.

As I leave the hospital in the evening, removing those roller skates and settling down to a normal pace gives a deep sense of satisfaction. While on call, handling "Level 1 trauma" cases, attending code 99s, intubating on the floor/ICU and managing critical care patients are some of my memorable learning experiences. With excellent guidance from all faculty members and support from colleagues, my CA-1 year was a busy, challenging yet enjoyable ride. The crew over at "the operating room" is fantastic and easy to work with. As I continue on in my CA-2 year, I am

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Emory: A resident's view

Gaurav Patel, MD | CA-2

What a year! Surely, that seems like a trite phrase. But I see no other way to describe the past year for Emory residents. As a CA-2, I am literally in the middle, and I can feel the trepidation amongst the new CA-1s and the confidence starting to build with the CA-3s. There have been many changes and many accomplishments over this last year that continue to make the Emory residency experience one of a kind.

I would be remiss not to first and foremost mention the recent graduates. Several decided to continue their training in a variety of fellowships including Cardiothoracic and Pediatric Anesthesiology and pain medicine – all at a variety of academic medical centers. A handful remain on faculty in the Emory Healthcare system, and several are joining private practices across the United States. They were great mentors to the junior residents and will certainly be missed (but Congrats!).

Secondly, a major part of this last academic year for all residents has been working on the "Professionalism in Medicine" project that encompasses every residency program in the Emory system. Anesthesiology residents were involved in a variety of poster presentations examining the very basis of professionalism. Projects included conflict resolution in the OR, favoritism in medicine, racism and sexism in medicine, among others. Residents worked on creating surveys, studies, videos, and posters over a majority of last year, all culminating with poster presentations in the spring. The anesthesia projects were well received by all departments and the Dean of the School of Medicine.

A major announcement came to residents just several months ago which will certainly shape the future of

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"The future depends on what we do in the present."
- Mahatma Gandhi

New duty hours recommendations

Matthew E. Patterson, MD | President, GSA Resident Component
Emory University School of Medicine

The Accreditation Council for Graduate Medical Education (ACGME) enacted standards on resident duty hours in 2003 which limited residents to 80 hours of work per week. These standards have been the source of much debate. Most notable was the 2008 Institute of Medicine's (IOM) report recommending more stringent standards. The ACGME Task Force on Duty Hours has further analyzed the matter, and in a June 2010 New England Journal Medicine article, Dr. Thomas Nasca provided the new recommendations of the task force and offered insight behind the decisions that were made. The new recommendations include the following:

Dr. Patterson presided over the Resident Component Annual Meeting. | July 17 at Lake Oconee

- Duty hours must be limited to 80 hours per week, averaged over a four-week period, and be inclusive of in-house activities and all moonlighting.
- Maximum duty periods of PGY-1 residents must not exceed 16 hours.
- Maximum duty periods of PGY-2 residents and above must not exceed 24 hours.
- An additional period of no more than four hours of on-site time is permitted for transitions in care.
- Residents may not attend continuity clinics after 24 hours of continuous in-house duty.
- In unusual circumstances, residents, on their own initiative, may remain beyond the scheduled period of duty to care for a single patient (e.g. an unstable or severely ill patient to provide humanistic attention to the needs of a patient or family member). This time must be documented and reviewed by the program director.
- Residents should have 10 hours, but must have eight hours free of duty between scheduled duty periods and 14 hours free of duty after 24 hours of in-house duty.
- Night float duties are limited to six consecutive nights.
- In-house call must not be more frequent than every 3rd night.

The intended goal of duty hour restrictions is to limit resident fatigue and the possibility of medical errors. All residents aspire to one day become experienced clinicians capable of the independent practice of medicine. These new recommendations will impact some specialties more than others and will likely have a greater effect on smaller programs. Some organizations have already come forward and claimed that the new recommendations do not go far enough in terms of limiting duty hours for all residents. Therefore, a balance must be made between gaining the experience necessary to grow into capable anesthesiologists, and responsibly providing safe and effective care to patients.

Duty hour restriction is the issue that has received the most attention, but the new recommendations also address the area of supervision. The new model provides a graded level of expected supervision that is based on the resident's level of training. This can range from direct supervision or immediate on site availability for a first-year resident, to the supervising physician reviewing physician reviewing the encounter after the care has been delivered for more experienced residents. Ultimately, all residents must become independent clinicians by the end of their training. Residents should be given some level of independence as they gain experience so that they can be ready for independent practice one day in the future. Therefore, there is value in the proposed recommendations in which residents will require less supervision as they gain experience.

Ultimately, there will be changes in residency education in the future. There are many different organizations that have taken an active interest in these matters which have lead to the proposed recommendations from the ACGME task force. The ACGME allowed public comment on the new standards up to August 9, 2010, and the task force will make modifications where it is needed. The new standards will be put into effect in July 2011. These are changes that will affect all training institutions in the country, so I would anticipate that residents will see some changes in the coming year.

References: Nasca TJ, Day SH, Amis ES Jr; the ACGME Duty Hour Task Force. The New Recommendations on Duty Hours from the ACGME Task Force. N Engl J Med. 2010 Jun 23. [Epub ahead of print]
http://www.acgme.org/acWebsite/dutyHours/dh_index.asp

Committee Reports

Committee for Responsible Healthcare Policy

Katie Meredith, MD | Chair

As the general election nears, GSA-PAC continues to support candidates who have demonstrated an interest in protecting patient safety and improving the delivery of quality healthcare in Georgia. A state with 236 lawmakers offers tremendous potential for building relationships from the ground up. Jet Toney, along with members of the GSA Government Affairs Committee, hand delivers campaign contributions to both Democrat and Republican members of the state House and Senate who are in positions to positively impact issues important to anesthesiologists and our patients.

In the summer primary and run-off elections, candidates supported by GSA-PAC won 53 of 61 races. The PAC will be involved in more than two dozen general election contests.

It is more important than ever to be active in GSA's advocacy program and to support the PAC. Opportunities abound to support friends of organized medicine. There is still time give to the GSA-PAC in 2010. Your contribution will enable us to continue to build relationships with the lawmakers that have demonstrated support for pro-patient, physician led healthcare.

Thank you for boosting our ability to work more effectively on your behalf.

Program and Education Committee

Carolyn Bannister, MD | Chair

Thank you to all the summer meeting attendees who completed the course evaluations and meeting survey. I know there was a bit of bribery and arm-twisting to get a good response rate, but it worked! We will now use the responses to plan the summer 2011 meeting.

Per the ACCME accreditation guidelines for CME activities, the Program and Education Committee must now demonstrate that our meetings are tailored to provide information that will equip members to close "knowledge gaps." To that end, we changed the educational survey somewhat to ask what areas the membership considers to be "knowledge gaps" so that we may make conscious decisions to bring speakers with expertise and skill in those areas. We will thoroughly review all surveys to determine future educational themes and learning objectives.

Thanks to Dr. Arnold Berry, a very exciting development in our educational mission is the pilot project with the ASA to jointly sponsor our CME meetings. As this is a new endeavor, the Program and Education Committee members are learning the process. So stay tuned; the goal is for this to be seamless for the membership.

The winter 2011 educational meeting is just around the corner (believe me, Christmas will be here in a blink it seems.) The program coordinators are Drs. Tom West and Ginger Zarse. Please refer to their article and the GSA website for more information.

When you attend the educational meetings, please take a moment to respond to the educational survey; we need very specific recommendations for meeting content. Dr. Kreisler and I would also appreciate emails or phone calls with your suggestions for speakers or educational content. We hope to see you at the Winter meeting.

Contribute to GSA-PAC online at www.gsahq.org

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Raphael Gershon, MD, MBA

Representative to Medicare/Medicaid Carrier Advisory Committee

After a full year-and-a-half of meetings, emails and much hand-wringing, a coalition of practice/billing managers, the GA Association of Anesthesia Administrators, the third-party payer section of MAG and the GSA have successfully advocated for implementation by the Department of Community Health of revised policies on codes 01967 and 01968. These codes relate to Obstetric Anesthesia care for labor analgesia and surgical anesthesia for Caesarean section.

As a direct outcome of the last meeting on July 30, 2010, DCH has decided to reinstate the recouped payments on 01968 for dates of service in 2008 regardless of billing methodology as long as it passed the system edits at the time billed. Along with this decision is the determination that further recoupments will not be processed against 01968 for dates of service prior to the system edit change.

Additionally, DCH has written a detailed payment policy regarding codes 01967, 01968 and 01969. This payment policy includes allowances for different providers to bill codes 01967 and 01968 and for any combination of concurrency modifiers to be used so long as the primary procedure is on file. The policy further details the correct allowed amounts for each code and modifier combination. The policy will also be included in the next revision of the Medicaid Policies and Procedures Handbook.

As invariably the only physician in a room filled with DCH reps, practice managers and billing specialists, my job often entailed reminding the 30-40 people present that these are actual patients we are taking care of and we are real anesthesiologists placing those labor epidurals and performing those general anesthetics for emergency caesarean sections at 2:00 am. Furthermore, the anesthesia care of the citizens of Georgia relies on proper, timely and appropriate Medicaid payments not only to pay today's bills, but to ensure the education of future generations of anesthesiologists practicing in our state. That being said, the issue of pay inequity within the academic model for physician-to-physician oversight (anesthesiology attending and resident) with regards to labor epidural placement, and an anesthetist not involved in the actual procedure still remains on the table. To be continued...

SCIP, PQRI, Alphabet Soup

The Physician Quality Reporting Initiative (PQRI) is a voluntary individual reporting program that provides an incentive payment to identified eligible professionals (EPs) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B beneficiaries. EPs will have the opportunity to use participation in the PQRI program to improve the care of the patients they serve through the evidence-based measures that are based upon clinical guidelines. Participating in PQRI is a way to prepare for future pay-for-performance programs and a financial incentive is available to reward participating EPs.

A PQRI participant who reports satisfactorily will earn a financial incentive based on a percentage of the Medicare Part B PFS total estimated allowed charges for covered services provided during the longest, or most advantageous, reporting period for which the professional satisfied criteria for at least one reporting option. CMS will review and analyze data reported to determine satisfactory reporting and eligibility for an incentive payment based on a percentage of Medicare Part B PFS total estimated allowed charges for covered services furnished during the reporting period.

If an EP begins reporting on a particular PQRI measure, CMS will assume that measure applies to the EP and will require submission of the measure for at least 80% of the patients or encounters eligible for the measure in order to deem the EP successful. CMS does not require an EP to submit three measures. However, if an EP submits fewer than three measures, the Measure Application Validation (MAV) process will determine whether he/she should have submitted quality data codes (QDCs) for additional measures.

CMS is migrating from a payer of quantity to a payer of quality. The PQRI program is evolving, and to acknowledge the quality efforts made by the provider, CMS provides an incentive bonus for successful quality reporting which for 2010 is 2% of the individual provider's Medicare allowable charges.

For the full text of this article, go to...
www.gsahq.org

"PQRI is a way to prepare for future pay-for-performance programs... CMS is migrating from a payer of quantity to a payer of quality."

Director's Report

Peggy Duke, MD

ASA Director

Editor's note: Dr. Duke serves as GSA's representative to the ASA Board of Director's. In this responsibility she is exposed to the full range of national issues which, often, evolve and later impact anesthesiologists and patients in Georgia. Dr. Duke's impassioned plea represents that of most highly involved physicians who are aware of the trends which could adversely impact the specialty and, thus, change the way anesthesiologists practice. Below is an opening excerpt of her semi-annual report. Please read the entire article at www.gsahq.org.

If you have not yet read the online New York Times editorial, I suggest that you take a few minutes and do so.

http://www.nytimes.com/2010/09/07/opinion/07tue3.html?ref=editorials

The following is a direct quote: *There is not much difference between the two professions (CRNAs and anesthesiologists) in the amount of training they get in administering and monitoring anesthetics. Where the anesthesiologists have a big advantage is in their much longer and broader medical training that, many doctors say, may better equip them to handle complex cases and the rare emergencies that can develop from anesthesia.*

If that does not cause you to sit up and take notice, then perhaps you do not care about the future of our medical specialty.

Have no doubt about this: CRNA national organization leaders believe that nurse anesthetists are equivalent to anesthesiologists --they just cost less -- and that they should be allowed to practice independently in direct competition with anesthesiologists. The "cost less" message along with some of the studies they quote, flawed as they may be, sends a strong message in this era of healthcare reform as everyone is looking for ways to reduce medical costs.

The opt-out debate is a state-by-state issue and Georgia currently requires physician supervision for nurse anesthetists. Having all anesthesiologists in Georgia be active in the GSA and contribute to the GSA-PAC is crucial if we want to have a voice in the local issues that impact our specialty. The opt-out debate will likely rear its head once again in our state.

> **"Will you sit on the sideline as our specialty is assailed?"**

Will you sit on the sideline as our specialty is assailed by those who do not know why an anesthesiologist should be involved in every anesthetic? CRNAs should be supervised by an anesthesiologist in as many anesthetizing locations as possible. It is the responsibility of every Georgia anesthesiologist, those in training, those currently practicing and even those retired to give back to our specialty by being an active member of the GSA and making a substantial contribution to the GSA-PAC.

The NY Times editorial continues by saying that it costs six times as much to train an anesthesiologist and that anesthesiologists are twice as expensive as CRNAs. The writer of the editorial states that anesthesia has become so safe in recent decades, with roughly one death occurring in every 200,000 to 300,000 cases in which anesthetics are administered during surgery, child birth or other procedures that health care reformers seeking to contain medical spending should consider whether allowing nurse anesthetists to practice independently is a good way to restrain costs and reduce reliance on "high-priced medical specialists."

Nowhere in the article does it question how we have reached such a state of safety in providing anesthesia care. Nowhere is there a comment that describes the increasing acuity and age of patients. Nowhere in the article does it give credit to the fact that anesthesiologists have been involved in the anesthesia care of almost all patients for several decades and that this direct involvement by anesthesiologists is likely the reason anesthesia has become so much safer.

Nowhere in the article does it give credit to all the researchers and clinician anesthesiologists who have been the ones to introduce new drugs and new techniques thus contributing to the overall safety that is now taken as a given. Nowhere does it address the complexity of new minimally invasive surgical procedures which frequently require more complex and technically demanding anesthesia care.

Already, 16 states have exempted nurse anesthetists from the Medicare requirement that they be supervised by a physician. California and Colorado (rural only) recently opted out.

***For the complete report, go to* www.gsahq.org**

Ballot Box

Atlanta, October 3 – GSA members individually invested more than $11,000 in contributions to the re-election campaign of U.S. Senator Johnny Isakson, R-GA. The veteran lawmaker has demonstrated his support for physician-led healthcare since his election to the state House in 1976 and throughout his terms as a state senator, U.S. Representative and U.S. Senator. Dr. Bannister presented an ASA-PAC check at the event.

Among the GSA members attending (l-r) Dr. Don McLeod, Dr. Pat Maher, Dr. Kathryn Grice, Dr. Steve Sween, (Sen. Isakson), Dr. Carolyn Bannister, Dr. Patty Goggins and Dr. Stephen Grice.

YES on 2

Yes2SaveLives.com

GSA endorses the passage of proposed Constitutional Amendment #2 on the November 2, 2010 General Election statewide ballot. Passage of the question and implementation of a $10 automobile tag fee could raise as much as $80 million annually to improve trauma care and save lives.

This dedicated funding will help train 911 staff, EMS personnel, critical care nurses and physicians, improve patient transport, provide new equipment, and help transform more emergency rooms into trauma centers.

The fact that Georgia remains above the national average for trauma related deaths is not surprising—1 in 10 Georgians live too far from trauma centers to receive timely care. Help inform Georgia by informing your client base and other associates that a vote of "Yes" on ballot question #2 is a vote for saving lives!

For more information visit www.Yes2SaveLives.com or email info@Yes2SaveLives.com. For text message updates on this important initiative text Yes2 to 99702.

Maryland state Senator Andy Harris, MD, addresses GSA members and families during the July 2010 Summer Meeting at Lake Oconee. Harris, a candidate for the U.S. House of Representatives, would become the only anesthesiologist serving in Congress if he is elected. GSA members have invested in Harris' campaign with personal contributions.

GSA member Dr. Don McLeod is investing personal time helping raise contributions from anesthesiologists all over the country.

Zaidan ...continued from page 1

It is not news to anyone that after 33 years of being in charge of something in the department at Emory, I will be stepping down as Chair this year. After a decade as Chair and simultaneously as Associate Dean for GME, it is simply time. I plan to increase my time in the cardiac operating rooms and continue on as Associate Dean caring for Emory's 88 programs and 1100 residents. I am still active in FAER, and I will finish my appointment as a member of the Institutional Review Committee of the ACGME.

To all of you whom I have helped train for all these years, **I have the deepest respect for you**, the care you provide to your patients, the research ideas you explore and the new residents you teach. And to those who are worried, Dr. Tom Philpot, Mama Judy, Karen and Chanta will continue doing all of their truly outstanding work, counseling and mentoring. I have the right leaders in the right places in the department; so, in fact, I can quietly back out and the department will continue functioning as the orchestra that plays in tune.

Head ...continued from page 1

classroom. Our lectures can be broadcast to the iPhone and potentially to our community in the future. Further, our department recently purchased an upgraded SimMan, and we are creating our own medical scenarios for training which are tailored specifically to our hospital setting.

The next recruiting cycle is just around the corner and our program coordinator, Ms. Susan Dawkins, is getting ready for a new round of resident candidates. We have some of the best resident facilities to train residents. Each resident can study at his or her own cubicle with access to 11 computers and color laser printers in our electronic library. A librarian (as does the chairman) works to help faculty and residents prepare well-written abstracts, manuscripts and grant applications. Soon, iPhone application capabilities for education and improved communication will be available.

As the oldest academic department of anesthesiology in the South, we are proud of our accomplishments in education and proud of our past residents that are now practicing at some of the leading academic institutions and in private practice.

GSA 2011 Winter Forum

January 22, 2011

The Future of You

External forces on your ability to provide patient care

The Westin Atlanta Perimeter North (near Perimeter Mall)
Atlanta, Georgia

2011 Winter Forum to forecast practice of tomorrow

Tom West, MD & Ginger Zarse, MD; CME Activity Co-Directors


Dr. West


Dr. Zarse

The days of practicing medicine in isolation have passed. JCAHO, CMS and even professional societies share the premise that requirements, regulations and guidelines can improve patient outcomes. Managed care, Congress and CMS presume to lessen expenditures without affecting quality. Corporate employment, hospital stipends and clever staffing models have become a common reality in these unsettled times. The GSA 2011 Winter Forum will focus on external forces that impact your professional future and consequently how you provide care. This will not be a whine fest but rather an opportunity to learn what may be coming your way and hopefully to be even better prepared for change.

Maximize your future ability to provide clinical skills required by your patients.

Faculty:

Stanley W. Stead, MD, MBA
Stead Health Group
Encino, California


Dr. Stead

Richard Gilbert, CEO
Southeast Anesthesiology Consultants, Charlotte, NC
Quantum Clinical Navigation System

Richard E. Wild, MD, JD, MBA, FACEP
Chief Medical Officer
CMS Atlanta Regional Office


Dr. Dutton

Richard P. Dutton, MD, MBA
Executive Director
Anesthesia Quality Institute

Norman A. Cohen, M.D.
Medical Director for Professional Revenue Performance
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Oregon Health & Science University
Portland, OR 97239


Dr. Cohen

***Register at* www.gsahq.org**

Registration opens November 2010 at **www.gsahq.org**

What is the Future of You?

Panel: Non-Traditional Practice Models

David Gale, MD
Pain Centers and ASCs

Brian Thomas, MD
National Group Practice

Stan Plavin, MD
Company Model Fee-Splitting

Tim Wallace, MD
Multisite FTE Locum Tenens Coverage


Dr. Thomas

One day meeting offering 8 CME hours instruction

The Georgia Society of Anesthesiologists designates this educational activity for a maximum of eight (8) AMA PRA Category 1 Credit(s)TM.
The Georgia Society of Anesthesiologists is accredited by the Medical Association of Georgia to offer continuing medical education to physicians.


Dr. Gale

Fill your knowledge gaps!

- Non-traditional practice models adopted by your peers
- Measuring quality may improve security and income beyond P4P
- What CMS is thinking & planning for you
- Accountable Care Organizations - sharing risk for cost and complications
- Surviving health care reform

Don't be naïve to your future.

This conference is for Physicians | Resident Physicians | Billing Managers | Group Managing Partners | Physicians in Transition

Editor's Corner ...continued from page 2

impressive selection of locally and nationally renowned speakers. The meeting focused on diverse topics relevant to daily anesthesia practice, the reality of more complicated and sicker patients in all anesthetizing locations and increasing government regulation intruding into the practice of anesthesiology.

Make plans soon to attend the GSA 2011 annual Winter Meeting, "The Future of You: External forces on your ability to provide patient care", to be held January 22, 2011 at The Westin Atlanta Perimeter North in Atlanta, GA. Activity Co-Directors Dr. Tom West and Dr. Ginger Zarse have a great program planned. Find details inside this edition.

This edition of ***scope*** highlights the fine quality of the two anesthesiology training programs in Georgia. The Medical College of Georgia and Emory University continue to train great residents and fellows who enter the anesthesia workforce with a solid foundation in the practice of anesthesiology. Also evident within this edition is the tireless work of many GSA members who dedicate a great deal of their own valuable time to work on behalf of their fellow anesthesiologists as well as all physicians and patients in Georgia.

MCG ...continued from page 6

experiencing a myriad of learning during different subspecialty rotations and building on a solid CA-1 base.

Our residency program at MCG is being rejuvenated with excellent team members and great leadership from our program director, Dr. James Mayfield, and assistant program director, Dr. Mary Arthur. With their support, we are matching up with residents at a national level. Our program is incorporating the latest technologies as learning modes, including a new simulator.

A record number of residents are participating and presenting at the ASA annual meeting this year. For the first time our department is presenting a Scientific/Educational exhibit on our anesthesia clerkship program by Dr. Ranita Donald, Clerkship Director. Learning and discovery are translated into innovation by all in the department and, needless to say, there are several ongoing research projects within our department. **Our department faculty members are committed to excellence in clinical care** and education and hold deep academic values.

I always wonder how much has changed over the years from days of chloroform, ether, Schimmelbusch mask, Goldman's vaporizer and Boyle's minor and major anesthesia machine to the modern era of advanced anesthesia care. The future remains bright, promising and full of potential. We are proud of what our department has accomplished over the years and look forward to greater achievements in the future.

Emory ...continued from page 6

the residency program. Our incredible chairman, Dr. Zaidan, made the announcement that he will be stepping down from the chairmanship at the end of the coming academic year. While this will not cause a major immediate change in the department, it is interesting to observe the department as they lead a national search for a new chairman. Residents are strongly involved -- highlighting Emory's dedication to its residents. We are working on all levels of the search process, including meeting with the search committee, discussing our department with chairs of other departments and leading discussions with anesthesiology chairs from other schools.

Emory continues its trek to be a leader in anesthesia research. Residents are intimately entwined in research projects with many faculty members on a variety of levels, including the basic science and the more clinical.

We continue to have residents present at university, local, and national meetings, including the ASA national meeting and the New York Assembly.

As I sit here, only a few days before mock oral exams, I cannot help but realize how talented and impressive my fellow residents are. Emory not only attracts some of the best and brightest, but it continues its tradition of molding the future leaders of our field.

Navigating ...continued from page 3

made after the policy coverage terminates. If your prior carrier is unable or unwilling to provide you with a reporting endorsement, you will have to seek coverage for these "prior acts" through your new carrier.

However, new carriers will consider the financial stability of your prior carrier. If the prior carrier is considered financially unstable or insolvent, the new carrier will be less willing to extend coverage for any prior acts. Since this could impact your insurability and create coverage gaps, it is important to purchase coverage from financially stable companies. Remember, coverage, including extended reporting endorsements, is only as good as the long-term financial health of your carrier.

> **"Effective risk management is critical for all health care professionals... ...find creative answers and meet the most pressing challenges."**

As with the policy itself, review the language of any reporting endorsement offered. Understand your right to obtain an offer of tail coverage, how the premium (if any) will be determined, and the length of time you are given to report claims.

What triggers coverage?
Whether you have a claims-made or occurrence policy, understand what triggers coverage. Does the claims-made policy, for example, allow you to trigger coverage by reporting medical incidents you reasonably believe could result in a claim? If not, when can you trigger coverage? Do you have to wait for a formal demand for damages or lawsuit before the policy responds?

Is your premium guaranteed?
Typically, admitted professional liability carriers are "Advance Premium" companies. This means that the premiums paid by the policyholders are established at the beginning of the policy period and are guaranteed not to increase regardless of any adverse loss development experienced by the company for that policy year.

What about policy cancellation or modification?
What if there is a change to the policy terms or conditions? Will you receive advance, written notice? Will you have the opportunity to examine your options and secure alternative coverage if necessary?

Beyond the Policy – Risk Management Solutions
Does your professional liability carrier go beyond the policy to help you improve patient safety and reduce risk? Do you have access to the tools and resources necessary to support those efforts?

Effective risk management is critical for all health care professionals. It requires extensive knowledge of the myriad of issues affecting today's providers, and helps you find creative answers and meet the most pressing challenges.

Understanding the relationship with your professional liability carrier is critical. Invest the time to examine your policy's benefits, coverage and costs.

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SAVE THE DATE

July 22-24, 2011 | **King & Prince Beach & Golf Resort**
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GEORGIA SOCIETY OF ANESTHESIOLOGISTS Summer Meeting 2011





A ENRICHING FAMILY EXPERIENCE ALONG GEORGIA'S GOLDEN ISLES...

President's Letter

WAKE UP!

Rickard S. Hawkins, MD

The ASA's motto hit me suddenly last week while in a long cosmetic case. The motto is simply one word -- **VIGILANCE**. The ASA's seal represents the anesthesiologist "piloting" the patient through the unknown waters of the peri-operative period, and it is vigilance that allows us to provide the extremely safe care our patients deserve. Vigilance is the process of paying close and continuous attention, watching for possible danger. We should be vigilant in our patient care and care of our profession.

We have seen tremendous advances in communication technology over the last couple of decades. Many of us have integrated these advances into our daily practices. We use the internet for scheduling; we text our colleagues; we check emails, surf the web, and some probably play games during long cases. We have formularies, drug data bases, medical texts, etc on our smart phones for quick access in the OR.

The motto, VIGILANCE, hit me while I was checking my emails. We should never allow the tremendous safety that our specialty has achieved with technology and pharmaceuticals to cause us to dismiss the key attribute of an expert consultant in anesthesiology -- VIGILANCE. I believe that these technological aids can be an asset to our patient care; however, regardless of our knowledge and techniques and monitors, if we are not VIGILANT then we are failing our patients and, likewise, our profession and colleagues.

> "You are either engaged or you are a freeloader."

WAKE UP!

Vigilance for our patients and profession is not limited to the operating room. We need to be vigilant as to the forces and institutions that are constantly attacking our specialty. Consider the following current examples:

- As much as a 35% Medicare cut in Jan 2011,
- increasing government intrusion into how we practice (IPAB in the new healthcare law),
- two AANA-funded, misleading studies by economists recommending that the MCR supervision rule be eliminated in all states to decrease the cost of anesthesia services. They justify this by saying the care of an independent CRNA is equivalent to care involving an anesthesiologist.

These attacks threaten our jobs, but more importantly, they threaten our patients' safety. If we do not speak up for our patients' peri-operative safety and care, no one will. At the same time, just as we are unparalleled in our acceptance of new, safer drugs, monitors and techniques, we have to have open minds concerning new ideas on anesthesia delivery models and payment models.

Anesthesiologists should be the ones conceiving, testing and implementing new ideas, not government, hospital administration or corporate entities. We cannot live in the past. We must be innovative, open minded and flexible.

It is time for ALL of us to WAKE UP! It is time for vigilance in the OR and vigilance in the public policy arena. Stop accepting inappropriate distractions in the OR and stop standing on the sidelines. Help the ASA and the GSA educate the policy makers as to what anesthesiologists do.

The days of being able to just do your job and go home have long gone away. WE ALL have to at least give to the GSA and ASA PACs and ALL must get involved with public policy locally, in the state, and federally. You are either engaged or you are a freeloader.

WAKE UP and be VIGILANT!

> "Vigilance is the process of paying close and continuous attention watching for possible danger."

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Welcome to the Team!

New or upgrading members in 2010

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