Apathy and ignorance have no place in our profession. In Dr. Michael Gosney’s article in the July 2010 ASA Newsletter titled Ignorance and Apathy, he states: “Advocacy for our profession should be ingrained in all physicians. Advocating for one’s profession should be the foundation upon which all other actions are based.”

Please review the following tables comparing GSAPAC contributors for 2009 & 2010 as well as comparing GA to Alabama (for 2010 ASAPAC involvement).

I realize that the economy has been rough the last few years; however, PAC contributions are mandatory spending not discretionary. In addition, there is no offseason for advocacy and PAC work regardless of the political calendar. Most of the successful advocacy takes place every day of every year and not just during election cycles. All great victories are actually a series of small victories; therefore, we need everyone involved each year.

Many of you probably do not like politics or feel capable in this area; therefore, PAC contributions are an easy way to contribute to the vitality of your profession. Each and every one of us has a duty, an obligation, to be members of the GSA and ASA at a minimum. I find it hard to accept that there are active anesthesiologists in this state who are not even members of GSA and ASA.

We all also have a duty to contribute yearly to the GSA PAC and ASA PAC. They are like the mortgage of our profession. If we fail to keep them robust, we may one day find that our profession has been foreclosed. (As I stated in my last article, there is a rising chorus of poorly informed individuals - economists, politicians, etc- who want to replace anesthesiologists with CRNAs on the premise that it would lower healthcare costs).

Apathy and ignorance have no place in our profession.
Welcome to 2011

I hope you are well as another great New Year begins. I hope you plan to attend the GSA Winter Forum, “The Future of You”, Jan 22, 2011 at the Westin Atlanta Perimeter. Drs. Tom West and Ginger Zarse have assembled an impressive group of speakers who will present an eye-opening day of lectures. There will be a minimum of “whine” but much “food” for thought as we consider how the practice of medicine and anesthesiology will certainly change and evolve.

As the chill of winter settles over Georgia, mark your calendars now for the GSA Summer Meeting. Drs. Ken Stewart and David Pae are Co-Activity Directors of “Basics at the Beach” to be held July 22-24, 2011 at the newly updated King and Prince Beach & Golf Resort on St. Simons Island, GA. So don’t forget to set aside some time to join your colleagues and friends, plan a short family vacation, and attend the GSA 2011 Summer Meeting.

Resident research thrives at both of Georgia’s anesthesiology programs. Be sure to look inside this edition for a glimpse at what residents are doing at both Emory University and Medical College of Georgia. The future of anesthesiology certainly looks bright in the hands of these motivated young anesthesiologists.

Members are encouraged to submit their questions, opinions and comments for publication in the newsletter. Submit commentaries to kstack@emory.edu. All submissions will be included at the discretion of the editorial staff. Please visit the new updated GSA website. Many thanks to Jet Toney and Cornerstone Communications for their ongoing efforts to improve communication and provide timely updates and valuable information for members. Check the website at www.gshaq.org and stay up-to-date on the latest news and information, pay dues, make PAC contributions, and register for events.

2011 Nominating Committee Report

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Any physician who has been through it can tell you: being a defendant in a medical liability claim is an extremely stressful experience.

Increasingly, physicians and their families are aware of the psychological trauma caused by litigation. Physicians may feel angry, betrayed, depressed and isolated; they may grow fearful and begin to question their clinical abilities. Some of these reactions are visible, sometimes they’re kept “inside.” Whether expressed or hidden, such powerful emotions will likely create conflicts and tension for physicians, spouses and family members.

Back in the 1980s, Sara C. Charles, MD, a psychiatrist in Chicago, wrote of her experience with what she began to term “malpractice stress syndrome.” Her book, Defendant: A Psychiatrist on Trial for Medical Malpractice (1985), made national headlines and the phenomenon of “malpractice stress syndrome” became a catchphrase. Working with the Illinois Medical Society, she helped organize a Physician Support Group to help doctors deal with the psychological pressures arising from a medical liability suit. The Support Group concept involved a panel of volunteer physicians who had themselves experienced a suit and agreed to serve as informal and sympathetic telephone listeners for stressed physicians. The Medical Society publicized the Support Group and facilitated communication among telephone callers and listeners/counselors.

Dr. Charles continued to promote the idea of support for the lawsuit-stressed physician. In February 1987 she was a featured speaker at the Medical Association of Georgia’s Leadership Conference. Shortly thereafter MAG and its auxiliary for spouses organized a Support Group and publicized it among its members. The well-meaning initiative, headed by the late Earnest C. Atkins, MD proved to be short-lived.

But Dr. Charles has persevered in her work. She is the driving force behind the Physician Litigation Stress Resource Center, a website (www.physicianlitigationstress.org) which offers help for physicians experiencing emotional stress from lawsuits. MAG Mutual, through our website (www.magmutual.com), also offers a link to it. Physician insurance companies across the country similarly offer articles, videolinks and other resources to their policyholders.

Along the way what was called “malpractice stress syndrome” in the 1980s is now termed more broadly “litigation stress.” And the literature treating the phenomenon continues to develop. Adverse Events, Stress and Litigation is Dr. Charles’ recent book (2005). Another entry is How to Survive a Medical Malpractice Lawsuit (2010) by Ilene R. Brenner, MD, an emergency physician in Atlanta. Writers on the subject are not always physicians, as psychologists and other counselors weigh in. Example is John-Henry Pifferling, PhD, writing on such topics as “Mitigating Malpractice Misery.”

The unfortunate phenomenon of litigation stress will not be going away anytime soon. A recent study by the American Medical Association, surveying nearly 6,000 physicians during 2007-2008, finds that 61% of physicians age 55 and older were sued at least once.

Among all interviewees, 42.2% said that they had been sued at least one time in their careers. Anesthesiologists mirrored the national data almost exactly: 42.4% of anesthesiologists surveyed said they had been sued at least once.

Just as professional liability lawsuit has become a sad fact of life for physicians, so too is the emotional duress associated with the experience.
For the first time in GSA history we have the special honor of having the ASA jointly sponsor our summer event. This new pilot relationship with ASA’s education department will help us increase our focus on the educational needs and objectives of GSA members and, perhaps enhance our marketing to a broader audience.

Content for Basics at the Beach is based on your feedback in educational surveys and post-meeting evaluations over the last few years. The educational focus will update attendee knowledge on some of the basics of anesthesia as well as snapshot the future of anesthesia in the clinical setting.

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I KNOW that my peers can and will do better in 2011 and beyond.

You also are advocating when you spend the time with each patient to listen to their concerns, explain the anesthetic course and explain our unique role in their care.

If we are not advocating for our patients and our profession, then who will? It takes us all. Each of us has unique skills and resources that we can bring to our professional organizations which create a whole that is immensely stronger than the sum of the parts.

I would like to leave you to think about one of Aesop’s Fables: The Four Oxen and the Lion

A Lion used to prowl about a field in which Four Oxen used to dwell. Many a time he tried to attack them; but whenever he came near they turned their tails to one another, so that whichever way he approached them he was met by the horns of one of them. At last, however, they began quarreling among themselves, and each went off to pasture alone in a separate corner of the field. Then the Lion attacked them one by one and soon made an end of all four.

United we stand, divided we fall.
The private practice of anesthesiology is ever more challenging. Collectively, the trends in reimbursement, operating costs and demographics reduce compensation and increase the complexity of care.

These trends are not unique to anesthesiology. They have impacted many physicians, but the effects on specialty physicians and ambulatory facilities have resulted in new business propositions and new types of anesthesiology contractual arrangements. Some of these arrangements can raise legal concerns having serious consequences to both contractual parties.

The business side of a private medical practice is unique from other industries. The American Medical Association says, “In most industries, businesses are able to set the price of their services and goods based on costs incurred and a reasonable profit margin. For physicians, however, reimbursement is based on a complex array of factors, most of which are largely outside of their control.” Operating costs consume a greater part of revenue, profit margins suffer and, for some, the result is business failure.

The MGMA 2007-2010 survey identified 45 items of “considerable or extreme practice management challenges.” The number one concern is “dealing with rising operating costs.” The AMA reports a 20% increase in the gap between Medicare payment updates and practice costs over the nine year period from 2001 to 2010. Over the last 10 years, the changing demographics of the uninsured, Medicare and Medicaid recipients in Georgia have further challenged the physician’s practice. In 2007, these groups of people represented 40% of Georgia’s health insurance mix. In addition to lower reimbursement for this population, the time and complexity of their care is greater due to more co-existing obesity, diabetes, tobacco use and cardiovascular disease.

These overall trends between 1995 and 2005 have caused income to decline, in real terms, for the average primary care physician and specialist by 10% and 2%, respectively.

This causes physician specialists to seek practice in free-standing single and multispecialty ambulatory facilities. This arrangement affords more control over insurance mix, overhead costs and efficiencies. An efficient and well-managed ambulatory facility is an attractive place for anesthesiologists to provide services. A facility and/or an anesthesiologist might choose to leverage their position through “non-traditional” contractual arrangements.

These arrangements can be broken down into three categories:

1. “traditional model” where the anesthesiologist contracts with a center to provide service and fully bills and retains the professional fee,

2. “hybrid model” where the anesthesiologist contracts with a center to provide service and fully bills and retains the professional fee, but has an additional arrangement to recognize the anesthesiologist’s utilization of facility resources (through for example, leased space, rented equipment) or a required contribution by the anesthesiologist to facility resources (for example, contribution of drugs, equipment, or additional personnel),

3. “company model” where the anesthesiologist contracts with a center to provide service and receives an hourly/daily compensation. The anesthesiology billing is provided by the center or its subsidiary. Arrangements under a “hybrid” or “company model” can risk running afoul of existing healthcare law.

The two areas of the law often cited when concerns under such arrangements are reported, include the Anti-Kickback statute and the False Claims Act. Both of these statutes carry severe consequences. The Anti-Kickback statute for violations is punishable criminally by up to five years imprisonment, a fine of $25,000, or both, and exclusion from participation in Medicare and Medicaid programs. A violator of the False Claims Act is liable for three times the government’s damages plus civil penalties of $5,500 to $11,000 per false claim.

Concerns regarding the legal risk exposure under the “company model” have been expressed by the ASA. On two occasions, both in a letter dated March 19, 2009 and again on June 16, 2010, a communication was sent to the Office of Inspector General (OIG) requesting the OIG to issue a Special Advisory Bulletin on the “company model”. To date, no Advisory Bulletin on this issue has been published.

All physicians are challenged by our current healthcare environment. Many of us will have to consider new business propositions. These new service arrangements are best evaluated through a risk management process. We manage the risk of poor patient outcomes through insurance, education and legal advice. We manage billing risk through our compliance programs. For the benefit of ourselves and our colleagues, we need to manage these new types of service arrangements through either avoidance or education and legal counsel.

We need to manage these new types of service arrangements... (which) can raise legal concerns having serious consequences.

...punishable criminally by up to five years imprisonment...
...civil penalties of $5,500 to $11,000

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1 “The Physician Practice Environment in Georgia 2010” Medical Association of Georgia 2010, p.17
2 Id.
3 “The Physician Practice Environment in Georgia 2010” Medical Association of Georgia 2010, p.16
Clinical research forms an integral part of anesthesiology residency training at the Medical College of Georgia. In the past year, residents presented 19 abstracts, case reports and medically challenging cases to such societies as the American Society of Anesthesiologists (ASA), the American Society of Regional Anesthesia and Pain Medicine (ASRA), the Society for Ambulatory Anesthesia (SAMBA) and the Society for Pediatric Anesthesia (SPA).

Residents were involved in four presentations at the recent 2010 ASA Meeting in San Diego. Dr. Thomas Gallen (CA-3) worked with Drs. Mary Arthur and Manuel Castresana to compare outcome differences between two different anesthetic regimens in patients undergoing hybrid convergent procedures for atrial fibrillation and atrial flutter. In this minimally invasive procedure, a cardiothoracic surgeon and a cardiac electrophysiologist work together to simultaneously ablate the epicardial and the endocardial surface of the beating heart, respectively. The study revealed that the group receiving ketamine with propofol had less hemodynamic instability and a 100% conversion rate to sinus rhythm after 3 months compared to the group receiving propofol alone.

The anesthetic management of patients for elective Direct Current Cardioversion (DCCV) presents the challenge of providing short-term deep sedation with rapid emergence. Drs. J. Lee Rawlings and Jerry Spivey (both CA-3) and Dr. Castresana found that the combination of low-dose propofol and low-dose ketamine was an efficient and pleasant anesthetic technique for DCCV without the unwanted side effects commonly seen with these two agents when used independently at higher doses.

Dr. Harsha Setty (CA-3), who is one of the pioneers of video rigid flexible laryngoscopy (RIFL), demonstrated its success rate well above the other video laryngoscopes in patients with a known history of difficult intubation. This novel stylet-based laryngoscope combines the advantages of fiberoptic bronchoscopy and video laryngoscopy into one instrument. Dr. Setty is also currently studying the efficacy of a new device, the FlexBlade, which is designed to eliminate the use of a third hand and increase precision by directing the endotracheal tube where the sensor is facing.

Dr. David Webb (CA-2) and Dr. Arthur retrospectively studied the use of transesophageal echocardiography (TEE) and pulmonary artery catheterization (PAC) to guide inotropic therapy in cardiac surgery. They concluded that PAC still had a limited role to play and served as a good adjunct to TEE in clinical decision making in patients undergoing cardiac surgery.

Among the five medically challenging cases presented at the 2010 ASA, Dr. Nikova Mason (CA-2) working with Dr. Ranita Donald presented a cesarean section in a patient with pulmonary stenosis, pulmonary hypertension and tetralogy of Fallot repair. Drs. Ram Janardhanam (CA-3) and William Hammonds presented a patient with an epidural catheter receiving thrombolytic therapy. Dr. Brandon Grinage (CA-2) with Dr. Robert O’Bannon presented a report on an ex-utero intrapartum treatment procedure for a neonate with NAGER Syndrome. Dr. Brandon Grinage (CA-2) with Dr. Robert O’Bannon presented a report on an ex-utero intrapartum treatment procedure for a neonate with NAGER Syndrome. Drs. Ram Janardhanam (CA-3) and William Hammonds presented a patient with an epidural catheter receiving thrombolytic therapy. Dr. Brandon Grinage (CA-2) with Dr. Robert O’Bannon presented a report on an ex-utero intrapartum treatment procedure for a neonate with NAGER Syndrome. Dr. Brandon Grinage (CA-2) with Dr. Robert O’Bannon presented a report on an ex-utero intrapartum treatment procedure for a neonate with NAGER Syndrome. Drs. Ram Janardhanam (CA-3) and William Hammonds presented a patient with an epidural catheter receiving thrombolytic therapy. Dr. Brandon Grinage (CA-2) with Dr. Robert O’Bannon presented a report on an ex-utero intrapartum treatment procedure for a neonate with NAGER Syndrome. Dr. Brandon Grinage (CA-2) with Dr. Robert O’Bannon presented a report on an ex-utero intrapartum treatment procedure for a neonate with NAGER Syndrome. Drs. Ram Janardhanam (CA-3) and William Hammonds presented a patient with an epidural catheter receiving thrombolytic therapy. Dr. Brandon Grinage (CA-2) with Dr. Robert O’Bannon presented a report on an ex-utero intrapartum treatment procedure for a neonate with NAGER Syndrome. Dr. Brandon Grinage (CA-2) with Dr. Robert O’Bannon presented a report on an ex-utero intrapartum treatment procedure for a neonate with NAGER Syndrome. Drs. Ram Janardhanam (CA-3) and William Hammonds presented a patient with an epidural catheter receiving thrombolytic therapy. Dr. Brandon Grinage (CA-2) with Dr. Robert O’Bannon presented a report on an ex-utero intrapartum treatment procedure for a neonate with NAGER Syndrome.

You can be sure to expect more exciting work from our institution as we grow and change from the Medical College of Georgia to the Georgia Health Sciences University in 2011.
The practice of anesthesiology is an ever-evolving field. Over the past few decades, our everyday practice has changed because clinical research made us aware of outcomes or correlations which affected the standard of patient care. Emory University residents continue to embrace the importance of research and how it will change our profession. Emory’s residents are seeking answers to clinical questions in their prospective research projects and in their retrospective analyses and review articles.

Christopher Voscopoulos, MD (CA-3) has been involved in several research endeavors this year. He recently completed a review article with Mark Lema, MD, Ph.D entitled, “When Does Acute Pain Become Chronic.” This article focuses on perioperative acute pain and the continuum of pain and will be published in the British Journal of Anesthesia in 2011. Christopher will also have an article in Anesthesiology News next summer entitled, “The Glide scope assisted fiberoptic intubation: Drawing attention to a possible life saving technique.” In addition, he is writing a chapter on the distribution of local anesthetics and regional techniques to improve vascular surgery outcomes for the textbook, Atlas of Pain Management Procedures. Largely due to his research and his ambitions towards a future in academic medicine, Christopher has been awarded the Arnold P. Gold Foundation in Humanism and Excellence in Teaching Award for 2010.

Meg Van De Water, MD (CA-3) is completing a six month research elective in the area of perioperative anaphylaxis. She is working with Jerrold H Levy, MD, Professor and Deputy Chair for Research at Emory University School of Medicine, to evaluate the association between neuromuscular blocking drugs (NMBDs) and anaphylaxis by researching adverse reactions to NMBDs reported to the FDA over the past 10 years, particularly with Rocuronium. Often allergic and anaphylactic reactions have led to the withdrawal or disapproval of agents from the market and because NMBDs are acknowledged as being a leading cause of anaphylaxis, finding a correlation, or lack thereof, may have important implications in our practice. Meg will be submitting her findings to the International Anesthesia Research Society (IARS) at the 2011 annual meeting.

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The days of practicing medicine in isolation have passed. JCAHO, CMS and even professional medical societies have embraced the premise that requirements, regulations and guidelines can improve patient outcomes. Managed care companies, Congress and CMS presume to reduce expenditures without negatively impacting quality.

What is an anesthesiologist or practice group to do in the face of rising demands for reporting and measuring outcomes while physician compensation falls below business-cost levels?

The 2011 GSA Winter Forum focuses on external forces that impact anesthesiologists’ professional future and, consequently, how anesthesiologists provide patient care in a rapidly evolving practice environment. This continuing education seminar is an opportunity to learn what may be in your future and to equip you to prepare for new practice models while improving patient care and outcomes.

2011 Winter Forum to forecast practice of tomorrow

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

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

Faculty:

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

**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

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

Register @ [www.gsahq.org](http://www.gsahq.org)
Georgia Society of Anesthesiologists, Inc. Newsletter

Panel: Non-Traditional Practice Models

• 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

Fill your knowledge gaps!

This conference is for...

Physicians
Resident Physicians
Billing Managers
Group Managing Partners
Anesthesiologists Assistants
Physicians in Transition

Don’t be naïve to your future.

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)™. The Georgia Society of Anesthesiologists is accredited by the Medical Association of Georgia to offer continuing medical education to physicians.

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

Register @ www.gsahq.org
The GSA leadership ladder requires the person serving as vice-president to also chair the Bylaws Committee and update the governing document as necessary to reflect the reality of our changing world and to promote member participation. With more digital technology available to headquarters staff and members, processes for new application warrant changes in procedure outlined in the Bylaws. Also, the Executive Committee seeks to open more leadership positions to a diversity of members seeking enhanced participation in the Society.

The vote on these proposals will be held at the January 22, 2011 General Business Meeting in conjunction with the Winter Forum CME conference entitled “The Future of You.”

Note: Changes in blue type. Strikethroughs denote language to be deleted.

Proposed Amendment #1
Purpose: to reflect the new member application process which is now digitally coordinated with ASA and is offered on-line.

4.05 Application for Membership: Application for membership in any class of membership, other than honorary membership, shall be made in such manner and form as the Committee on Membership or the Board of Directors may from time to time designate. Application for membership with the Georgia Society of Anesthesiologists can be initiated through one of two mechanisms. The applicant may complete the GSA online application or the GSA will accept a completed ASA application from the American Society of Anesthesiologists. A nonrefundable application fee equal to the annual assessment for the class shall accompany all such applications, provided, however, that if application for membership is being made for the first time, the application fee shall equal the annual fee prorated to the remaining months of the membership year. Such application fee shall, upon approval of the application, be used to satisfy the applicant’s annual assessment requirement for the year of application. By making application for membership in the corporation, each applicant agrees to abide by and be bound by the Articles of Incorporation and Bylaws of the Georgia Society of Anesthesiologists.

Proposed Amendment #2
Purpose: to define term limits for members holding the office of Secretary-Treasurer.

Officers
8.02 Number and Election:
 c) Secretary/Treasurer:
The Secretary/Treasurer shall be elected once every two years at an annual meeting of the members and shall serve as Secretary/Treasurer for a term of two (2) years, beginning from the date of his/her election as Secretary/Treasurer, or until his/her successor is elected, whichever is applicable, or until his/her earlier resignation, death, removal or the termination of the office of Secretary/Treasurer.

Proposed Amendment #3
Purpose: to more clearly identify offices which may be held simultaneously and to solve attendance conflicts which occur when the ASA House of Delegates and the MAG House of Delegates meet simultaneously.

8.03 Officers Holding More than One Office:
No person may simultaneously hold more than one office except the Director and/or Alternate Director, Delegate to the ASA and/or Alternate Delegate to the ASA, Delegate to MAG and/or Alternate Delegate to MAG. However, No person may simultaneously hold an ASA Delegate/ Alternate Delegate and MAG Delegate/ Alternate Delegate position.

Proposed Amendment #4
Purpose: to add nomination of MAG Delegate and MAG Alternate Delegate to the Nominating Committee recommendations and to delete the term “District” in references to ASA Director and Alternate Director (“District” is no longer used by ASA).

9.03 Standing Committees:
f) Nominating Committee: At least sixty (60) days before the annual meeting of the members, the President shall appoint a Nominating Committee, consisting of a Chairman and three (3) other members, all of whom shall be active members in good standing, representing various geographical locations. Within twenty (20) days thereafter, the Nominating Committee, in a written report, shall nominate the following:

1) One (1) candidate for each position of Vice-President, President-Elect, ASA Alternate Delegate and MAG Alternate Delegate, as authorized and provided in Sections 5.10 and 8.02 of these Bylaws; and

2) One (1) candidate for such positions as are vacant for the offices of Secretary/Treasurer, ASA and MAG Delegate(s), ASA and MAG Alternate Delegate(s), District Director and Alternate District Director.

Proposed Amendment #5
Purpose: to clarify the endorsement requirements for AA student, resident, and medical student membership applications.

a) Application:
All persons applying for membership, other than for membership as a retired member, shall submit their applications to the Committee on Membership.

Resident Member Application:
An application for membership as a resident member shall be endorsed by either the Chair of Anesthesiology or the director of the residency program who is directly connected with the applicant’s training.

Medical Student Member Application:
An application for membership as a resident member shall be endorsed by either the Chair of Anesthesiology or the director of the residency training program or a member of the faculty of the college attended by the student.

Practicing AA Educational Member Application:
An application for membership as an educational member shall be endorsed by one (1) active GSA member who is a current primary and/or secondary sponsoring physician as specified by the Anesthesiologist Assistant’s application for licensure with the Georgia Composite State Board of Medical Examiners.

Student AA Educational Member Application:
An application for an AA student educational student membership shall be endorsed by the education program medical Director of the CAHEP accredited program in which the student is enrolled. The educational program must be located in the State of Georgia.

For the complete Bylaws, login @ www.gsahq.org and click Resources
ASA approves guidelines, advisories

At the ASA House of Delegates (HOD) meeting October 20, 2010, the following performance and outcome measures were deliberated and approved:

1. Multimodal Postoperative Nausea and Vomiting (PONV)
   This will be submitted to the National Quality Forum (NQF) for endorsement and to the Centers for Medicare and Medicaid Services (CMS) for adoption as part of Physician Quality and Reporting Initiative (PQRI).

2. Intraoperative Normothermia
   This is a revision of the current measure on intraoperative normothermia and will be submitted to the AMA Physician Consortium for Performance Improvement (PCPI) and NQF for endorsement. (These can be found on the ASA website, www.asahq.org)

The ASA Committee on Standards and Practice Parameters continues to evaluate areas that lend themselves to development of Practice Standards, Guidelines, and Advisories. The CPOM reviews and updates current Standards, Guidelines and Advisories as appropriate. All newly developed and updated guidelines must then go to the annual HOD meeting for an up or down vote.

At the 2010 annual meeting the HOD voted to disapprove Practice Guidelines for Central Venous Access. This practice guideline would have required use of static view ultrasound imaging (U/S), if available, before internal jugular central line placement. The Reference Committee on Professional Affairs heard long and conflicting testimony regarding the proposed guideline and suggested obtaining input from a broader range of the ASA general membership. It was hoped that there could be consideration of language that allows more flexibility in response to individual practice circumstances and education of the membership regarding the advantages of ultrasound guidance in central venous cannulation.

Prepare to begin using U/S in the near future because this will likely be required by regulatory bodies and many hospitals and will be coming back before the ASA HOD.

The HOD voted to approve the following:


b. ASA Practice Advisory for the Prevention of Perioperative Peripheral Neuropathies

c. ASA Practice Advisory for the Perioperative Management of Patients with Cardiac Implantable Electronic Devices: Pacemakers and Implantable Cardioverter-Defibrillators

The complete documents can be found on the ASA website: www.asahq.org

Perioperative management of patients with Cardiac Implantable Electronic Devices.

Perioperative management of pacemakers and ICDs has become more complex as the technology has advanced. Biventricular synchronous pacemakers used for patients with refractory heart failure adds to the complexity of managing patients with these devices in the perioperative period.

In addition to the recently HOD-approved ASA Practice Advisory on Perioperative Management of CIEDs, the Heart Rhythm Society (HRS)/American Society of Anesthesiologists (ASA) Expert Consensus on the Perioperative Management of Patients with Implantable Defibrillators, Pacemakers and Arrhythmia Monitors: Facilities and Patient Management was approved by the HRS in July 2010 and endorsed by the ASA in November 2010. This document was a joint project with the American Society of Thoracic Surgeons (STS), the American College of Cardiology (ACC), the American Society of Anesthesiologists (ASA) and the Heart Rhythm Society (HRS), and was done in collaboration with the American College of Cardiology (ACC), the Society of Thoracic Surgeons (STS), and the American Heart Association (AHA).

ASA members with expertise in managing patients with pacemakers and/or ICDs reviewed both documents, making recommendations for changes in the HRS/ASA document. The HRS/ASA Committee made revisions resulting in two strong documents with no major substantive differences.

I strongly recommend reading both documents. Both documents recommend more stringent requirements for perioperative management of patients with Cardiac Implantable Electronic Devices.

Editor’s note: Dr. Duke serves as GSA’s representative to the ASA Board of Directors. In this responsibility she is exposed to the full range of national issues which impact the specialty.

Currently anesthesiologists have only three measures that can be used to send to CMS for PQRI. Most anesthesiologists actually have only two, since central lines are used in only a small percentage of all anesthetics. Having meaningful additional performance and outcomes measures developed and vetted by anesthesiologists for anesthesiologists is important. Standardized measures allow one practice to benchmark with other practices to demonstrate a specified level of quality. In addition, CMS and other regulatory bodies will require practices and individual anesthesiologists to have measures by which they can be compared to others. Whether one wants to do this or not, it will be necessary. Thus, having pertinent, meaningful measures is important.

Via ASA’s Committee on Performance and Outcomes (CPOM), ASA affiliations with AMA PQRS, NQF have actively participated in involving anesthesiologists in the process of developing measures that can be used by our specialty. In the future, the Anesthesia Quality Institute (AQI) will have significant impact on data collection, analysis and reporting back to practices to allow for more outcomes measure development to begin addressing quality improvement in areas not yet defined.

Documents online @ www.asahq.org

Prepare to begin using U/S in the near future because this will likely be required
Georgia’s CRNA professionals have generally agreed that such expansions will not enhance the ability of CRNAs to provide care given current practice models. In fact, each year in recent history that such APN proposals have come forth, the GANA has exempted CRNAs from the legislation. GSA will, however, work with the Medical Association of Georgia and the other medical specialty societies to defeat any legislative changes which compromise the delivery of quality health care or imperial patient safety.

- Tort Reform – Recent court decisions have tossed key elements (e.g. caps on non-economic damages) of 2005. GSA will work with other medical societies and the medical liability insurance providers to shore up existing reforms.

- State Health Insurance Reform – Last year, MAG and its allies (GSA included) were close to passing powerful new tools to require health insurers and third-party administrators to simply do what they are supposed to do: pay legitimate claims at contracted rates. GSA will again align with others to 1) require the disclosure of “rental networks” which are often inappropriately used by health insurance plans and 2) expand Georgia’s prompt pay statute to third party administrators.

- Office-Based Surgery Regulations – GSA continues to work with the State Composite Medical Board to write guidelines or regulations to protect patient safety when surgical procedures are done in physician offices and outside of ambulatory surgical centers or hospitals (which are regulated). More than 27 states have law, rule or guidelines to protect patient safety in the office setting.

- Medicaid Payment to Physicians – With a $2 Billion state budget deficit looming in FY 2012, the new governor and legislative budget writers will consider further reducing “big ticket” items such as Medicaid payments to all providers, including physicians. The medical community may have a knowledgeable, seasoned new advocate at DCH. MAG Executive Director David Cook has been appointed by Governor Nathan Deal to head the massive department. Mr. Cook was Chief of Staff for Deal when he was state Senate President Pro Tempore and, through MAG work, certainly knows how shrinking payments to physicians could imperil the quantity and quality of patient care.

For more information on GSA’s legislative agenda, contact Government Affairs Chair Mark Huffman, MD, mmhuffman@comcast.net, or GSA lead lobbyist Jet Toney, jet.toney@politics.org.
2011 GSA-PAC

2010 was an extraordinary year in state and national politics. Across the nation, voters told incumbents that citizens are paying attention and they don’t like the direction the country is headed. Here at home, Georgians elected a new governor, more than three dozen new members of the legislature, and a new insurance commissioner among other statewide offices.

The impact of the change is already being felt on a practical level for physicians as Governor-elect Nathan Deal has appointed former Medical Association of Georgia Executive Director David Cook, Esq. to head the Georgia Department of Community Health where Medicaid decisions are made.

GSA-PAC was heavily involved in statewide races and mightily involved in legislative races across the breadth of the 236-member General Assembly. Your PAC invested more than $70,000 in contributions to these candidates; 90 percent of GSA-backed candidates will take the oath of office on January 10.

But time marches on and so does politics. GSA-PAC must now re-load its treasury for 2011 and beyond. Congratulations and thanks to the following GSA members who are already on board with GSA-PAC for 2011 (received through December 28).

Emory...

Matthew Whalin MD, PhD (CA-2) continues to work on a quality improvement project focused on management of ventilation during codes at Grady Memorial Hospital. Matt seeks to determine methods to reduce the incidence of aspiration and improve ventilation during code situations in hospital settings.

Whether it is through a research elective during the CA-3 year or simply a desire to better understand aspects of clinical practice, the residents at Emory continue to show initiative in the area of research. Their efforts will undoubtedly contribute to the future of anesthesiology.
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*MAG Mutual Insurance Company Board of Directors. Dividend effective June 1, 2009. Dividend payments are declared at the discretion of the MAG Mutual Insurance Company Board of Directors.
Editor’s Note: Dr. Timothy N. Beeson begins his presidential term on January 22, 2011. He practices at Trinity Hospital in Augusta and is a founding principal in BDT Anesthesia Associates, LLC.

If you are reading this newsletter you are probably in the “Choir”. I am writing to praise you not to preach to you.

You, the members of the GSA, are the financiers of our society. You receive monetary requests from local, city, county, state and national organizations and you have personal and professional expenses, and yet you choose to support the GSA. The GSA mission relies on your participation to function and to be one of the premier state Anesthesia societies.

Together the ASA and GSA are essential parts in developing and maintaining our positions in medicine. These two organizations need each other to work on state and federal issues. The GSA and ASA help in organizing, coordinating and implementing the policies that will shape our future. Thank you for your support.

Some individuals in the “Choir” have also chosen to support the GSA and ASA PACs. These committees were extremely successful this year. Individual and GSA contributions to Nathan Deal, Johnny Isakson and others contributed to having more allies in government. The fund raiser the GSA held for Maryland’s U.S. Rep.-elect Andy Harris helped us land the first anesthesiologist in the U.S. House. According to the Capitol Hill newspaper POLITICO, the ASA PAC is the leading PAC in healthcare. The ASA PAC winning percentage was 62.5.

Access to state and federal lawmakers is our best hope with our ongoing battles to protect our profession and our patients. Residents, AAs, academic Anesthesiologists and private practice Anesthesiologists who contribute to these PACS are to be appreciated.

You are a member of the “Choir,” but are you all in? Do you know others that should join us? All anesthesiologists are in this battle and must work together to ensure our future. Financial times are difficult and our future is very uncertain, but if we work together we can make a difference. Most of us know someone who could join us. We all need to encourage their participation for our future.

I am incoming President for the GSA and I thank you for the opportunity to serve. Please help me bring more people into our “Choir.”
Save The Dates!

Summer Meeting

BASICS at the BEACH

New Date!!! July 22-24, 2011

King & Prince Beach & Golf Resort
St. Simons Island, GA

Winter Forum

THE FUTURE OF YOU

January 22, 2011

The Westin Atlanta Perimeter North
Atlanta GA