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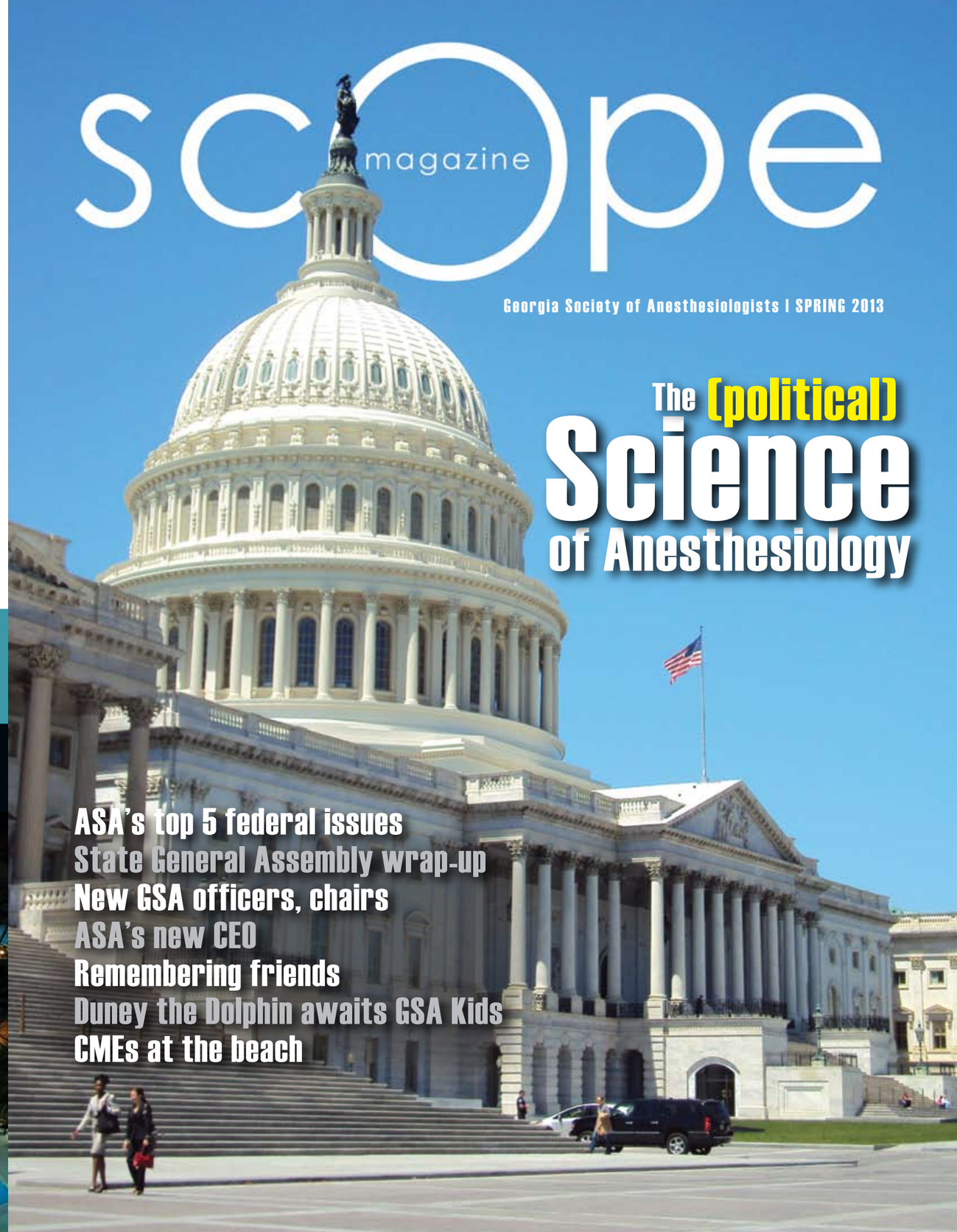

scOpe

scOpe is the quarterly magazine of the Georgia Society of Anesthesiologists, Inc. The print version is mailed to 900-plus members, exhibitors and advertisers. The digital version is posted in the members section at www.gsahq.org. scOpe is intended to inform members of contemporary issues and opportunities in anesthesiology, pain management, peri-operative care and patient safety. Opinions expressed in this publication do not necessarily reflect the official position of the Society or its leadership. Direct correspondence to:

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Editor's Corner

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

New format
New chairs
New guarantee

By now you have noticed a new format for *scOpe*, the quarterly magazine and primary communication medium of our Society. If your email software is not blocking email from GSA headquarters, you have by now also noticed a new format for notifying members of breaking news and information – GSA *E-news*. The magazine format of *scOpe* is intended to provide members detail on key issues. The blurbs of *E-news* are a quick read focused on evolving issues and milestones. *E-news* will be delivered via email every two weeks unless urgent notification is warranted. The information will also be posted behind the *E-News* icon at www.gsahq.org.

If we send it, you will benefit.

As a member-purposed professional organization, GSA does not inundate members through excessive emails, tweets, letters, listserves, posts or robo calls. So when the Society does communicate with you, be confident the content is worthy of your time. This is our content worthy guarantee – if we send it, you will benefit.


Dr. Zarse

Other new Society approaches include a changing of the guard in key committee posts with a grateful nod to those who have toiled previously. President Jay Johansen, MD, is focused on diversifying the talent and leadership pools through the committee structure. Consequently, it is my privilege to welcome Drs. Zarse and Dozier as new committee chairs. Dr. Ginger Zarse assumes the post as Editor-in-Chief of *scOpe* and Communications Committee Chair and Dr. Heather Dozier is the newest Chair of the Program and Education Committee. Dr. Zarse brings great energy and enthusiasm to the editor's responsibility and will continue to expand and improve GSA communication. Dr. Dozier is a seasoned program director of GSA annual meetings and has played an integral role in GSA's transition to CME accreditation by the ASA. She will be a tremendous asset in the growth of our education programs. I have begun my transition into the role of president-elect working with President Johansen.


Dr. Dozier

A special recognition goes to Dr. Carolyn Bannister who has served as Senior Editor of the newsletter and Program and Education Committee Chair for so many years. Her dedication to the details and vision necessary for success in these mission-critical areas has raised the GSA brand in Georgia and across the breadth of state component societies.

Headquarters staff Jet Toney and Kristin Strickland (Cornerstone Communications Group) have been invaluable in developing, updating and improving GSA's communication over the years, and Kristin has added tremendous talent and fresh ideas since her arrival.

Not getting GSA e-News or GSA email?
Contact Kristin at kristin.strickland@politics.org or call 404-249-9178.

GSA Elects 2013 Officers

by Kristin Strickland
Associate Editor, *scOpe*

Jay Johansen, MD, PhD, and Kathryn Stack, MD, have been elected president and president-elect, respectively, of the GSA. The action was completed at the Society's semi-annual business meeting at the January 19 Winter Forum in Buckhead (Atlanta). Steven Walsh, MD, was recognized for his service as president during 2012.

"Dr. Steve Walsh led the Society to public affairs action on several key policy initiatives, including new laws and regulatory policy to clamp down on pill mills and to preserve physician-led health care," Dr. Johansen said. "His work as Treasurer of the Medical Association of Georgia demonstrates that Anesthesiologists can and should lead organized medicine."

Amanda Brown, MD, from the Medical Center of Central Georgia, was elected Vice-President and will also serve as a MAG Alternate Delegate. Matthew Klopman, MD, from Emory University, will serve as Secretary-Treasurer and as a GSA MAG Delegate. Gerry Moody, MD, of North Fulton Anesthesia Associates is the other MAG Delegate.

Dr. Steve Walsh, MD
North Fulton Anesthesiology

Peggy Duke, MD, was re-elected ASA Director, with Howard Odom, MD, as ASA Alternate Director. ASA Delegates are Mary Arthur, MD; Timothy Beeson, MD; Rickard Hawkins, MD; Jay Johansen, MD, PhD; William "Bob" Lane, MD; Howard Odom, MD; and John Stephenson, MD. ASA Alternate Delegates are Edwin Johnston, MD; Kathryn Stack, MD; and Steve Tosone, MD.

GSA leader profiles

Dr. Johansen is a graduate of the University of Colorado Health Sciences Center and completed his residency at the University of California. He also serves as an ASA Delegate and formerly served two terms as GSA Secretary-Treasurer. Dr. Johansen and his wife, Marie, live in Alpharetta.

President Jay Johansen, MD, PhD
Associate Professor of Anesthesiology ,Emory University

Dr. Stack completed her residency and OB anesthesia fellowship at Emory University, before entering private practice for four years in Tennessee and Massachusetts. In 2001, Dr. Stack moved back to Georgia and began practice at Emory. She has served as editor of GSA's quarterly newsletter, *scOpe*, and chairs the Communication Committee. She resides in Sandy Springs with her husband and three children.

President-Elect Kathryn Stack, MD
Assistant Professor of Anesthesiology, Emory University

Dr. Brown completed her residency at John Hopkins Hospital, where she served as Chief Resident. She then completed a Pediatric Anesthesiology Fellowship at Children's Hospital of Philadelphia. Upon completion of her fellowship, Dr. Brown stayed at Children's Hospital of Philadelphia as an Assistant Professor of Clinical Anesthesiology & Critical Care Medicine. In 2008, Dr. Brown moved to Georgia and began practice at NEXus Medical Group, LLC. She resides in Macon with her husband and two daughters.

Vice-President Amanda Brown, MD
Anesthesiologist, NEXus Medical Group, LLC

An Atlanta native, Dr. Klopman completed his undergraduate degree, medical degree, residency, and fellowship at Emory. He currently practices Cardiothoracic Anesthesiology at Emory University Hospital and Emory University Hospital Midtown. Dr. Klopman has also served as GSA's Resident Liaison to the Governmental Affairs Committee, MAG alternate delegate and Activity Co-Director for the 2012 Summer Meeting. He and his wife, Andrea, have two young daughters and live in Sandy Springs. Andrea is a pediatrician with Roswell Pediatric Center.

Secretary-Treasurer Matthew Klopman, MD
Assistant Professor of Anesthesiology, Emory University

President's Letter

Physicians must retake ground

Jay Johansen, MD, PhD

Simple questions often lead to a new understanding of systemic problems. Why is healthcare in the U.S. so costly? Who benefits from the current system? U.S. healthcare is so large and complex that understanding this marketplace seems impossible. Despite being a physician who has been involved in healthcare for more than a quarter-century, I count myself among the confused masses. When I review the E.O.B. from my insurer describing the cost of my family's care, I have no idea how the prices for the listed services are determined. They all seem exceptionally high. The amount of my 10 to 20 percent co-pay seems more expensive than the actual costs of the individual charges.

Steven Brill, journalist and founder of American Lawyer magazine, attempts to answer many unsolved questions about American healthcare in a recent article published in *Time* magazine. Brill examined six patients' bills and came up with some startling revelations about the costs associated with providing health care. As a physician, this article grabbed my attention.

Powerless patients, powerful hospitals

Hospital/outpatient expenses make up approximately one-third of healthcare costs; prescription drugs are 10 percent. Families are destroyed by healthcare costs, with 62 percent of bankruptcies being related to illness or medical bills. The un- and under-insured patients are asked to pay the highest prices. However, having insurance doesn't prevent a personal financial disaster either. In fact, 69 percent of people experiencing medically related bankruptcy were insured at time of filing. While patients are powerless, Brill explains that hospitals have an unfair advantage. He states, "On average, most hospitals receive 35 percent of what they bill. Yet thousands of nonprofit institutions have morphed into high-profit, health systems/sellers while the purchasers of healthcare are generally powerless," says Brill.

The natural market in U.S. healthcare has been broken for many decades. Customers generally enter into the market against their will, have no or limited choice in care, while prices are set after the fact. There is no transparency, no ability to compare care across different health systems.

A problem for all Americans

The demand for healthcare is increasing and is a critical factor in rising cost. In the U.S., people spend almost 20 percent of GDP on health care compared to about half that in most developed countries. It is estimated that $2.8 trillion will be spent on healthcare this year in the U.S. This is more that the next 10 highest spenders in the world combined. Medicare and Medicaid cost accounts for $800 billion of this amount, which continues to drive the federal deficit. Yet in every measurable way, the results of our healthcare system are no better and often worse than those in other countries.

Brill explains that another problem lies in the unequal balance of power between patients and health care facilities. "When you follow the money, you see the choices that have been made. Why are the bills so high? What is so different about the medical ecosystem that causes technology advances to drive bills up instead of down? Power is concentrated in the high-profile businesses that have the best of both worlds. They are low-risk public utilities that pay their operators as if they were high-risk entrepreneurs. No regulator caps hospital profits. Nonprofit health systems do not disperse profits to shareholders. They use their profits to pay senior administrators multimillion dollar salaries, build/expand facilities and merge with rival systems creating an expanding upward spiral. The physicians and nurses often do not share in this profitable expansion. Average nonprofit operating profit margin is 11.7 percent after paying their chief executives. In healthcare, being nonprofit produces more profit! Healthcare systems make money on Medicare, while physician practices within those systems do not."

Explanation of charges

By examining six patients' bills, Brill unravels some of the complexity to medical billing. He concludes, "Every hospital/health system maintains an internal price list for all goods and services called the 'chargemaster'. These documents have been developed over decades through opaque processes that are subject to no oversight but remain key to overall price of healthcare. The prices bear little or no relation to actual costs. Profit margins are baked into the chargemaster prices and are jealously guarded by obfuscation and misdirection by hospital executives. Identical items and services are charged differently between different hospitals/health systems and there is no cost transparency. Medicare/Medicaid and insurance companies negotiate discounts for their covered patients based on these chargemaster prices at individual health systems. While executives dismiss the absurdity of the chargemaster prices, maintaining these fictional prices is key to their health systems' overall profit margin.

I count myself among the confused masses.

Washington, DC -- GSA President Jay Johansen, MD, explains physician payment concerns with Thomas Dorney, health policy aide to veteran U.S. Representative John Lewis. Dr. Tom West (left).

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ASA component relations

Partnering for strength

Paul Pomerantz
Chief Executive Officer
American Society of
Anesthesiologists

Thank you for the opportunity to address the Georgia Society through this newsletter column. Georgia holds a key place in the history of the specialty, and is certainly a leader in advocacy, member communications, professional education, and patient safety. Perhaps most significantly, the Georgia Society is a major source for the specialty's leaders. Two Georgians, Dr. Steven Sween and Dr. Arnold Berry, serve on ASA's Administrative Council, and many more serve on our Board and committees.

ASA's major strengths are its engagement of members and its grassroots involvement. Strong state organizations are essential to the success of the specialty in advancing the interests of its members and their patients. With the implementation of the Accountable Care Act, action on health reform moves to the state level, where issues of access, benefits, insurance exchanges, and licensure will be determined. Anesthesiology's success will require continued strengthening of the national-state partnership.

Although I officially began my tenure at ASA on March 4, I've worked for months with members and staff to develop a plan to strengthen ASA's influence where it matters most. In particular, we have dedicated resources in two areas: Advocacy and Communications.

Anesthesiology is well represented in Washington, but today's challenges require an even more pro-active approach. To that end, we recently reorganized our Washington D.C. office, appointing Manuel Bonilla, M.S., to serve as Chief Advocacy Officer. Manny is a 16-year veteran of ASA and a well-recognized expert on health policy. We've added a State Affairs Department, headed by Jason Hanson, J.D., to more effectively track, inform and support our efforts across the country. And we have created a Health Policy Research Department, under Tom Miller, Ph.D., to ensure that ASA is not just a strong voice, but a resource for quantifiable, proven data.

ASA members' voices are our greatest asset.

These new departments will join our experienced staff in Congressional and Political Affairs, Quality and Regulatory Affairs, and Payment and Practice Management. Our staff will work with you – side by side – to support ASA's efforts to curb and overturn state opt-outs, champion the need for physician-led care, and address the company model, among other areas. Critical to our success at the Federal and state level has been the support of our members of ASAPAC and state PACs. Today, ASAPAC is the largest and most active physician PAC in existence. But you know this, of course; GSA members gave $46,000 to ASAPAC, which was instrumental in helping us reach $1.83 million in contributions in 2012.)

As important are our initiatives to strengthen ASA's messaging and public communications. Recently the ASA Communications and Public Relations team worked with Reingold Associates and PCI, two leading firms, to refresh and enhance our messaging to ensure that it resonates with – and motivates – key audiences. Our goal is to spark favorable actions from legislators while simultaneously educating the public about anesthesiologists' critical role in ensuring the safety of all patients. ASA members' voices are our greatest asset, and we want to underscore our message with your personal patient stories. We encourage you to send us your most powerful stories, perhaps illustrating when your medical training saved a life during an emergency. Look for updates on our communications strategy in our newsletter and on the website.

ASA's future depends on collaboration. We look forward to working with you, federal and state legislators, hospital administrators and other medical professionals to advance your interests.

I look forward to working with each of you and to having the opportunity to meet you in person.

Retake ground...

Continued from Page 5

A general rule of thumb is that chargemaster charges are routinely at least 2 times the list price for implantable devices generating profit margins in excess of 150 percent. Simple items may produce much higher returns.

Administrators defend the chargemaster prices stating that they charge everyone the same. However, everyone pays a different reduced price based on negotiation except for patients with limited or no insurance coverage. The patients least able to pay are expected to pay full chargemaster prices. This pricing model has dramatically influenced costs and profits within health systems. The shift to outpatient services that began in the 1990s has dramatically increased outpatient procedures and shortened hospital stays. It was expected to dramatically reduce costs. Experts estimate that outpatient service are now packed with so much hidden profit that 2/3 of the overspending in McKinsey research on health care comes from payments for outpatient services. Outpatient ER care profit margin averages 15 percent and non-emergent outpatient care averages 35 percent profit. On the other hand, inpatient care has a margin of just 2 percent profit. Laboratory tests, pharmacy and radiological exams have become high-value revenue creating enterprises. As hospital systems expand, these core services become more profitable.

Possible Solutions

Brill suggests some solutions but these quickly devolve into politicized opinions. Medicare is not a template for future healthcare reform. All these issues are well known to policy experts in Washington and many others. There remain some illuminating observations to which most would agree.

Medicare reimburses physicians poorly. Anesthesiologists generally receive less than 33 percent of the usual and customary fee paid by insurance carriers. Physician fees have long been capped with no cost shifting or balance billing allowed. Health systems have no regulation on what they charge so steep discounts can still result in healthy overall profit margins. In the internet age, the cost data is there. It just requires the willpower to examine the issue. Brill made his conclusions from six patient bills; what would happen if a systematic review of costs occured across tens of thousands of bills? Maybe something like the standardization of fees that physicians have enjoyed for the last three decades.

We must follow the data.

The first is that there should be increased transparency in medical billing and costs should be provided upfront to consumers. Physicians need this information as well so that informed discussion can be held with patients and families to determine what services they really need and want.

The second observation is that the chargemaster pricing list is fiction. However, it clearly serves an important function in the health economy. Medicare and Medicaid price discounts helped produce our current problem. This started in 1966 when CMS regulators set prices, promoting volume of care over quality and cost efficiency.

Third, we must ask "how much profit is necessary to maintain our health systems and provide for continuing improvements to medical care?"

Finally, we must follow the data. Comparative effectiveness studies need to be funded and the results implemented. By the same reasoning, regulating clinical policy without a solid foundation in factual data should be stopped.

Continued on Page 9

State Issues Update

Solons okay pain clinic regulation

Mark Huffman, MD
Chair, Government Affairs
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Editor's Note: The Georgia General Assembly adjourned its 40-day session on Thursday, March 28 at midnight. The following briefs summarize action on bills impacting health care and patient safety. For copies of legislation, go to www.legis.ga.gov.

Medical offices which provide a substantial amount of treatment for chronic pain must undergo licensure under passage of the so-called "pill mill" bill adopted by the Georgia General Assembly earlier this year. Governor Nathan Deal has signed the legislation, and the Georgia Composite Board of Medical Examiners will begin the process of adopting rules governing pain practices.

Five years in the making, HB 178 empowers the Composite State Board of Medical Examiners to license and regulate medical practices in which more than 50 percent of patient care is for chronic pain. GSA has been at the forefront of this long-term effort to equip state regulators and law enforcement officers to crack down on illegal "pill mills." State Rep. Tom Weldon, R-Dalton, and state Attorney General Sam Olens created the legislation with assistance from the GSA Government Affairs Committee, the Medical Association of Georgia, the Georgia Society of Interventional Pain Physicians (GSIPP) and other impacted stakeholders.

"I commend the Georgia General Assembly and Governor Deal for taking action to curtail the rapid growth of pill mills in Georgia," said Attorney General Sam Olens. "Pill mill operators are nothing more than narcotic traffickers, and we will not tolerate them in our State. HB 178 strikes a balance that will allow us to identify and curb bad actors without getting in the way of the many excellent doctors who offer legitimate pain management to patients."

Dr. Bruce Hines, a GSA past-president, testified before House and Senate hearings at the request of GSIPP and GSA Executive Secretary and lead lobbyist James E. "Jet" Toney presented for us.

"The benefit of this legislation is the power it gives to the Medical Board to regulate and license the treatment of pain," Dr. Hines testified on February 11. "It assures appropriate training, licensing and regulation for pain treatment."

'Pill mill operators are nothing more than narcotic traffickers.'

CRNA amendment nixed
At the last committee hearing, the General Counsel to the Georgia Association of Nurse Anesthetists sought an amendment to authorize CRNA practice in clinics when a physician is not present. She testified that the wording of the bill would unfairly prohibit CRNAs from practicing in licensed clinics when physicians or other providers with prescriptive authority are not present. The AG's staff noted to lawmakers that the intent of the bill is to encourage physicians to be even more actively involved in the treatment of pain. CRNAs do not have prescriptive authority under Georgia law.

GSA will actively and materially participate in the promulgation of rules governing licensure and activity of pain clinics.

APN scope expansion fails
Legislation that passed the Senate and would expand the authority of Advanced Practice Nurses to order radiographic tests under protocol failed to gain passage in the House Health and Human Services Committee chaired by state Rep. Sharon Cooper, R-Cobb County. The Medical Association of Georgia and the Georgia Radiological Society strongly opposed SB 94.

Nurse whistleblower bills stall
Senate Bill 13 and House Bill 50, which would have required nurses to report to the Georgia Board of Nursing if they suspect another nurse has violated any of the board's grounds for discipline, failed to complete the legislative circuit this session. The senate sponsor, Sen. Buddy Carter (R-Pooler), a pharmacist, said the bill would keep bad nurses from being quietly fired from medical facilities only to get a job elsewhere in the state. The bills each passed one chamber and will carry over to the 2014 session.

Approved Rx pads list expanded
House Bill 209 adds Medicare and Medicaid approved prescription pads under the definition of "security paper". Passage expands the list of acceptable scripts.

Waivers for multi-specialty ASCs held
Legislation that would have waived Certificate of Need requirements for multi-specialty ambulatory surgical centers (read "clinics") was held in the House Health and Human Services Committee. HB 279 was opposed by hospitals and ASCs with high government-pay patient loads who said such waivers would empower certain facilities to skirt the rigorous CON requirements and to skim insured and private pay patients.

Med Mal "Comp" System studied
A controversial mechanism that would replace Georgia's tort-based court claims system for adjudicating medical malpractice lawsuits will be studied over the interim. SB 141, the so-called "Patient Injury Act", would establish a no-fault system by which compensation would be determined and awarded in a manner similar to how workers' comp claims are now handled. The controversial measure is touted by its proponents as a means by which physicians could avoid the "trauma" of lawsuits, but opponents voiced numerous concerns about the yet-untested approach. The legislation has not been passed in any other state and such system is not in operation anywhere in the United States. A similar bill, HB 662, was introduced in that body late in the session.

Burke, Hufstetler Senate's medical resource; Dr. Watson running, too

by Kristin Strickland
Associate Editor

GSA-PAC contributions in 2012 helped elect two new healthcare professionals to the 2013 Georgia Senate: Dean Burke, MD (R-Bainbridge) and Chuck Hufstetler, AA (R-Rome).

Sen. Burke is an obstetrician, gynecologist and former city councilman from Bainbridge. He won a February 5 special election for the seat in Senate District 11, after long-term Senator John Bulloch resigned due to health reasons. Dr. Dan Beeson met with Dr. Burke prior to the election and presented Dr. Burke with a GSA-PAC check. Senate District 11 represents Colquitt, Decatur, Early, Grady, Miller and Seminole Counties, along with portions of Mitchell and Thomas Counties.

Sen. Hufstetler is an Anesthesiologist Assistant at Redmond Regional Hospital and the former Chair of the Floyd County Board of Commissioners. He was elected to Georgia's 52nd Senate District in November 2012. District 52 includes Floyd County and portions of Bartow, Chattooga, and Gordon counties.

The addition of two experienced medical providers in the state Senate helps replace the knowledge of Dr. Don Thomas, R-Dalton, who retired from elective office two years ago. He continues to treat patients.

Domino effect
Of note, Dr. Ben Watson (R-Savannah), who has served in the Georgia House since 2011, has announced he will run in 2014 for a State Senate seat currently held by pharmacist Buddy Carter (R-Pooler) who is running for Congressman Jack Kingston's seat. Kingston has announced his run for the U.S. Senate seat held by the retiring Sen. Saxby Chambliss.

Drug shortages: a market failure

Joel Zivot, MD FRCPC FCCP
jzivot@emory.edu

Editor's Note: Joel Zivot, MD, FRCPC, FCCP, is the Medical Director of the Cardiothoracic Intensive Care Unit at Emory University Hospital Midtown. In 2012, Dr. Zivot planned a consensus conference entitled "On the Ethics of Drug Shortages" in partnership with ASA and the Emory University Center for Ethics. The conference engaged individuals from various academic disciplines, industry, and professional associations to develop a consensus report on future practice and policy actions to address drug shortages.

Some claim that the problem of generic injectable drug shortages is just too complex and multifactorial to understand. It has become the new normal but is better understood as the normalization of deviance. Drug shortages are, in fact, solvable and are the direct result of a market failure.

Drug shortages are, in fact, solvable.

Markets fail for specific reasons, and in the case of drug shortages two specific reasons are worth noting. First, drugs are a public good. A public good is non-rivalrous and non-excludable. When we think of public goods, we think instead of things like clean air, lighthouses, or national defense. Sterile generic drugs are a public good in that within the practice of medicine, they must always be available in sufficient supply and quality to meet everyone's need. Narrow margins lead to insufficient generic drug manufacturing to meet actual demand. The resulting problem of insufficient supply is perpetuated by the second cause of the drug production market failure, that is, the transaction cost.

The transaction cost is the fee extracted to make the contract between generic vendor and purchaser. Group purchasing organizations (GPOs) have been granted a safe harbor exemption from the Federal anti-kickback statute. In this arrangement, the purchasing group charges a fee, or a kickback, directly to the vendor in exchange for market access. GPOs have created enormous leverage to such a degree as to function as a buyer's monopoly, or monopsony. Monopsony power has further allowed group purchasing organizations the capacity to set a price that is not market clearing and, in addition, extracts fees that erode the small amount of margin that may have otherwise been realized by the vendor.

Markets fail for specific reasons, and in this case, GPOs contract with vendors for an extended period of time. Those vendors not awarded the contract leave the market. A single vendor is the manufacturer of many generics. When demand exceeds supply, the product is not available at any price and no other vendor can easily re-enter the market to offset the shortage. A freer market would allow more vendors to access the market, resulting in a market clearing price and sufficient supply. This broken market can be repaired by, at the very least, removing GPO capacity to directly charge transaction fees to vendors. This would be accomplished by repeal of the anti-kickback safe harbor.

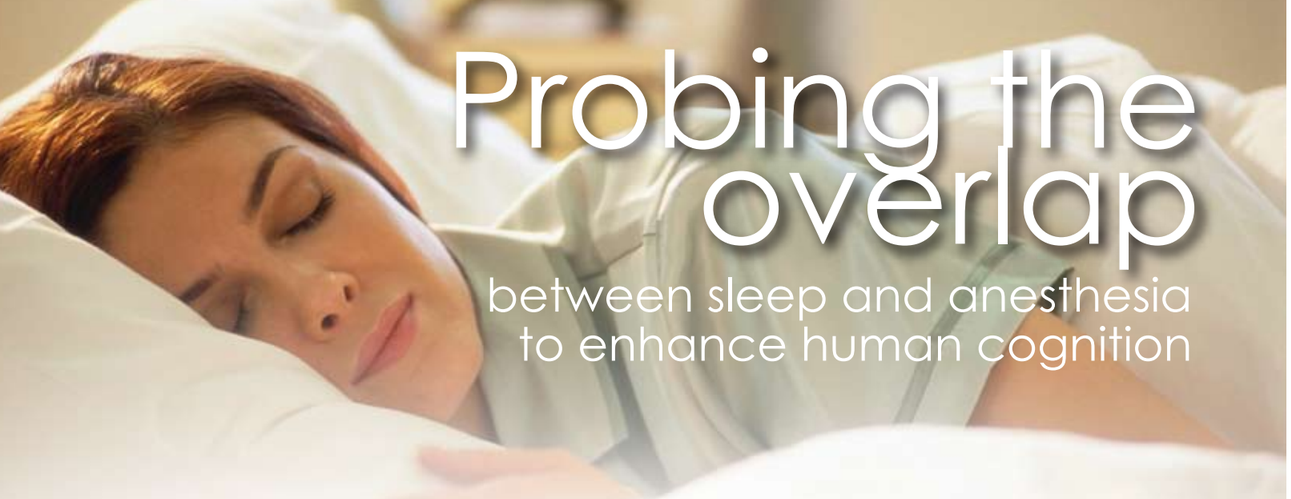
All generic forms of a drug must be the same so the only way for vendors to compete is through price. Non-market pricing will rapidly result in market failure and must be avoided. Sterile injectable generic drugs are a public good and this market warrants close monitoring. A safe and sufficient sterile generic injectable drug supply is absolutely critical to the practice of medicine in every specialty. In anesthesiology, without the sterile generic injectables our effectiveness drops -- in some situations it plummets -- and the risk to our patients needlessly increases.

Retake ground...

Continued from Page 7

Conclusion
Read the article. Think about what is going on. Ask questions. How can anesthesiologists and other health system and hospital-based physicians deal with this issue? How can physicians use our current relationships with health systems to foster positive change? Can we shift the debate to cost and remain patient advocates? How can we reestablish a trustworthy physician-patient relationship? Is this an issue that can help physicians reclaim decades of lost ground?

Bitter Pill. Steven Brill. Time, 3/4/2013, Vol. 181 Issue 8, p16-55



Probing the overlap

between sleep and anesthesia to enhance human cognition

Paul S. García, MD, PhD
Emory University School of Medicine
Assistant Professor of Anesthesiology

Editor's Note: Dr. García has been interested in the cognitive processes of sleep and anesthesia since he was first involved as a medical student in the care of hypersomnic patients from Emory's sleep clinic. He has been awarded a $1.5 million dollar collaborative research award from the James S. McDonnell Foundation (www.jsmf.org) to investigate the intersection of sleep and anesthesia during emergence.

Sleep and anesthesia are distinct brain states that share a common phenotype - unconsciousness. Although the importance of sleep to cognitive tasks is well-established, we still lack an understanding as to why this concentrated quiescence is so necessary for optimal brain health and function. Intraoperative electroencephalographic and electromyographic (EEG/EMG) recordings reveal that some characteristic features of natural sleep are present during surgical anesthesia. Why then is sleep restorative and fundamental to cognitive processes while anesthesia disrupts memory and might contribute to poorer cognitive health? Perhaps, if the restorative properties of natural sleep can be mimicked, pharmacologic sleep or anesthesia could potentially be used therapeutically for cognitive problems.

Anesthesia could potentially be used therapeutically for cognitive problems.

Preliminary work in my study of sleep and anesthesia suggests that different brain regions re-activate at different times, resulting in several possible sequences of brain activation that eventually lead to a successful "wake-up". My research group is currently recruiting patients for an observational study that aims at distinguishing among the specific sequences that lead to emergence from anesthesia and determine if they correspond to specific post-anesthesia trajectories (i.e., pain scores and post-operative delirium).

Sleep offers an opportunity to study natural transitions from unconsciousness to consciousness. Over 50 years ago, the electroencephalograms (EEGs) of 33 patients undergoing 127 nights of uninterrupted sleep launched the field of sleep medicine by categorizing distinctive EEG patterns based on expert opinion. Scientists have begun to unravel specific sequences of regional activation/inactivation of the brain that characterize "waking up" from natural sleep. Unfortunately, much less is known about recovery from anesthesia. Surgical anesthesia represents an enormous opportunity for data collection; the CDC estimates that 48 million inpatient surgeries were performed in 2011. Despite the widespread availability and use of EEG-based monitors designed to measure depth of anesthesia, the opportunity to collect and analyze this source of focused data on brain state transitions has gone largely unrecognized.

The re-establishment of a conscious baseline in a diverse patient population among the great variety of anesthetic drug mechanisms and surgical diagnoses provides a rich data set to be mined for the most salient features involved in cognition. With the help of my collaborators (Divya Chander, MD, PhD, Stanford University and Jamie Sleigh, MD, Waikato University, New Zealand), I aim to establish a large collaborative repository of EEG data collected during surgical anesthesia using a structured emergence protocol (www.accesshq.org). Only through this international, collaborative, multi-site effort can we capitalize on anesthesia for surgery as a tool to explore the brain's ability to transition among conscious and unconscious states.

e-News

Not getting GSA emails or e-News?

Communication Chair Kathy Stack, MD, has announced the creation of e-News, a GSA semi-monthly electronic newsletter. Distributed via email and posted on www.gsahq.org, e-News will supplement the quarterly scOpe magazine.

"This delivery mechanism is intended to provide members with timely news and updates about issues which impact anesthesia practice and patient safety," Dr. Stack said. "It will also announce member benefits and events and provide a hyperlink to more information about educational, practice management and advocacy opportunities."

Issues of e-News will be emailed to all members approximately every two weeks. To prevent the newsletter from being sent to spam, members should add the following addresses to their "safe sender" list: gesa@memberclicks-mail.net, kristin.strickland@politics.org, and jet.toney@politics.org.

Members should also verify their preferred email address with Kristin Strickland, GSA Member Services Manager. Contact Kristin at kristin.strickland@politics.org 404-249-9178 x6.

All issues of e-News are posted at www.gsahq.org/e-news.

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Advances in Anesthesia

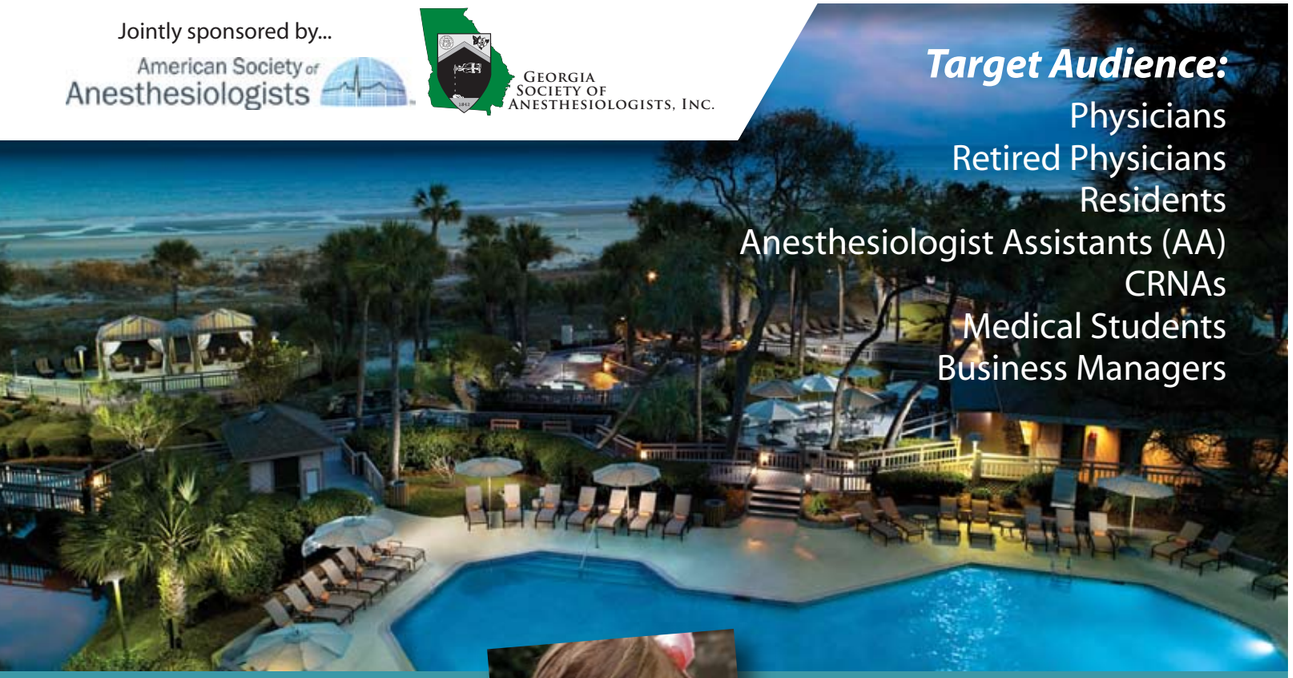
UPDATES TO IMPROVE PATIENT CARE

July 19-21, 2013 | *GSA Summer Meeting*
Omni Oceanfront Resort
Hilton Head, South Carolina

Jointly sponsored by...

American Society of Anesthesiologists

Georgia Society of Anesthesiologists, Inc.



Target Audience:

Physicians
Retired Physicians
Residents
Anesthesiologist Assistants (AA)
CRNAs
Medical Students
Business Managers

Activity Co-Directors:

Ratna Vadlamudi, MD
Emory University

Sona Arora, MD
Emory University

This CME activity is supported by educational grants. A complete list of supporters will be published in the course syllabus.

Advances in Anesthesia

UPDATES TO IMPROVE PATIENT CARE

GSA 2013 Summer Meeting Schedule

Friday, July 19, 2013

3:00 – 7:00p	Registration - **Activity Center Lobby**
4:00 – 9:00p	Exhibitor Set Up - **Sabal**
5:00 – 7:00p	Board of Directors Meeting - **Savannah River**
7:00 – 8:30p	Welcome Hospitality with the Exhibitors - **Sabal**
8:30p	*Dinner on your own with family and friends*

Saturday, July 20, 2013

6:00 a	Exhibitor Set Up - **Sabal**
6:30 – 7:20a	Registration/Breakfast with Exhibitors - **Sabal**
7:20 a	*Welcome* - **Palmetto Ballroom** Jay Johansen, MD, PhD - GSA President
	Introductions- **Palmetto Ballroom** Sona Arora, MD & Ratna Vadlamudi, MD Summer Meeting Activity Co-Directors
7:30-8:25 a	*ASA Update* John Zerwas, MD
8:30-9:25 a	*Conundrums in Ambulatory Anesthesia I* Girish Joshi, MBBS, MD, FFARCSI
9:30-10:00 a	Break with Exhibitors - **Sabal**
9:30-12:00 p	Resident Section Meeting
10:00-10:55 a	*Conundrums in Ambulatory Anesthesia II* Girish Joshi, MBBS, MD, FFARCSI
11:00a-11:55 p	*The Older Anesthesiologist: Does Experience Count?* Arnold Berry, MD, MPH
12:00 p	**Meeting Adjourned/Lunch with family and friends**
1:00 p	13th Annual GSA Golf Tournament **Robert Trent Jones Course**
3:00-4:00 p	10th Annual Family Ice Cream Social - **Courtyard**
6:30-8:00 p	Evening Reception - **Shorehouse**
7:30-9:00 p	Faculty Dinner - **HH Prime**

Sunday, July 21, 2013

6:30-7:30 a	Registration/Breakfast with Exhibitors - **Sabal**
7:00-7:30 a	General Business Meeting for GSA Members
7:30-8:25 a	*Meaningful Use of Health Information Technology for Anesthesiology* Matt Weinger, MD, MS
8:30-9:25 a	*Fitness for Duty in Anesthesia Practice* Matt Weinger, MD, MS
9:30-10:00 a	Break with Exhibitors - **Sabal**
10:00-10:55 a	*Novel Oral Anticoagulants: Pharmacology Update - No More Rat Poison* Jerrold Levy, MD, FAHA, FCCM
11:00-11:55 a	*Allergic and Anaphylactic Reactions* Jerrold Levy, MD, FAHA, FCCM
12:00 p	**Meeting Adjourned**

Note: Opportunities for Q&A will be provided at the conclusion of each presentation.

Duney the Dolphin Welcomes GSA Kids

Omni Kids Club: Just For Kids (Ages 4 to 12)
Friday Night: *Hawaiian Luau*
Saturday Night: *Pirates of HHI*
6 to 9 pm
$55 (includes dinner)

Omni Kids Camp
Half Day & Full Day Camps Available
9 am to 4 pm
Offered Monday - Saturday

Faculty Disclosure/Resolution of conflicts of interest:
The American Society of Anesthesiologists and The Georgia Society of Anesthesiologists adhere to ACCME Essential Areas, Standards, and Policies regarding industry support of continuing medical education. Disclosure of the planning committee and faculty's commercial relationships will be made known at the activity. Speakers are required to openly disclose any limitations of data and/or any discussion of any off-label, experimental, or investigational uses of drugs or devices in their presentations.

In accordance with the ACCME Standards for Commercial Support of CME, the American Society of Anesthesiologists will implement mechanisms, prior to the planning and implementation of this CME activity, to identify and resolve conflicts of interest for all individuals in a position to control content of this CME activity.

Special Needs Statement:
The Georgia Society of Anesthesiologists is committed to making its activities accessible to all individuals. If you are in need of an accommodation, please do not hesitate to call and/or submit a description of your needs in writing in order to receive service.

Cancellation Policy:
Cancellations and/or changes in registration or participation in all or any portion of the meeting must be received at GSA headquarters by Monday, July 15, 2013, to qualify for refund. Absolutely no refunds will be issued for changes received at GSA headquarters after Monday, July 15. The cancellation policy will be strictly enforced.

Accreditation Statement:
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of American Society of Anesthesiologists and The Georgia Society of Anesthesiologists. The American Society of Anesthesiologists is accredited by the ACCME to provide continuing medical education for physicians.

Credit Designation:
The American Society of Anesthesiologists designates this live activity for a maximum of 8 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

To Register... Contact Kristin Strickland, GSA Member Services Manager: 404-249-9178 x 6; kristin.strickland@politics.org

Advances in Anesthesia

UPDATES TO IMPROVE PATIENT CARE

Educational & Learning Objectives

Arnold Berry, MD, MPH
American Society of Anesthesiologists, VP for Scientific Affairs
Emory University School of Medicine, Professor of Anesthesiology | Atlanta, GA

The Older Anesthesiologist: Does Experience Count?

At the conclusion of the presentation, the learner will be able to:
- Calculate the demographics of the anesthesia workforce and the numbers of older anesthesiologists
- Associate the physiologic changes of aging to how they may impact an older anesthesiologist's practice
- Demonstrate how older anesthesiologists can continue to serve their practices in new roles

Girish Joshi, MB, BS, MD, FFARCSI
University of Texas Southwestern Medical Center at Dallas,
Director of Perioperative Medicine and Ambulatory Anesthesia
Professor of Anesthesiology and Pain Management | Dallas, TX

Conundrums in Ambulatory Anesthesia I:
Patient Selection (OSA, obesity, difficult airway)
At the conclusion of the presentation, the learner will be able to:
- Describe identification of preoperative risk factors in the obese including sleep apnea
- Illustrate the importance of appropriate selection of adult obese patients and sleep apnea patients scheduled for ambulatory surgery
- Discuss anesthetic risks including difficult airway in this patient population
- Specify criteria for discharge of these outpatients

Conundrums in Ambulatory Anesthesia II:
ICD and diabetes management
At the conclusion of the presentation, the learner will be able to:
- Differentiate between pacemakers and ICDs
- Describe recent practice guidelines regarding CEIDs and recognize how they impact daily clinical practice
- Review the evidence on glucose control in diabetic surgical
- Describe the perioperative management of diabetic patients scheduled for ambulatory surgery

Jerrold Levy, MD, FAHA, FCCM
Professor of Anesthesiology and Surgery
Duke University School of Medicine
CoDirector, Cardiothoracic ICU

Novel Oral Anticoagulants:Pharmacology Update - No More Rat Poison
At the conclusion of the presentation, the learner will be able to:
- Review mechanisms of actions of the new oral anticoagulation agents dabigatran, rivaroxaban, and apixiban
- Review indications for their use including atrial fibrillation and thromboembolic prophylaxis
- Discuss perioperative management of the new agents

Allergic and Anaphylactic Reactions
At the conclusion of the presentation, the learner will be able to:
- Review the different life threatening anaphylactic and allergic reactions a clinician may encounter
- Differentiate mechanisms of anaphylaxis and discuss agents most often responsible for reactions including drugs, blood products, and environmental agents including latex
- Discuss therapeutic approaches to the treatment and prevention of anaphylactic reactions and cardiopulmonary dysfunction that occurs

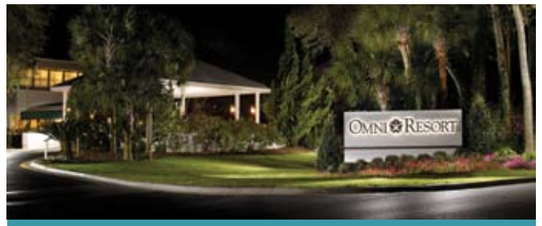
Matthew Weinger, MD, MS
Vanderbilt University School of Medicine,
Norman Ty Smith Professor of Patient Safety and Medical Simulation
Professor of Anesthesiology, Biomedical Informatics, and Medical Education
Director, Center for Research and Innovation in Systems Safety (CRISS)
Nashville, TN

Meaningful Use of Health Information Technology for Anesthesiology
At the conclusion of the presentation, the learner will be able to:
- Define the terms HIT, meaningful use, and usability
- Describe the ONC's meaningful use criteria of greatest relevance to anesthesia professionals
- Identify the major obstacles to anesthesia professionals attaining meaningful use criteria in currently available EHRs and AIMS
- Articulate their concerns about EHRs/AIMS to hospitals/practices and vendors with regard to these systems meeting their needs for perioperative patient care safety, effectiveness, efficiency, and satisfaction

Fitness for Duty in Anesthesia Practice
At the conclusion of the presentation, the learner will be able to:
- Review the consequences of 'performance shaping factors' (PSFs)
- Review the negative interactive effects of PSFs on clinical performance
- Describe different types of PSFs and sleepiness countermeasures
- Reflect on the implications of PSFs in your own practice

John Zerwas, MD
American Society of Anesthesiologists, President
US Anesthesia Partners | Richmond, Texas

ASA Update
At the conclusion of the presentation, the learner will be able to:
- Relate the American Society of Anesthesiologists' role in an education, research and scientific association of physicians
- Delineate how practitioners can use its resources to enhance their patient care and professional activities



Accommodations

For hotel reservations, please visit...

http://www.omnihotels.com/FindAHotel/HiltonHead.aspx

or contact The Omni Oceanfront Resort at 1-800-843-6664 and request the Georgia Society of Anesthesiologists room block.

The group block code is 071413GASOCIETY. You must use the above link and enter the group code to secure the group rate and receive a waiver from the 5 night minimum requirement. Please note that the last day to book under the GSA room block is Monday, June 17, 2013. It is recommended that you make arrangements for accommodations as soon as possible.

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Register at www.gsahq.org

Five reasons why...

Bullish on physician-led medicine

Jet Toney
GSA Executive Secretary

Editor's note: Jet Toney has served GSA for more than 20 years. Originally hired in 1992 to represent (lobby for) GSA at the state level, Jet and his firm, Cornerstone Communications Group, now provide administrative, meeting management and messaging services to the Society. This personal column may or may not represent the views of Society leaders, but his perspective paints a portrait of how lay persons view the physician community and the role doctors may play in future health care models.

My son the insurance and investment counselor tells me that I should be "bullish" on how well my retirement savings are performing. I hope he's right. As a self-employed business owner I am responsible for creating my own retirement strategy and supporting it with monthly contributions. The decisions and contributions I make today will determine the extent of my resources when I get to an age or health condition where I cannot generate revenue.

From my perspective, physicians are in an analogous position regarding their role in the future delivery of health care in our nation. That is to say that the decisions and personal strategies which physicians make and employ now will determine whether or not they will be a highly-utilized resource in the future.

Some have stated that because of the "affordable health care" legislation, low payment for services and the increase in reliance on non-physician providers that doctors won't have a significant role in U.S. health care in the future. I refuse to accept this "going to hell in a hand basket" approach regarding physician-led medicine just as I refuse to depend solely on Social Security for my later-life revenue stream. For the following five reasons, I am bullish on the prominent role physicians, and especially anesthesiologists, will perform in the future of U.S. and global health care:

5. The population is NOT getting younger, healthier, slimmer, more fit, better looking or common sensed.

For this reason alone and regardless of what the "it" is, the talent and skills of well-trained physician-led medical teams will be required to make it look younger, fix it, slim it, make it larger, replace it, bend it, shape it, straighten it, extract it or save it.

Bottom line: Non-physician providers will increase in prominence, but the demand for "healing arts" cannot be satisfied by anyone other than those who choose to apply their extensive education and training in personal, productive ways.

Common sense adage: You don't bring a knife to a gun fight.

4. Education, training and expertise continue to be valued when "it" needs to be done right. Be the one.

Let's face it, physician extenders are valuable members of the health care team and will play a more prominent role in health care delivery, particularly at the primary care level. Let's also take comfort in the notion that when a 380-lb., morbidly obese, 38-year-old female smoker with severe diabetes, high blood pressure and an extremely sour attitude goes downhill in the procedure room, you will never hear the shouted words "somebody go get the recent graduate of a medical assistant program."

Bottom line: Anesthesiologists must constantly inject their presence in the delivery of health care as the most important provider in the room.

Common sense adage: 90 percent of success in life is just showing up.

3. Anesthesiologists who work at it make good money.

According to the Bureau of Labor Statistics' Occupational Employment and Wage Estimates survey, anesthesiologists rank No. 1 with an average annual pay of $232,830. The medical field dominates the top nine spots for best-paying jobs. The salary and employment data from May 2012 were collected from more than 1 million businesses.

Bottom line: America, Americans and America's economy are bloated. If the economic downturn of 2008 hasn't demonstrated that, then nothing I say will persuade a mal-content physician that despite the stricture of managed care and the rigor of "affordable care", being in medicine is still a pretty good gig. And so is the job I have.

Common sense adage: It's not what you make, but what you save. Live within one's means.

2. Leadership is a vacuum; it's going to suck someone into the pipeline. Make it you.

Regardless of the industry, profession or organization, someone is going to be drawn into the role of leader and/or decision maker. This is good news for anesthesiologists. The physician who recognizes the opportunity to grab the reigns of leadership also recognizes that leaders are well-placed to make decisions which raise the opportunities and performance of all stakeholders, including one's self.

Bottom line: As doctors trained to make split-second decisions of life-sustaining impact, anesthesiologists are uniquely positioned to push to the head of the class – in the hospital, the ASC, the community, the electoral and policy processes, and professional medical organizations.

Common sense adage: If you are not the lead dog in the sled team, the scenery never changes.

1. Locker slammers will be replaced by the value-adding entrepreneurial anesthesiologist.

Because of the performance and cost pressures placed on hospitals, ASCs and other places where health care is dispensed, owner-operators of such medical engines are looking for intelligent, highly-trained, visionary professionals to lead organizations. The shift-working doctor who puts in his/her "eight" and slams the locker door in a rush to a grande double latte and two hours of mindless social media is doomed to a career of always being subject to someone else's policy, whim or low valuation of his/her skill set. The visionary, entrepreneurial anesthesiologist who takes the reins in the facility, who walks the halls of Congress to help mold policy, who helps elect another doctor to office is subject to a life of progress. I see these "winners" in the leadership ranks of medical societies; I see these traits in the rising resident physicians at Georgia's medical education programs.

Bottom line: See number two.

Common sense adage: Nobody takes care of your business like you can.

Rickard S. Hawkins, MD
Chair, Committee for Responsible Health Care Policy

GSA-PAC

Pro-active politics
protects patients, practice

Our Society's state-level political and electoral participation was well-fueled in 2012 with more than 392 investors in the GSA-PAC. Also known as the "Committee for Responsible Health Care Policy", GSA-PAC made more than $52,000 in contributions to state legislative candidates during last year's election cycle where many of the 236 state House and state Senate seats were contested.

Turnover is good, right? It assures new ideas and keeps lawmakers on their toes, correct?

Not necessarily so. Historically, the members of the legislature in our state have been very supportive of physician-led health care. But moods, attitudes and perceptions change as younger generations win election to policy making positions. Today, fewer Georgia legislators know the name "Marcus Welby, MD" than know the name of the CVS/Walgreen's nurse practitioner.

And, certainly, fewer policy makers know the name of anesthesiologists practicing in their districts.

There is little political success in anonymity.

Our General Assembly has experienced monumental turnover since the end of 2006. The state House has seen 60 percent turnover of members while the state Senate is less senior with over 50 percent newcomers.

This brings the point back around to why GSA needs a strong, vibrant, aggressive political action committee -- so that our profession, our practices and our patients are not forgotten under the Golden Dome in Atlanta.

Next year is an important election year in Georgia. We will elect 236 state lawmakers, the Governor, the Insurance Commissioner, and a new U.S. Senator.

Fewer Georgia legislators know the name "Marcus Welby, MD" than know the name of the CVS/Walgreen's nurse practitioner.

My advice and my request is that you begin to engage politically and that you encourage your peers to do likewise. Remember, there is little political success in anonymity. Make sure your local state legislators know who you are, and more importantly, that your patients are their constituents.

2013 GSA -PAC Contributions | November 1, 2012 – May 8, 2013

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Joy Rusmisell, AA-C, MHSc	$50

e-News

Not getting GSA emails or e-News?

Communication Chair Kathy Stack, MD, has announced the creation of e-News, a GSA semi-monthly electronic newsletter. Distributed via email and posted on www.gsahq.org, e-News will supplement the quarterly scope magazine.

"This delivery mechanism is intended to provide members with timely news and updates about issues which impact anesthesia practice and patient safety," Dr. Stack said. "It will also announce member benefits and events and provide a hyperlink to more information about educational, practice management and advocacy opportunities."

Issues of e-News will be emailed to all members approximately every two weeks. To prevent the newsletter from being sent to spam, members should add the following addresses to their "safe sender" list:

gesa@memberclicks-mail.net,
kristin.strickland@politics.org, and
jet.toney@politics.org.

Members should verify their preferred email address with Kristin Strickland, GSA Member Services Manager.

Contact Kristin at
kristin.strickland@politics.org
404-249-9178 x6.

All issues of e-News are posted at
www.gsahq.org/e-news.

ASA Legislative Conference

GSA goes DC for you, patients

Kathy Stack, MD
President Elect

An energetic team of 20 GSA members represented you, your practice, your profession and your patients before the health care policy staff of Georgia's 14 members of the U.S. House of Representatives and two U.S. Senators on May 1. The Hill visits were part of the 2013 Washington Legislative Conference conducted annually by the DC office of the ASA. This year's meeting, themed Focus on the Future, prepared members to engage effectively in the legislative, regulatory and political processes on behalf of the specialty.

Drs. Amanda Brown and Joel Zivot also attended the highly popular ASA Leadership Spokesperson Training prior to the conference. The program provides media, story and message training to help prepare attendees to speak with policymakers and the public on important issues impacting the specialty of anesthesiology including physician-led care.

The following summaries of ASA's top five federal issues were presented to a health policy legislative assistant in each Congressional and Senate offices with personal comments from GSA members:

Washington, DC - On the steps of the Library of Congress, a GSA team huddles between Capitol Hill visits on May 1, 2013. (back row) Drs. Rick Hawkins (l) and Susheel Dua; (middle row, left to right) Drs. Chris Malgieri, Justin Scott, Steve Walsh and Doug Smith; (front row) Drs. Al Head and Kathy Stack.

Truth and Transparency

House Resolution 1427, the "Truth in Healthcare Marketing Act," would improve transparency in the identification of health care providers and health care provider-related advertisements and marketing. Introduced by Reps. Larry Bucshon, MD, and David Scott (D-GA), HR 1427 addresses an increase in patient confusion regarding the different health care providers, such as physicians, technicians, nurses, and physician assistants. When patients have a better understanding of the roles of each healthcare professional, they will be able to make wise decisions on the services they want and ultimately the expenditure of health care dollars.

Rural Pass Through

The rural "pass-through" program addresses the lack of healthcare access to rural citizens by creating incentives for anesthesia providers to practice in small, rural hospitals. The incentives are created by allowing eligible hospitals to use reasonable-costs based Part A funds in lieu of the conventional Part B fee schedule to induce anesthesia providers. Unfortunately, the Centers for Medicare and Medicaid Services (CMS) interpret the statute to apply only to anesthesiologist assistants and nurse anesthetists, excluding anesthesiologists from eligibility of "pass-through" funds. Legislation introduced in the 112th session of Congress would clarify the program so that rural hospitals may use already available "pass-through" funds to employ all types of anesthesia providers, including anesthesiologists, as well as anesthesiologist assistants and nurse anesthetists.

Medicare Payment

To address the national deficit, some are calling for a decrease in governmental payment for medical services. This would be especially detrimental to anesthesiologists, who are currently paid through Medicare at the lowest rate among all health professionals at only 33% of private payment rates. Furthermore, the Independent Payment Advisory Board (IPAB) has unlimited power to mandate across the board cuts, in addition to SGR and sequestration cuts. To address these various risks to Medicare payment, ASA supports legislation to repeal IPAB, such as House and Senate Resolutions 351, also known as the "Protecting Seniors' Access to Medicare Act of 2013." ASA also pushes for implementation of the Perioperative Surgical Home model of coordinated care, which could help hold down overall hospital costs and improve quality care related to surgery. Finally, ASA supports the repeal of SGR and the implementation of a replacement formula that would more accurately reflect the cost of providing care to Medicare beneficiaries.

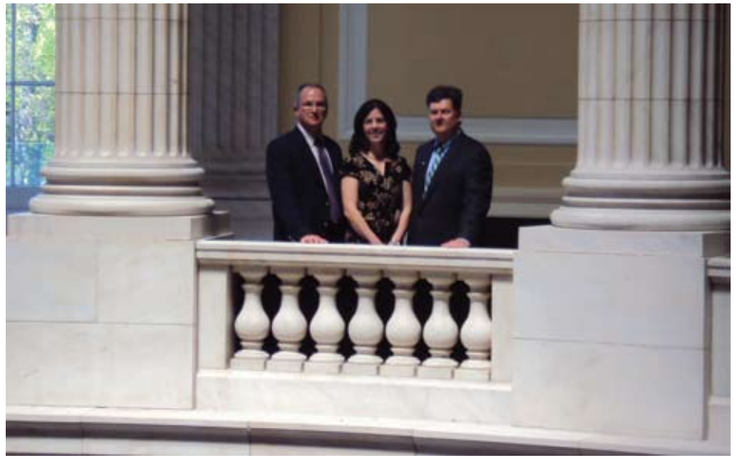
Drug Shortages

An increased number of drugs are in shortage, resulting in delay of medical treatments, less optimal outcomes and sometimes death. The bi-partisan passage of the Food and Drug Administration Safety and Innovation Act (FDASIA) was a successful step towards addressing the multiple causes of drug shortages. The FDASIA mandated the GAO study of drug shortages, which will provide agencies and Congress with guidance to address drug shortages. ASA is working to monitor the implementation of FDASIA and the GAO study to support any additional legislative and regulatory actions that may be necessary to address drug shortages.

Maintain Patient Safety

An independent peer reviewed study found that there were 25 excess deaths per 10,000 Medicare general orthopedic surgical cases when anesthesiologists did not provide or direct anesthesia care. Medicare's current physician supervision safety standard provides increased safety for patients without adding any additional cost. ASA is an advocate for the longstanding Medicare standard. The Society opposes any legislative or regulatory changes to the standard.

Heard in Washington:



Cannon House Office Building – (l to r) Drs. Jay Johansen, Amanda Brown, and Tom West await appointments with Congressional staff representing Georgia officials.

Mark your 2014 calendar!

The 2014 ASA Legislative Conference will be held May 5 - 7, 2014, at the JW Marriot in Washington D.C.

GSA handles and covers the registration fee for any member who attends and commits to making Hill visits. Attendees are responsible for costs of travel and accommodations. Look for an announcement in 2014 with instructions for registering.

Georgians on Capitol Hill

John Blackburn, MD (Resident)
Amanda Brown, MD
Claire Chandler, AA
Heather Dozier, MD
William Dozier, MD
Susheel Dua, MD
Rick Hawkins, MD
C. Alvin Head, MD
Mark Huffman, MD
Jay Johansen, MD
Christopher Malgieri, MD (Resident)
John Neeld, MD
Michael Nichols, AA
Justin Scott, MD
Doug Smith, MD
Kathy Stack, MD
Billy Thomas, MD (Resident)
Jet Toney
Steve Walsh, MD
Thomas West, MD
Joel Zivot, MD

If we want the best for our patients there is an increasingly important science that we can no longer ignore - Political Science.
- Steve Walsh, MD, Roswell

Grassroots advocacy by state societies impacts the healthcare changes at hand by counterbalancing bureaucratic decisions with legislator response.
- Amanda Brown, MD, Macon

After hearing from government officials on issues impacting our profession, it's clearer than ever before we must advocate in the political process.
- John Blackburn, MD, Resident, Augusta

We have an obligation to educate ourselves to explain our views to the lawmakers.
- Billy Thomas, MD, Resident, Augusta

Regarding health care policy, there is confusion among legislators and agencies with no real focus and, thus, no viable plans.
- Rick Hawkins, MD, Woodstock

A lot of policy makers in both parties are worried about issues with PPACA roll out.
- Mark Huffman, MD, Marietta

There is no substitute for personal intersection with your legislators and their staff.
- Kathy Stack, MD, Atlanta

Passive defiance has never been a strategy. Active participants will do right by their profession, practice and family.
- Tom West, MD, Clayton

It was fascinating to see how nervous staff are about the imminent changes in their own individual healthcare choices and costs as PPACA is implemented.
- Jay Johansen, MD, PhD, Alpharetta

As we complete residency and enter practice, it is our duty to carry the flag for physician led health care.
- Chris Malgieri, MD, Atlanta

For effective advocacy, it is important to be educated on issues in other states and to build relationships with our own lawmakers.
- Justin Scott, MD, Alpharetta

With some perseverance, determination and organization we handle the issues at hand.
- Heather Dozier, MD, Atlanta

Why give?

Members contribute $51K to ASA PAC

ASA PAC is one of the largest 100 political action committees in the nation and America's largest physician PAC. In the 2011-2012 election cycle, ASA PAC raised nearly $3.5 million. These funds helped elect 23 new and 160 returning representatives, as well as three new and eight incumbent senators. Of the supported, 13 are physicians, including Andy Harris, MD (R-MD-1), the first anesthesiologist ever elected to Congress.

"PAC dollars empower and equip your lobbyists to advocate for sound health care policy," GSA lobbyists James E. "Jet" Toney told resident physicians at Georgia Regents University in April. Toney has materially participated in 38 sessions of the Georgia General Assembly and hundreds of political campaigns as staff, lobbyist, contributor or counselor. "The more support GSA and ASA supply to quality candidates, the higher effectiveness of both parent organizations' effectiveness in shaping public policy."

Tim Beeson, MD
GSA past president

The PAC gives you a seat at the table and, hopefully, off the menu.

In 2012, ASA PAC contributions from Georgia totaled $51,090, which came from 24.3% of GSA's membership.

Issues that affect Anesthesiologists have a profound effect on the AA profession, patient safety, and quality peri-operative care," said Claire Chandler, Immediate Past-President of the American Academy of Anesthesiologist Assistants. "It is an honor and a privilege to be able to foster trust in advocacy, represent our mutual concerns through a bipartisan team approach, and pursue our collective goals to ensure the best care for all by making a financial contribution to the ASA PAC."

Claire L. Chandler, AA-C
immediate past president, AAAA

Contributing to the ASA PAC is an opportunity to demonstrate my professional respect, appreciation, and support for the anesthesiologist-led anesthesia care team.

John Neeld, MD
ASA past-president

Supporting the PAC gives ASA and its representatives access to elected officials and staff so that we can make the case for preserving the anesthesiologist led care team to protect our patients.

How to Contribute

To make a contribution to ASA PAC, visit www.ASAhq.org/ASAPAC. Your username is your first initial followed by last name, and your password can be retrieved using the email address you provided to ASA during the membership renewal process. Once logged in, click on the ASAPAC tab and then the blue contribute button.

Contact the Washington Office at 202-289-2222 for details.

Georgians Support ASA PAC! (2013)

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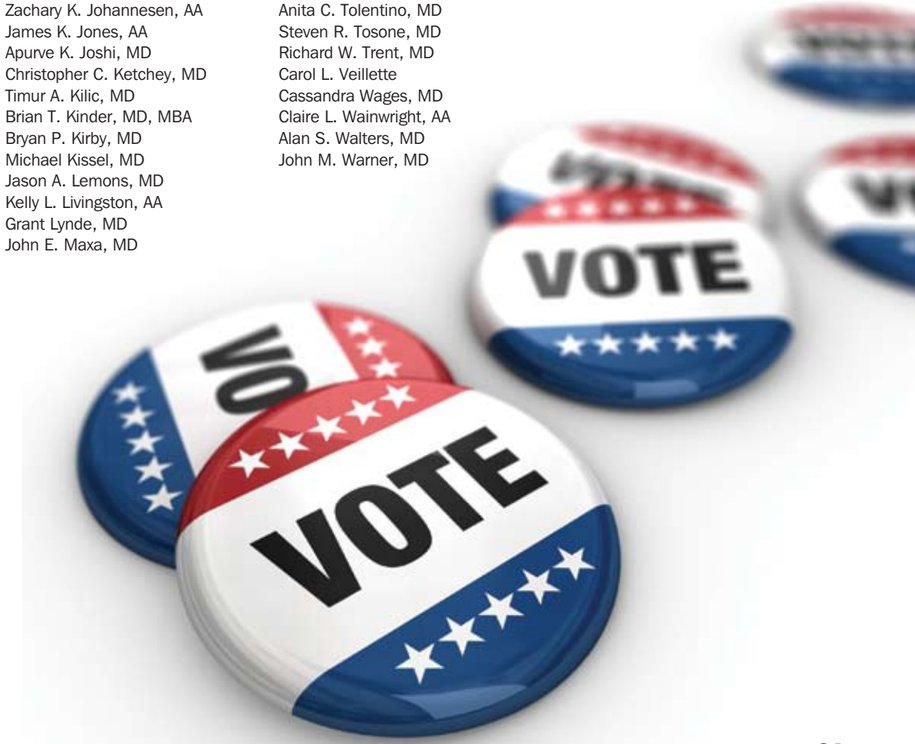

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Winter Forum
January 19, 2013

Drs. Colin Brinkman and Heather Dozier served as Activity Directors for the GSA Winter Forum in January.

Exhibitor VIPs

Anesthesia Business Consultants
Lisa Smith

Cadence Pharmaceuticals
Todd Shirley

CIVCO Medical Solutions
Gary Fuller
Erik Newby
Mike Saunders

Covidien
Chris Lengkeek
Maggie Pora

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Justin Grant
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Michael Basille
Amanda Nestlehutt

Pall Medical
Tom Knox

PharMEDium Services, LLC
Brad Settel

Preferred Physicians Medical
Gary Maughan
Steve Stark

Sensational Anesthesia Staffing
Nicole Castoreno
Alicia Worley

Guest Exhibitor:
Georgia PHP, Inc.
Robin McCown
Paul Earley, MD, FASAM

Remembering...

Editor's Note: The editorial policy of the GSA is to inform of the passing of members and other persons regarded by the Society. The Communication Committee chooses to conduct such notification through member email, e-News and SCOPE magazine.

Daufuskie Island, SC – (l to r) Yung-Fong Sung, MD, and her husband Steve Holtzman, PhD, with Don Drury, MD, and Phyllis Drury on the grand lawn of the hotel at the GSA summer meeting July 28, 2001.

Phyllis Drury

Phyllis Drury, wife of former GSA President Dr. Don Drury, died on December 10, 2012.

Mrs. Drury, age 68, of Valdosta, Ga. was a graduate of the Medical College of Georgia where she received a BS in Radiological Technology. She also attended the University of Georgia where she was a member of Zeta Tau Alpha Social Sorority. Mrs. Drury co-founded Executive Travel, a travel agency in Valdosta. A member of Park Avenue United Methodist Church since 1973, Mrs. Drury served on a number of church committees. She also was a member of the Junior Service League and chaired the organization's Arts and Crafts Fair.

Mrs. Drury is survived by her husband, Dr. Don Drury, who has been a member of GSA for 39 years and served as president in 1984. Other survivors are her two sons and a daughter- in-law, Dow and Jennifer Drury of Bluffton, SC, Clark Drury of Brunswick; five granddaughters, Gracyn Drury, Emma Drury, Kendall Drury, Maggie Drury, Reagan Drury; her mother, Margaret Clark Whitaker of Valdosta; sister and brother-in-law, Peggy and Mike Pollock of Elgin, Texas.

The funeral service was held on Thursday, Dec. 13, 2012, at Park Avenue United Methodist Church.

Compiled from GSA files and the Valdosta Daily Times.

Stephen G. Holtzman, PhD

Stephen G. Holtzman, husband of GSA Treasurer Emeritus Dr. Yung-Fong Sung and past-president of three professional societies including the American Society of Pharmacology and Experimental Therapeutics, passed away on April 23, 2011. Born in Brooklyn, NY on August 14, 1943, he received his B.S. in pharmacy from Columbia University in 1965, and Ph.D. in pharmacology from the University of Michigan in 1969, where he studied in the laboratory of Julian Villarreal. That same year, Dr. Holtzman joined the Department of Pharmacology at Emory University as a postdoctoral fellow and spent the rest of his career at Emory until retiring as Professor in 2007.

One of his lasting scientific achievements is the principal role he played in the development and validation of behavioral drug discrimination in the characterization of CNS-acting drugs. He was among the first to propose that the discriminative stimulus effects of drugs in animals are analogous to their subjective effects in humans. His published reports in the 1970s through the 1990s contributed significantly to the eventual widespread adoption of drug discrimination methodology within the scientific community. The method is used widely to study drug-receptor interactions in behaving organisms, and has also become a standard screening procedure within the pharmaceutical industry as it can provide important information for early decision-making on new compounds in the early stages of preclinical development.

At Emory Dr. Holtzman was well known as an outstanding research mentor. He trained 17 PhD graduate students and mentored 21 postdoctoral fellows.

Compiled from GSA and Emory University files.

Dr. Denson

Donald Denson, PhD

Donald Denson, PhD, age 67, of Lilburn, Georgia, died November 18, 2012. Dr. Denson was an affiliate member of GSA since 1990.

Dr. Denson began his medical career at Stanford University in Palo Alto, Calif.; continuing to the University of Cincinnati School Of Medicine, where he remained for 14 years. In 1990, he moved to Atlanta, with his family, to pursue a career at Emory University School of Medicine. He retired from the Anesthesia Dept. of Emory University in August 2011 where he was a clinical pharmacologist and an Associate Professor of Anesthesiology. His tireless research efforts in the alleviation of pain were the focus of most of his academic life.

Dr. Denson served four years in the Air Force in the 1960s. After his service, he continued to pilot his own small plane for many years. He is survived by his wife of 32 years, Jeannine Overholser Denson; son, Chad Denson, Birmingham, Ala.; son, Todd Denson and fiancée, Kayla Jeffries, Lilburn, Ga.; and son, Zachary and wife, Grace Denson of Leesburg, Fla. His final resting place is Oakdale Cemetery in Urbana, Ohio.

Compiled from GSA files & the Gwinnett Daily Post.