virginia society of anesthesiologists

UPDATE

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SUMMER 2021: **CONTROVERSIES IN ANESTHESIA**

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Feature Article

Friend or Foe: Legalizing Cannabis in Virginia

By Jeffrey Katra, DO
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Dr. Jeffrey Katra

In the past few years, cannabis in Virginia has gone from a banished foe to an increasingly friendly acquaintance.

Since the 1930's it has been propagandized as the "demon weed" that could cause everything from teenage zombiedom to desperate prostitution. The D.A.R.E. campaign in the 1980's likened cannabis use to one's brain frying in a hot skillet like an egg. Despite these colorful past categorizations, cannabis, along with other Schedule 1 substances like psilocybin and LSD, has reemerged in the medical community because of its potential therapeutic uses.

In 1979, Virginia passed legislation allowing doctors to recommend cannabis for glaucoma or the side effects of chemotherapy. In early 2016, Virginia allowed medical cannabis for the treatment of intractable epilepsy. The aforementioned medical use of cannabis was protected by the "affirmative defense," the opportunity for a patient to present their medical documentation in court to quell legal charges.

Since July 2020, medical cannabis has been legal in Virginia and can be recommended by state certified medical practi-

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Reduce Pollution by Eliminating Anesthesia Gases

By Matthew J. Meyer, MD
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Disclaimer: Matthew Meyer serves as a member on the steering committee of "Virginia Clinicians for Climate Action".

Dr. Matthew J. Meyer

The United States healthcare industry creates 8.5% of the United States' carbon footprint.[1] NHS (National Health System) UK estimates 2% of its carbon footprint comes from anesthesia gases.[2] In a single hospital, anesthesia gases may be up to 63% of the carbon footprint of the entire operating room suite.[3]

As anesthesiologists, we can make a major improvement in the health of the world simply by dialing back (or off) our volatile anesthesia consumption.

The health of our patients is dependent upon the health of our community and environment. Fossil fuel pollution has been linked to 10 million deaths per year.[4] Pollution and waste directly and indirectly cause exacerbations of acute and chronic health conditions. In respect of the impact humans are having on the world, the World Health Organization identified climate change as

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vsa virginia society of anesthesiologists UPDATE

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The ***VSA Update*** newsletter is the publication of the Virginia Society of Anesthesiologists, Inc. It is published quarterly. The VSA encourages physicians to submit announcements of changes in professional status including name changes, mergers, retirements, and additions to their groups, as well as notices of illness or death. Anecdotes of experiences with carriers, hospital administration, patient complaints, or risk management issues may be useful to share with your colleagues. Editorial comment in italics may, on occasion, accompany articles. Letters to the editor, news and comments are welcome and should be directed to: Brooke Trainer, MD • brooke@gvsahq.org.

SAVE THE DATES

ANESTHESIOLOGY 2021
October 8-12, 2021
San Diego, CA
https://www.asahq.org/annualmeeting

ANNUAL VSA LUNCH AT ASA
October 9, 2021
Tentatively scheduled for the
Marriott Marquis San Diego Marina,
San Diego, CA

MSV WHITECOATS ON CALL LOBBY DAY
January 25, 2022

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The Arts

COVID Pandemic Anniversary

By Jaikumar Rangappa, MD, DABA, FACA
Retired Lt Col US Army,
Desert Storm Veteran
Hampton, VA

Dr. Jaikumar Rangappa

WHO declared global COVID pandemic a year ago
With remote online learning, students to school forgo
With shortage of essential workers all did frown
Republicans & Democrats in politics booed down.

COVID virus spread everywhere like a wild fire
As firefighters doused burning CA homes & tire
Food and toilet paper were city people's desire
Shortage of which caused politicians to conspire
To blame President Trump in Washington's mire
And governor Cuomo's Nursing homes dead retire.

Doctor Fauci predicted the deadly viral calamity
With his sincere daily advice on TV did he pity
The indifference of government & people in city
Over half a million died of the Corona disease
The blame games of the wily politicians did not cease.

As many states opened businesses and restaurants
Pandemic spread all over again with Fauci's taunts
President Biden inherited Covid virus in the new year
With new strains virus & vaccine shortage as the fear
An aging new confused US President is so lost
And his first term to help America may be the last.

Airlines fly with passengers few, movie theaters closed
As the wild citizenry to the spreading virus were exposed
Sports Stadia with no games all but remain empty
Though Netflix and Amazon TV got rich fast plenty.

Investors on Wall Street became millionaires overnight
As many lost jobs and homes & starved day and night
Social isolation has hit the depressed and the lonely
Many mourn deaths in the nursing homes patients sadly
Lockdowns are different by race, gender and class
As men and women & children experience a loss.

Home offices opened up for business, shut down city
Road traffic & pollution came down, thanks Almighty.
With the rains and floods, fires, and the mudslides
Marriages are postponed, wait the lonely grooms, brides

The corona virus has killed the rich and the poor
Greed & exploitation will not be tolerated any more
Lord has warned and sent a message door to door
To help and share God's planet with all and adore!

Common Goals Don't Eliminate Controversy

By Marie Sankaran-Raval, MD
President, VSA

Dr. Marie Sankaran Raval
VSA President

The practice of medicine has always been fraught with controversy across all specialties. Examples include end of life care, childhood vaccinations, circumcisions, and genetic engineering, just to name a few.

As anesthesiologists, we face controversial surgeries everyday such as organ transplantation, bariatric surgery, and abortions. Our goal, above all else, is to provide quality anesthesia care and keep the patient safe.

As a practicing pediatric anesthesiologist at VCU Health, I have faced controversial situations, such as guardianship issues or a lack of consent for blood transfusions. Taking a step back and proceeding with the welfare of the child as the guiding principle helps to procure an appropriate and safe solution.

We encounter disputes outside of the operating room as well. A legislative issue that has been controversial in medicine over the past few years is "Surprise Billing."

Surprise Billing refers to an insured patient unexpectedly receiving a large medical bill from an out-of-network provider for services rendered. This most often occurs with emergency visits when the patient does not have the time to determine if the physician, ambulance, or hospital is in their health plan's network.

This is unfair to the patient and ultimately represents a war between physicians and the insurance companies who want to use their own fee schedule. In the state of Virginia, we have worked tirelessly with our lobbyists and were successful in getting legislation approved towards this issue in the spring of 2020.

It allows out-of-network providers to be paid the commercially reasonable amount, based on payments for the same or similar services provided, in a similar geographic area, as determined by an advisory group, and the Virginia Health Initiative. The VSAPAC helped earn this win and we are thankful for your support.

And let us not forget the COVID-19 pandemic, which has wreaked havoc on our healthcare system and created multiple ethical dilemmas.

The lack of PPE and the need to ration available resources amongst front line workers was alarming. Another devastating reality was the limited number of ventilators in various countries, causing adequate care to be withheld from patients.

Healthcare disparities were made strikingly evident by the large number of COVID infections and deaths amongst different racial and ethnic groups.

And finally, vaccine trials created debate as trials on secondary vaccines were started after a vaccine had already been deemed safe and effective. Was an effective treatment being withheld during a pandemic or was a more novel vaccine being trialed that could improve immunity?

While COVID numbers are decreasing and the CDC has withdrawn their indoor mask mandate for vaccinated individuals, we should all maintain vigilance and continue to practice safely and cautiously in the months ahead.

I hope you enjoy this issue as we explore more controversies in Medicine and Anesthesiology including Informed Consent, Medical Malpractice, and Medical Marijuana Legislation.

There is also a review of the Anesthesia Care team model explaining the differences between Certified Anesthesiologist Assistants (CAAs) and Certified Registered Nurse Anesthetists (CRNAs).

As always, feel free to reach out to me at marie.sankaranraval@vcuhealth.org or to your local VSA representative if you have any issues you think we can offer assistance.

We are here to help and I believe our voice is stronger together.

Encourage Your Practice Administrators to Join VSA

VSA encourages your practice administrators to join! We have two options:

1 If 90% or more of a group's physician anesthesiologists are VSA Active Members in good standing and all members will be on a single group bill, the annual dues are FREE.

2 If less than 90% of a group's physician anesthesiologists are ASA Active Members in good standing, or the group does not participate in group dues billing, the annual dues are $75.00

To have your practice administrator join, go to: https://www.asahq.org/member-center/join-asa/educational

- Click on Anesthesia Practice Administrators and Executives – Educational Member
- Click on the + sign next to the title
- The box that opens will contain full details and the membership rate(s)

Pushing OSA Guidelines into the Next Decade: Integrating Patient Safety with Perioperative and Precision Based Medicine

By Daniel H. Gouger, MD
Resident Editor, VSA Update Newsletter
VCU Health Department of Anesthesiology


Dr. Daniel H. Gouger

We've come a long way in anesthesiology since 1984, when movies like Sixteen Candles, Karate Kid, and Footloose were in theaters. But, the nostalgia of those also reminds us that that was only thirty-seven years ago.

An effort at that time, between the University of Washington at Seattle and the American Society of Anesthesiologists, resulted in the Closed Claims Project to analyze closed malpractice claims and trends in anesthesia-related patient safety topics.

Early data in the 1990s and 2000s showed claims transitioning from surgical anesthesia to chronic and acute pain management, as well as monitored anesthesia care cases. And while regional pain management claims still accounted for approximately twenty percent of cases (even through the late 2000s), respiratory system management issues were still seventeen percent of the mix, with approximately a quarter of those respiratory claims due specifically to inadequate oxygenation and ventilation.[1]

The Closed Claims Project (CCP) is a relevant historical narrative for understanding inadequate oxygenation, ventilation, and the emergence of practice guidelines for perioperative management of Obstructive Sleep Apnea. Between CCP data and a rising incidence of case reports over two decades correlating adverse outcomes to poorly optimized OSA, in 2010 an interdisciplinary group of anesthesiologists, surgeons, sleep physicians, and scientists formed the Society for Anesthesia and Sleep Medicine (SASM)[2].

> *The concept and physiology of airway obstruction is seemingly straightforward to the anesthesiologist. However, the 2016 Guidelines from SASM underscore that up to ninety percent of patients with moderate to severe obstructive sleep apnea are undiagnosed, and often present for surgical interventions.*

As a group, they spearheaded the formation of the OSA Near Miss and Death Registry as part of the CCP, as well. Their specific mission in part was, and continues to be, advancing standard of care for perioperative management of sleep disordered breathing.

And while the ASA (among other specialty organizations) had released guidelines in 2006 with updates in 2014, in 2016 SASM sought to publish practice guidelines that underscored evidence of OSA as a perioperative risk factor. These guidelines also offered insight on objective assessment to identify patients with OSA and sought to establish a focused, practical approach to OSA that reduced postoperative adverse events while being thoughtful toward allocation of healthcare resources.[3-4]

It's worth the time, then, to unify some terminology. Sleep Disordered Breathing is an umbrella term for a constellation of sleep related breathing disorders, as well as abnormalities of respiration during sleep that do not meet criteria for a disorder.

In general, there are three characteristics used to describe sleep disordered breathing events: duration, amplitude, and what their end consequences are on oxygen saturation or maintenance of sleep. Using those characteristics, we can describe four types of respiratory events: apnea, hypopnea, respiratory effort related sleep arousals, and snoring.

These events are either centrally mediated events, where there is a lack of inspiratory effort, or obstructive events, where inspiratory effort is maintained or increased in the setting of airway narrowing or collapse, resulting in apneas and hypopneas. Overall, sleep related respiratory events produce increased sympathetic activity/stress, surges in blood pressure, and sleep disruption or fragmentation, as well as hypoxemia.[5]

The concept and physiology of airway obstruction is seemingly straightforward to the anesthesiologist. However, the 2016 Guidelines from SASM underscore that up to ninety percent of patients with moderate to severe obstructive sleep apnea are undiagnosed, and often present for surgical interventions.

SASM further recommends that patients with a diagnosis of OSA should be considered at increased risk for perioperative complications. All adult patients at risk for OSA should be identified before surgery using screening tools such as STOP-BANG, the Berlin criteria, ASA checklist, or other validated screening instruments and questionnaires.

Notably, though, they highlight that there is insufficient evidence to support canceling or delaying surgery to formally diagnose OSA in those patients identified as being high risk of OSA preoperatively unless there is evidence of poorly controlled systemic disease or additional problems with ventilation or gas exchange.[4]

The role of anesthesiologists as perioperative physicians and experts in patient safety becomes pointed, then. Many institutions at this point have implemented streamlined pathways for identification, risk stratification, optimization, and surgical location and resource planning for this patient population.

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You're Getting on My Nerves… But Isn't That the Point?

Brooke Trainer, MD, FASA
Editor, VSA UPDATE Newsletter


Dr. Brooke Albright-Trainer

Do I have your attention? Being triple - specialized in Anesthesiology, Acute Pain, and Intensive Care, I sometimes find myself thinking about patient problems in unique ways.

For example, in October 2019 when a young patient in his 20s presented to the Neuro-Intensive Care Unit at UVA with Guillain Barre Syndrome, paralyzed and intubated on mechanical ventilation, in severe pain with autonomic dysfunction, my mind went to whether I could use peripheral nerve stimulation (PNS) as an alternative, non-pharmacologic, analgesic modality to get him through his acute illness and minimize his pain and suffering.

The rest of the ICU team at the time thought I was kidding because this modality of therapy had never before been tried in this patient population. As the ICU team increased his opioid and gabapentin dose, I went back to the literature and found a case of GBS in the 1970s where they had tried transcutaneous electrical stimulation with some relief in a GBS patient who presented to the pain clinic years after their initial presentation with chronic pain. This was reassuring that electrical stimulation may be useful in GBS.

The idea for PNS in GBS came to me through my work on a pilot study with a wonderful team of researchers at McGuire VA, implanting PNS in amputee patients with acute pain in the perioperative period. I had witnessed the dramatic reductions in pain scores in these patients which occurred immediately upon placing and activating the device. I saw first-hand how PNS was working to control amputee's phantom (neuropathic) limb pain.

The patient I encountered in the Neuro ICU did not seem so different – he was also experiencing severe neuropathic pain. Unlike the amputee patients, the pain was in every limb! He described it as a sharp burning pain that made his entire body feel like it was on fire. No wonder this young man's heart rate was in the 160s and blood pressure was in the 180s/100s – the neurologists called it "Autonomic Dysreflexia", but to me, this was due to severe excruciating pain! After all, he felt like he was on fire!

> *In medicine, there is only one thing we clearly know, and that is, we do not have all the answers. There is still plenty we haven't figured out. I hope this issue gives pause, opens your eyes to new and diverse perspectives, and allows you to consider alternative solutions – after all, medicine is just as much an art as it is a science.*

Rather than watch him become more and more sedated on intravenous pain meds, all of which are well known to have detrimental long term side effects, I advocated to place peripheral nerve stimulation therapy. I spoke with experts around the country who utilized PNS in their practice, none of whom had done so for GBS patients, but all of whom thought it was "worth a shot".

After obtaining full informed consent from the patient and his family, explaining that this had never before been tried for GBS, they agreed to allow me to place six leads, two around his brachial plexus, two around his femoral, and two around his sciatic nerves. The results were immediately evident – he had a dramatic decrease in his pain scores, level of satisfaction, and psychometric scale scores – for the first time in weeks he slept eight hours straight!

Over the next few days, his IV pain meds and adjuncts were weaned, his vital signs improved, and most importantly, now that he was feeling better, he was able to smile and wanted visitors to come and visit, evidence that his psyche had also improved (this was of course prior to covid).

The point of this story, and this issue on "Controversies in Anesthesia", is that we, in medicine, are still learning. This quarter's newsletter issue is dedicated to the themes and topics that many of us question, but either don't have the answers, or don't dare discuss for fear of being judged, uncomfortable, or on the wrong side of the issue.

In medicine, there is only one thing we clearly know, and that is, we do not have all the answers. There is still plenty we haven't figured out. I hope this issue gives pause, opens your eyes to new and diverse perspectives, and allows you to consider alternative solutions – after all, medicine is just as much an art as it is a science.

When the VSA newsletter staff and I came up with the idea for this theme, we were uncertain whether we'd garner any interest from authors. Fortunately to my surprise, this theme has become one of our most popular to date!

This issue covers a well-rounded variety of controversial topics, ranging from scope of practice, reintegration into Anesthesiology after addiction, use of medical marijuana, to the banning of inhaled anesthetic gases. Trust me, you don't want to miss reading this!

I'm thrilled the *VSA Update* is able to offer a platform for advocates standing up for thoughtful, well researched, relevant issues to anesthesiologists of Virginia, for an opportunity to affect change in our community.

Thank you to all the brave advocates willing to "Be the change that you wish to see in the world." — Mahatma Gandhi

Enjoy this issue!

And while most anesthesiologists at this point are familiar with CPAP therapy, it's worth pointing out that there are other management approaches. Simple weight loss of 5-10% of starting weight for most OSA patients will yield improvement in their Apnea-Hypopnea Index (AHI).

Although not as common or tolerated as CPAP machines, dental colleagues can fit OSA patients with oral appliances or mandibular advancement devices. Likewise, ENT surgical interventions like turbinate reductions, tonsillectomies and adenoidectomies, uvular reconstruction, or maxillary/mandibular advancements are all considered in some refractory patient populations.

Hypoglossal nerve stimulators which require drug-induced sleep endoscopies to assess oropharyngeal collapse patterns may be considered. Ultimately, though, we still rely on CPAP with guidelines recommending having equipment available for perioperative use or having the patient bring their own.[3-4]

Two randomized control trials from 2016, the RICCADSA study by Peker et. al and the SAVE trial by McEvoy et. al, both elucidate some worthwhile points regarding OSA. Night-time CPAP adherence often falls below three and a half to four hours of use, an inflection point at which the potential comorbidity benefits may be lost. This has led to evolution in CPAP fitting technology.

Likewise, OSA may have just as much impact on neuro/cerebrovascular outcomes as it does primary cardiovascular outcomes. But most importantly, these articles suggest that OSA is not a monolithic disease among all patient groups.[6-7]

A 2020 review article by Zinchuk et al. in CHEST proposes current guidelines for OSA reflect a one-size fits all approach whereby polysomnographic data are reduced to a single metric, like the Apnea-Hypopnea Index (AHI), and then patients are managed with CPAP trial and error.[8] Refractory cases may be referred to other treatments like oral appliances, stimulators, or surgical interventions as abovementioned.

But the article suggests different patient populations have varying OSA presentations in snoring and daytime somnolence versus insomnia and restlessness, as examples. Some patients may be at extremes of age, or some may not fit the conventional obese archetype; and these characteristics do not always predictably correlate to severity of the AHI score.[8]

While not yet fully demonstrated as reproducible in high powered studies, the prospect of these OSA "phenotypes" illustrates the potential for tailored approaches to perioperative management for OSA.

For instance, certain subgroups could theoretically benefit from new preoperative referral pathways for early evaluation for oral appliances, surgery, or other medical therapies beyond CPAP. Subgroup typing could justify additional postoperative risk mitigation resources in certain surgical settings or could potentially be paired with other objectively laboratory data points such as hemoglobin and serum bicarbonate to propose new risk stratifying models. Certain subsets of patients may be more at-risk for postoperative cognitive impairment as a cerebrovascular complication rather than typically thought-of cardiopulmonary sequelae.

This tailoring concept is paralleled in the Precision Medicine Initiative by NIH Director Francis Collins.[9] While first applied to oncologic management, precision medicine is quickly being extrapolated to a whole range of health and disease and undoubtedly will reach perioperative medicine.

So, as we reflect on Guideline updates from 2014-2016 from various specialty societies, the concept of individually varying presentations of OSA should challenge us to consider future optimization possibilities and our roles as anesthesiologists. OSA ultimately is a pathology-centered case model for what our specialty strives for with Enhanced Recovery After Surgery and the Perioperative Surgical Home paradigms.

Figuring out how to marry systems level patient safety and optimization pathways, then, with precision-based medicine principles yields exciting opportunities for anesthesiologists to continue to grow as leaders in perioperative medicine.

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tioners for any medical purpose without the need for an affirmative defense. Presently, dozens of different cannabis strains, all of which have different amounts of phytocannabinoids like THC and CBD, are available in Virginia.

Virginia has also moved to change the legality of non-medical cannabis possession and distribution. By July 2021, most cannabis possession, whether it is medicinal or not, will be largely decriminalized. No penalty will be imposed for possession of up to 1 oz., and a small $25 civil penalty will be administered for possession of more than 1 oz. and up to 1 lb. of cannabis.

The state will also allow patients to grow up to four cannabis plants at their home for personal use. Finally, Virginia became the first Southern state to legalize recreational cannabis with a plan that will take effect in 2024. Yet, the question remains for doctors: is cannabis a friend or a foe?

Cannabis Safety Profile

The CDC has clarified that cannabis is not a gateway drug; it does not necessarily lead to the use of more harmful substances. Moreover, its abuse potential has been shown to be relatively low: cannabis is about as addictive as caffeine and is not associated with any mortality.

High THC strains carry with them a greater chance for cannabis use disorder (albeit a relatively small one), while more balanced strains or those high in CBD have a lower risk. Most adverse health effects can be mitigated if users avoid smoking or vaping and, instead, chose to use other available formulations such as tinctures, edibles, capsules, lotions, suppositories, and patches.

In general, it is safer for the average person to use cannabis when compared to alcohol and cigarettes, both of which increase mortality and have a high addiction potential. Likewise, cannabis is often safer than many commonly prescribed medications including opioids, benzodiazepines, and hypnotics, which can be highly addictive or deadly when taken incorrectly. Compared to other legal substances and non- Schedule 1 medications, cannabis is typically safer.

Cannabis as Medical Treatment

Cannabis has been shown to be an effective treatment for many common medical disorders. First, cannabis has been studied for chronic neuropathic pain and has been shown to reduce pain in patients by 30%. In states where cannabis is legal, it has been correlated with a reduction in the use of opioids for both medical and recreational reasons, and, consequently, a reduction in opioid overdoses and deaths.

> *In sum, cannabis is a substance with a relatively safe, medicinal benefit in multiple disorders, a fact that makes its categorization as a Schedule I substance incorrect and stifling to further research.*

Second, cannabis has been shown to be an effective antiemetic and appetite stimulant in patients receiving chemotherapy treatment for cancer. Other studies even show that cannabis can cause apoptosis in tumor cells and may even work synergistically with certain cancer treatments.

Third, cannabis has been shown to decrease spasticity and pain in those with neuromuscular disorders like Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Parkinson's disease, and Huntington's disease.

Fourth, cannabis has been shown to decrease or even completely resolve intractable seizure disorders in children.

Fifth, there is growing evidence that cannabis can help treat insomnia as well as refractory anxiety disorders like PTSD. A list of potential medical uses for conditions such as IBD, glaucoma, HIV, addiction, Tourette's syndrome, ADHD, and insulin resistance are also being investigated with studies and clinical trials.

In sum, cannabis is a substance with a relatively safe, medicinal benefit in multiple disorders, a fact that makes its categorization as a Schedule I substance incorrect and stifling to further research.

Cannabis, Social Justice, and State Revenue

Many advocates of recreational legalization cite issues of unnecessary government intrusion and inequities in the criminal justice system. Why should the government outlaw a plant that has been proven to be safer than alcohol and cigarettes, both of which are legal?

In recent years, cannabis legalization has been seen as a mechanism of social justice: freeing the legions of poor, minority prisoners who were unfairly targeted and brutalized with severe sentences that destroyed their own lives and the lives of their families.

According to a 2020 ACLU study, "Black people are 3.64 times more likely than white people to be arrested for marijuana possession, notwithstanding comparable usage rates. In every single state, black people were more likely to be arrested for marijuana possession, and in some states, black people were up to six, eight, or almost ten times more likely to be arrested."

It is an unavoidable fact that laws banning cannabis possession and distribution have disproportionately led to the incarceration of minority groups and those with lower socioeconomic status.

Legalizing cannabis has also been seen as a way of increasing state tax revenues while taking money out of the hands of illegal drug cartels. Colorado, for example, which legalized cannabis in 2014, has seen increased revenues in the tens of millions of dollars. The state collects a 2.9 percent sales tax from both medical and recreational sales and a 15 percent excise tax when cannabis moves from grower to seller.

The 2.9 percent sales tax on medical marijuana goes entirely into the Marijuana Tax Cash Fund. According to Amendment 64, the first $40 million or 90 percent (whichever was greater) was to go to a capital construction grant program, where schools, districts, and various education providers could apply for money to build new buildings, renovate existing facilities, and create other educational programs focused on youth prevention.

In 2018, more than $20 million went to grants for school health professionals, early literacy programs, and dropout and bullying prevention. Thus, legalizing cannabis could not only help treat medical conditions; it could also help mitigate other ails of society.

Cannabis Risks and Contraindications

Continued on page 9

Cannabis, however, poses significant risks to certain patient populations, a fact that makes its legalization for recreational purposes problematic.

There are certain patients for whom medical cannabis should be contraindicated, or, at least, monitored for the risks and benefits of use. First, cannabis has been shown to significantly increase the chance of a psychotic break in those predisposed to schizophrenia.

In recent studies conducted in the Netherlands, researchers estimated that 30%-40% of cases of psychosis in that country could be prevented by limiting recreational cannabis. The added issue is that many people seek out cannabis, whether recreational or medicinal, because they have not had a proper psychiatric evaluation or an optimized trial of psychiatric medications for common diagnoses like anxiety or depression. Self-medicating without the input of a doctor is common.

Second, pregnant women should not use cannabis. It crosses the placenta and is found in breast milk. Studies have shown that infants who have been exposed to cannabis in utero have a higher risk for various psychiatric disorders such as depression, anxiety, ADHD, and even autism.

Third, cannabis use has been shown to adversely affect the neurodevelopment of children, which can cause amotivation and lower levels of educational attainment later in life. Likewise, as with many substances, chronic cannabis use at an early age can prime the brain for psychiatric and substance use disorders later in life.

To be fair, newer studies challenge the aforementioned conclusions, arguing that amotivation, lower educational attainment, and a higher chance for psychiatric issues is only correlated, but not caused by cannabis use. In other words, children who are otherwise prone to negative educational outcomes and psychiatric disorders seek out marijuana.

The data is mixed on whether legalizing recreational cannabis has led to a significant increase in use by adolescents. A current and sizable project called "The ABCD Study" will hopefully shed more light on the prevalence and effects of adolescent cannabis use.

Fourth, while cannabis use has been shown to decrease overall opioid use, there are also studies that show that chronic cannabis use can cause relapses in patients with opioid use disorder because it may, over time, "disinhibit" those with preexisting addictive tendencies.

Just as we have yet to uncover all of the potential medical uses of cannabis, we may also have yet to uncover all of the possible adverse effects, which provides yet another argument for cannabis to be removed from Schedule 1 status so it can be researched further.

In addition to contraindications, the other concern with legalizing cannabis for recreational purposes is that customers will purchase products without necessarily knowing which products can help them with their specific symptoms and which products can actually worsen them.

For someone seeking to alleviate anxiety, for example, a high CBD strain of cannabis has been shown to be anxiolytic while high THC strains, the kind most popular on the illegal market, have been shown to increase anxiety. Likewise, someone with addictive tendencies could buy a high THC strain of cannabis, which carries with it an increased chance of abuse (albeit still a low one) when compared to a high CBD strain.

Furthermore, in an age when "medical information" can be posted by anyone with a computer, where can patients go for reliable, evidence-based advice on cannabis use if not physicians? With recreational legalization, patients would lose the mandate to be medically screened and assessed for the proper cannabis strain and product.

Conclusion

While cannabis is relatively safe for most people, and has many proven therapeutic benefits, its properties could be utilized best under the supervision of a doctor who can evaluate a patient's history for contraindications and who can recommend proven strains and products to effectively help achieve their patient's stated goals. Cannabis can be most beneficial if it is coupled with safety measures and medical knowledge. It is one of the rare instances in life in which we can take a former foe, and, under the right conditions, make them a friend.

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Dr. Katra completed his Family Medicine training at Lower Bucks Hospital Family Medicine Residency in Bristol, PA. He is also a certified hypnotherapist who specializes in chronic pain, phobias, and addictive behaviors.

Dr. Katra has certificates in psychopharmacology from the Neuroscience Education Institute as well as in cannabis medicine from the Lambert Center for the Study of Medicinal Cannabis & Hemp at Thomas Jefferson University.

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the greatest threat to public health in the 21st century.[5]

Once administered, anesthesia gases are vented directly into the atmosphere. Volatile anesthesia gases are hydrofluorocarbons (desflurane and sevoflurane) and chlorofluorocarbons (isoflurane).[6] These volatile anesthesia gases along with nitrous oxide have tremendous atmospheric energy trapping capability.

Over a twenty-year period, desflurane has 3,714 times the energy trapping of carbon dioxide, isoflurane has 1401 times, sevoflurane is 349 times, and nitrous oxide is 289 times; notably, nitrous oxide's impact is underestimated using a twenty-year period as it remains in the atmosphere for 114 years.[7]

The movement to minimize or eliminate desflurane due to its financial cost and climate impact is mature.[8,9] Now, the focus is reducing the impact of the remaining anesthesia gases. The American Society for Anesthesiology sponsored the Inhaled Anesthetic Challenge 2020 with the goal of reducing anesthesia gas related emissions by 50%. NHS UK identified a reduction in the usage of anesthesia gases as a key step towards their goal of a 51% reduction in the NHS carbon footprint.[2]

As clinicians, our purpose is to care for our patients while avoiding unintended harm. If an equivalent option exists that results in less harm to public health, we are ethically obligated to choose this.

Volatile anesthetics could probably disappear from our armamentarium in adult anesthesia with minimal disruption to our ability to deliver high quality anesthesia. For patients who require general anesthesia, total intravenous anesthesia with propofol leads to greater patient satisfaction[10] and has a carbon footprint that is orders of magnitude less than volatile anesthetics.[11] For appropriate patients and procedures, neuraxial and regional anesthesia provide a huge potential reduction in climate and environmental impact compared to volatile anesthetics.[12]

Volatile anesthesia gases are frequently used because they are easy to use—they are built into modern anesthesia machines. Total intravenous anesthesia involves more setup. However, this slight time investment may prove beneficial to the large subset of patients; primarily, oncological patients[13] and patients with sensitivity to postoperative nausea and vomiting.[10]

> *People's health and well-being are affected by more heat waves, more flooding, more wildfires, and more and different vector-borne infectious diseases.19 Reducing the usage of volatile anesthetics will not independently stop climate change, but it can be done today, and provide additional time for our world to make and implement technological advances that may be needed to address the problem in its entirety.*

Transitioning from volatile anesthesia should be considered seriously. There does not need to be an abolition of volatile anesthetics, as they are the right tool in patients requiring mask inductions and other specific situations. However, there should be true clinical rationale for their utilization knowing the outsized harm they cause to the global environment and public health. Additionally, the mass adoption of alternatives needs to be done thoughtfully. If volatile anesthetics are replaced with increased nitrous oxide usage,[14] this may actually worsen the impact of anesthesia on the global environment and public health.

Sustainability interventions that reduce waste and use less energy often save money too. This was demonstrated by an educational intervention at UW Health directed at volatile anesthetics and reducing fresh gas flows. This multipronged intervention saved the health system $25,000 per month in volatile anesthesia expenditures while reducing the average CO2 equivalent emissions per patient by 64%.[15] The savings are even greater when the social cost of carbon is considered.

The social cost of carbon is an economic tool to financially assess the impact of energy trapping emissions on the world. A single ton of CO2 equivalent emissions is estimated to have a financial cost of $417.16 The 64% reduction in carbon equivalent emissions per OR case at UW Health saves approximately $120,000 in global financial loss each month.[16]

Climate change is an existential threat and many nations, including the US, are already being affected by climate related migration[17] and morbidity[18] such as that related to Hurricane Maria.

People's health and well-being are affected by more heat waves, more flooding, more wildfires, and more and different vector-borne infectious diseases.[19] Reducing the usage of volatile anesthetics will not independently stop climate change, but it can be done today, and provide additional time for our world to make and implement technological advances that may be needed to address the problem in its entirety.

If interested in learning more about these challenges, their impact on our clinical practice, and the opportunities that will come from solving them, there are many organizations local, national, and international, focused on the interaction of the environment and patient health and well-being.

A few notable organizations that are quite active include: Virginia Clinicians for Climate Action (virginiaclinicians.org), Practice Greenhealth (practicegreenhealth.org), and Healthcare Without Harm (noharm.org).

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TAP Blocks, To Consent or Not To Consent

By Steven Bradley, MD
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Dr. Steven Bradley

Regional anesthesia has become more popular in recent years due to several factors. An increasing prevalence of enhanced recovery after surgery (ERAS) protocols, increased access to improved ultrasound technology, and a greater appreciation for their opioid-sparing effects have made regional anesthesia a mainstay for a variety of practices.

One of the most ubiquitous blocks in an anesthesiologists' armamentarium is the Transversus Abdominal Plane (TAP) block. The TAP block is easy to perform, has a low-risk profile, and provides reliable analgesia for abdominal procedures. This procedure is so "safe", that some anesthesiologists wonder if it is appropriate to perform TAP blocks on anesthetized patients without obtaining consent.

A typical informed consent for a general anesthetic details common associated risks, including damage to the lips, teeth or gums, sore throat, hoarseness, pain, nausea, loss of airway. Uncommon, yet grave complications including heart attack, death or stroke should be mentioned as well and discussed as appropriate given a patient's comorbidities. If a regional technique or other invasive procedure is anticipated, they should be discussed. Clinicians know all-too-well that surgeries do not always go as planned. Surgical and anesthetic consent forms typically contain a clause explaining that the operative team will perform appropriate life-saving interventions as indicated.

TAP blocks are an adjunct to a multi-modal approach to analgesia. It is difficult to imagine a scenario when a TAP block would be regarded a life-saving intervention; however, if this scenario were to present, it would be appropriate to proceed based on one's clinical judgement. There are many scenarios when a patient would greatly benefit from a fascial plane block, especially in the setting of multiple co-morbidities when analgesia and opioid-reducing would greatly enhance recovery and possibly reduce morbidity. In these situations, it would be appropriate to consent the patient after emergence once capacity has been regained.

> *Some clinicians argue that TAP blocks have incredibly low rates of complications. Although this is true, clinicians should still refrain from performing a procedure for which a patient did not consent. The ethical principle of autonomy is not dictated by the associated procedural risks.*

Some clinicians may consider soliciting consent from the patient's medical decision-maker or healthcare power of attorney. However, since a TAP block is rarely (if ever) an emergent, life-saving intervention, this would be an inappropriate course of action. Obtaining consent from a surrogate decision maker should be reserved for situations in which a delay in care would lead to loss of life, limb, or increased morbidity.

Additionally, if it is likely that a patient will not regain capacity within a reasonable amount of time, then it would be appropriate to discuss goals of care with a surrogate decision maker and provide care that is conducive to the patient's prior-expressed goals. Soliciting consent from a surrogate decision-maker should be reserved for the gravest of circumstances.

Some clinicians argue that TAP blocks have incredibly low rates of complications. Although this is true, clinicians should still refrain from performing a procedure for which a patient did not consent. The ethical principle of autonomy is not dictated by the associated procedural risks. Autonomy is a patient's fundamental right to self-govern, and clinicians should attempt to respect this standard whenever possible.

A comparison has been made to establishing intravenous access. Anesthesiologists do not typically solicit consent prior to placing an IV in the preoperative holding area. However, a patient has consented to surgery and anesthesia merely by presenting to the hospital the day of surgery (likely following a work-up in the surgeon's clinic). Furthermore, a patient assents to an IV placement since they could at any point during the procedure, refuse all further attempts.

Performance of a TAP block should be preceded by an informed consent that discusses the possible complications that are common to all regional anesthetics: local anesthetic systemic toxicity, failed block, infection, hematoma, and/or damage to other structures. Respect for patient autonomy requires informed consent be obtained prior to performing an invasive procedure.

Some clinicians may argue that a TAP block is indicated for their patient based upon beneficence. Under the reasonable-patient standard, most patients would want the best option for pain management. Altruism makes it difficult to "doom" a patient to unmanageable post-operative pain. However, there are multiple options for post-operative pain control. Studies show that TAP blocks are not superior to a multi-modal analgesic approach to pain management that does not incorporate regional anesthesia. Alternative methods should be employed to provide adequate post-operative analgesia. Once a patient regains capacity, the clinician can discuss the risks, benefits and alternatives of a TAP block and solicit an informed decision.

Finally, some clinicians may argue that surgeons commonly perform TAP blocks without explicit informed consent. A surgeon's consent generally covers other indicated procedures. It is also not uncommon for surgeons to infiltrate local anesthetic into their surgical field.

A TAP block performed by a surgeon requires no significant deviation from their standard practice. However, as anesthesiologists, our standard practice is to obtain informed consent prior to performing an elective, peripheral nerve block. Diverging

Continued on page 13

Opioid Safety

Delegate Betsy B. Carr, 69th District, Virginia House of Delegates

Delegate Betsy B. Carr

Virginia, like much of the country, has battled an opioid epidemic for a long time, and, unfortunately, another consequence of COVID-19 is an increase in deaths by overdose. Staying at home, a lack of social interaction, loss of jobs, financial, and healthcare-related stress all weigh heavy on mental health and substance abuse issues.

I recently read a statistic from the CDC which stated that overdose deaths from all drugs (but largely driven by opioids) increased by 30% in 2020 compared to the previous 12 months. In 2019, the National Safety Council said a person is more likely to die of an opioid overdose than a car crash.

Because of this, for most of my career as an elected official, one of my priorities has been collaborating with the recovery community and healthcare professionals to introduce and advocate for legislation aimed at the reduction of overdose deaths.

In 2014, I was approached by individuals in my district who had loved ones either in recovery or who died of an overdose. As I spoke with my constituents and recovery groups, I learned that there had been opportunities for their loved ones to seek help when overdosing; however, the fear of getting in trouble with the law outweighed getting medical attention.

> *Saving lives is important to me. I believe addiction is a disease, not a crime, and people need help and access to recovery resources, not to be criminalized.*

As you know, the consequences of not calling 9-1-1 when overdosing are often fatal. Thus, I developed "Safe Reporting" legislation that would provide limited immunity for those who sought emergency medical attention when experiencing overdoses.

Given the composition of the legislature in 2014, it took several rounds of legislation from myself and other legislators on both sides of the aisle to get where we are today.

As recently as this past session, I supported a bill that expanded my initial "Safe Reporting" legislation. HB1821 becomes law on July 1, 2021, and ensures that individuals who are with the person overdosing are also immune from arrest or prosecution so long as they cooperate with law enforcement.

Additionally, it is now easier to access naloxone, a life-saving overdose reversal drug. Recent laws direct doctors to prescribe it along with certain opioids and expand who is authorized to administer naloxone.

While access to medical attention and naloxone has improved, there is still work to do in terms of preventing opioid use and misuse. Virginia was recently part of a multistate settlement with a consulting firm for its role in promoting and profiting off opioids and will receive more than $13.7 million.

HB2322, which passed in 2021, establishes the Opioid Abatement Authority and will use money from opioid-related settlements, judgements, and other court orders to fund grants and loans for the purposes of treating, preventing, or reducing opioid use disorder and the misuse of opioids.

Many opponents see these changes in the law as "get out of jail free cards," but for those with addiction issues, the idea of going to jail or getting in trouble is a deterrent from getting help.

Saving lives is important to me. I believe addiction is a disease, not a crime, and people need help and access to recovery resources, not to be criminalized.

If you or a loved one are struggling with an addiction to opioids or other drugs, the recovery community is available to help you.

Visit hardesthitva.com/resources to find a helping hand near you.

TAP Blocks, *from page 12*

from standard practice places clinicians into an area that may be difficult to navigate resulting in moral-distress, "doctor-shopping" or an internal ethical dilemma. The standard of care mandates an anesthesiologist solicits informed consent prior to performing an invasive procedure.

Although transversus abdominal plane blocks are a safe component of a multi-modal approach to analgesia, clinicians should always obtain informed consent prior to their performance. A simple solution would be encouraging clinicians to consent each patient undergoing intra-abdominal surgery for a potential TAP block. This approach allows for patient autonomy by providing a brief discussion of the associated risks and benefits of the procedure. Departments should work to develop policies and protocols, ensuring they provide standardized and consistent care.

Anesthesiologists must work to ensure ethical care is provided to all patients and for all services rendered.

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How I Became a Disabled Physician

By Stephanie Pearson, MD, FACOG
President, Pearson Ravitz Insurance


Dr. Stephanie Pearson

I was at the height of my career. I had just been asked to be the chairperson for our department. I was happily married with two small boys. I loved my life. We had plans to travel, to buy a bigger house, to live the dream. Then it all changed.

I was called to the labor floor for a precipitous delivery. Baby number four. They should have fallen out. Instead, as I arrived, fetal heart rates were in the 50s. My patient was complete and climbing up the bed. Too late for an epidural, the nurses and I coaxed her into position as I applied a vacuum to the baby's head.

As I was guiding the baby out, my patient kicked me. It felt like a direct hit to my brachial plexus and my left arm went numb. I felt tears well in my eyes but I still had a baby to deliver. I turned my body, hoping to protect myself. Unfortunately, a second kick occurred and I knew something was wrong. The baby was safely delivered, the nurses took over and I went to the emergency department.

Fast forward - I had a torn labrum which I was told would heal. I had steroid injections and cancelled surgeries for a month. I started losing range of motion. The pain worsened. It felt like no one believed me. I was figuring out how to compensate during exams, deliveries and surgeries when I restarted.

I knew something was not right. However, our profession is tough! Many doubted me openly and behind my back. I started to question myself. The tyranny of perfection that exists in medicine is real. We all know physicians who have come to work sick, in pain, or undergoing treatment for illnesses when we would have insisted that our patients rest and recuperate.

When I was finally diagnosed with a frozen shoulder several months later, I felt validated. I would need surgery to get back to myself. Unfortunately, after surgery, I continued to have significant range of motion deficits and chronic pain which would preclude me from performing the tasks for which I had spent the better part of my life training.

Before the surgery, my last day as a clinician, I could not get my left arm to do what I needed it to do and realized that I could not practice safely or ethically.

What now? I was in pain, I lost my identity, I had a family to help support. I was the primary breadwinner. Hours of physical therapy and mental therapy ensued. My husband thought we'd be okay financially, as we had prepared. I had a private disability policy, we had a group long term disability (GLTD) policy at work, and this was a workers' comp case.

We were shocked when we realized that we were not as prepared as we thought. First, the group benefit that I thought I had, in fine print, did not cover work related injuries. I was flatly declined and told I would have been better off had I fallen off my bicycle.

While that is the exception to the rule as far as GLTD policies go, I am seeing it more and more since COVID started. I am seeing policies that won't cover work related injuries or illnesses. Second, workers' comp initially declined my case. They said that, while my injury occurred, my frozen shoulder was idiopathic or my fault because I continued to work while injured. I had to sue for my benefit.

Fourteen months and three court appearances later, I settled. I couldn't take it anymore. During my case, it was suggested that I could be a billing secretary because I had the aptitude to learn codes. By the way, workers' comp varies by state. In PA, it maxes out at $3,500 a month.

Third, I found out that my private IDI was not as strong as I thought. I had two policies - one was truly specialty specific while the other was not. Thankfully, we had an emergency fund and my flight nurse husband could pick up more shifts while we were waiting for everything to work out.

It was a horrible thought to think that my family would've been better off financially had I died, instead of becoming disabled.

I have to admit that the loss of my identity was the hardest part. I felt like I didn't fit in anywhere; not with my working mom friends, not with my SAHM friends. My physician friends were some of the toughest. I like to think that they meant well, but hearing things like "You should be happy to be out of medicine," "Kick me in the shoulder if it means I can stop working," would reduce me to tears.

Even worse were the naysayers, "you really can't do your job anymore?" Or, "it's just your shoulder." Trust me, if I could do it safely, I would! It wasn't like I was home taking tennis and golf lessons. Chronic pain is horrible. Limited range of motion is a problem. I couldn't lift up my four-year-old, let alone do other activities I used to enjoy.

I had to reinvent myself. Find new hobbies. Find new passions. I still wanted to practice. I missed the operating room. It was really hard. I felt alone. Thankfully I knew a couple of other physicians out on disability with whom I could lean on.

I started a private facebook group called "Physicians for Physicians" for physicians who, because of injury or illness, had to limit their practice or leave medicine. I had no idea how many of us were out there. Just by word of mouth, social media, hundreds of physicians came out of the woodwork. Some who were better prepared than I but many

Continued on page 15

Meet Milly Rambhia, MD; Virginia Board of Medicine

Dr. Milly Rhambia

I was first introduced to the exciting field of anesthesiology during the summer of my first year of medical school at the University of Maryland. I had signed up for a summer anesthesiology externship and was exposed to various sides of anesthesiology, from general operating room cases, to regional nerve blocks, to obstetric anesthesia.

After completing my medical school rotations, I realized the fulfillment of being both the intensivist and internist in the operating room and applied to residency in anesthesiology.

I completed my residency at Northwestern in Chicago and fellowship at Duke in regional anesthesiology and acute pain medicine.

After fellowship, I joined Mid-Atlantic Permanente Medical Group in Northern Virginia. As a Permanente physician, I exclusively care for patients who purchase insurance through Kaiser Permanente.

As I am originally from Baltimore, being close to home was important to me and the group offered an excellent balance of cases and strong relationships with exceptional surgeons and staff.

Permanente Medicine promotes a truly innovative form of healthcare that is integrated, comprehensive, and places the patient at the center, which I really appreciated. Additionally, the organization offers early leadership opportunities and promotes physician wellness and diversity in a meaningful way.

As a relatively new, young anesthesiologist, I had the opportunity to enhance our use of regional anesthesia at our ambulatory surgery center, contribute to our group's COVID-19 Task Force, prepare our team at the onset of the pandemic last year, and become involved with our morbidity and mortality conferences.

I was informed of the opening on the Virginia Board of Medicine last year as the representative for my district was completing their term. I applied to the position because I felt the voice of an anesthesiologist, especially during the critical time of a pandemic, was important.

Anesthesiologists have a unique viewpoint of the difficulties a hospital or health system might face, as we work with many types of specialties and often coordinate preoperative, intraoperative, and postoperative care.

The Board of Medicine has many responsibilities, most importantly to protect the public. This aligns well with the role of anesthesiologist - perioperative physicians and leaders at the forefront of patient safety practice and guidelines; many specialties look to us to uphold the standard of safety and vigilance, especially in times of medical emergencies.

In my application, I noted that even if I wasn't personally selected, I encouraged the committee to consider an anesthesiologist for the opening because of our unique position. Nearly one half the states include a physician anesthesiologist as a member of their medical or osteopathic boards.

Through the American Society of Anesthesiologists, we are able to connect with each other to learn about contemporary advocacy issues that have already or are coming to our state's board. As an Anesthesiologist and Permanente physician, I hope to contribute meaningfully to the work performed by our Board of Medicine to promote patient safety, evidence-based medicine, and safe scope of practice principles in our state.

I encourage all Virginia anesthesiologists to use their expertise and unique training to pursue leadership positions at local, regional, state, or national levels, as it is our voices that genuinely can improve our society's healthcare.

Disabled Physician, *from page 14*

worse. It got me thinking about the topic more deeply. Why were so many ill-prepared? Why wasn't I better prepared? What could I do to help with this topic?

I found my passion. I started lecturing about disability insurance. I created a Grand Rounds to discuss the mental, physical and financial impact of physician disability. Physicians have to be prepared for the "what if."

Our work does not equal our life. We need to make sure that we have lives outside of medicine. We have to be financially diligent. Emergency funds and insurance are a must. There are so many nuances to disability insurance. Physicians need to make sure that we are speaking with brokers who understand the intricacies and important pieces of the products that physicians, specifically, need.

We need to practice self-care. Treat ourselves and our colleagues like we treat our patients. It is okay to get sick and take time off to heal. It is okay to take care of our mental health. See a therapist, have a solid group of confidants, find a mentor, be a mentor. Ask your colleagues if they are okay. Ask for help if you are not okay.

My passion grew from becoming aware of how many other physicians had similar plights, some fared better than me, others worse. After reviewing the policies of other physicians and friends, I came to the realization that many had fallen prey to insurance brokers that didn't really know the products, unaware what truly is needed for the protection of similar professions.

Along with the broker of a friend, who stepped in to help me when my broker was "unreachable", we started a brokerage. We focus on education of what all the fine print means, allowing the client to understand the policy they purchase. We have been able to assist thousands of clients, making a big step to assure what happened to me does not happen to my peers.

It can happen to anyone, anytime, without warning. The key is to prepare for the future, the good, the bad and the unknown. Please use my experience, and the experience of others to be the impetus to protect yourself and the ones you love.

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Healthcare in the United States is the Best in the World

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There is an aphorism that all budding entrepreneurs and grizzled veterans alike come to intimately understand: the market never lies.

Americans have among the lowest life expectancy of high-income countries, 78.6 years versus Switzerland for example at 83.6 years. The adult chronic disease burden stands at 28% of the population, compared to an average of 18% across these same countries. Obesity defined as a BMI of 30 or more is at a staggering 40% here, compared to an average of 21% in the group. And yet, over a million people travel to the United States every year for their medical care including heads-of-state, the wealthy and elite who presumably could have received care in their home country, or anywhere else in the world for that matter.

> *Over 100,000 Canadians, whose nationalized health system is rated above the United States, cross the border each year for medical care. These medical tourists recognize that on the whole, healthcare in the United States is the best in the world.*

These numbers don't even include the millions that are cared for by the international satellite campuses of the Mayo Clinic, Cornell, Harvard, and Johns Hopkins systems to name just a few, that have been established to bring American healthcare to the rest of the world.

Over 100,000 Canadians, whose nationalized health system is rated above the United States, cross the border each year for medical care. These medical tourists recognize that on the whole, healthcare in the United States is the best in the world.

The United States leads the world as a juggernaut of medical research and innovation. More Americans have received the Nobel Prize in medicine than Europe, Canada, Japan, and Australia combined, who have double the aggregate population of the United States. Half of the top 10 diagnostic or therapeutic innovations in the past 50 years have come in whole or in part from the US, along with 75% of the top 30.

When it comes to pharmaceuticals, half of the top 30 blockbusters have come from the United States alone. The advanced medical milieu that Americans therefore enjoy has led to the world's best cancer survival rates, a life expectancy for those over 80 that is actually greater than anywhere else, and lower mortality rates for heart attacks and strokes than in comparable countries.

There are many reasons that have been put forth to explain this dominance, but the most basic and powerful is very likely money. The free market healthcare economy of the United States, along with lower regulatory and tax burdens, strongly incentivizes corporations to focus their business in America.

At a fundamental level, greater financial compensation also provides individuals and their families the potential for a better quality of life, while greater autonomy spurs innovation. This is why the United States is routinely listed as the best country in the world to practice medicine.

One-quarter of all doctors in America are foreign-trained. Licensure is a daunting process that nearly always requires "starting over" for the immigrant physician, who is often fully licensed and practicing in their home country but must now sit for the USMLEs and spend years redoing all of residency and fellowship. Despite this challenge, estimates suggest that over $2 billion is lost annually from physicians leaving sub-Saharan Africa alone to set up shop in the United States.

This so-called brain drain is rampant in India, Mexico and Central America, and is not limited to physicians. In 2014, about 14,000 Filipino nurses left the country while only 5000 graduated nursing school. The United States represents 5% of the world's population, accounts for around 5% of the world's disease burden, but employs 20% of the global health workforce.

Contrast this environment with the nationalized health systems of two countries that each year rank higher than the United States: England and Canada. When resources are controlled by a single-payer, queues form and wait times for care invariably lengthen substantially. The NHS itself in England reported that one-quarter of all cancer patients didn't start treatment on time despite an urgent referral from their physician. Wait times for medically necessary treatments in Canada average three months, which the treating physicians documented as one month longer than clinically reasonable.

Universal healthcare also leads to an increased tax burden. The United States tax rate of 26%/GDP is among the lowest of 34 advanced nations, whereas Canada sits at 32%, England at 34%, and France the second-highest in the world at 45%. Some estimate that a single-payer conversion in America would potentially increase taxes by up to 20%.

For those with the means to pay, there is a

Continued on page 17

Dr. Cherayil Named VSA Northern Virginia Regional Director

By Gerald (Gerry) Cherayil, MD, MBA
Chairman Advisory Board
Fairfax Anesthesiology Associates/NAPA Anesthesia
Director, OB Anesthesiology
INOVA Fairfax Hospital


Dr. Gerald Cherayil

Hello Everyone!! My name is Gerald (Gerry) Cherayil and I will be heading up the Northern Virginia Region of the VSA!

I was born and raised in Milwaukee, Wisconsin, and did both my undergraduate and medical school in Milwaukee. After graduating from the Medical College of Wisconsin, I travelled to Boston to do my residency in anesthesiology and a fellowship in OB anesthesiology at the Brigham and Women's Hospital.

Post fellowship, I travelled here to Virginia to practice predominantly OB Anesthesia for the past 20 years at INOVA Fairfax Hospital. We are a level one trauma center with over 10,000 deliveries/year. When I am not working, I love wine (Napa Cabernet), travel, spending time with my family, and the Green Bay Packers!!

OB Anesthesia is a very unique specialty among the many in anesthesiology. We not only have to think of the patient, but also of the baby, as well as the partner. There is no other area in the hospital where we allow someone to be screaming and think it is normal. It is very satisfying to be able to alleviate some of the worst pain that human beings must face.

Things do not change much in OB due to the inherent difficulties in doing good scientific trials. No one wants to put a baby's life or health at risk. We have achieved a very safe, reproducible anesthetic technique that serves the vast majority of our patients.

While that technique did not change much, with the advent of COVID-19, the surroundings of the obstetric floor changed quite a bit. Now, masks are a mainstay not only on the labor and delivery floor, but across the hospital. Also, family members have been limited to only one support person.

Testing, while still a challenge, is much more prevalent now than in the past. We have dedicated COVID rooms that have everything covered, combined with plenty of PPE. Communication has become a bit more difficult; it is harder to hear others with masks on, especially with double masks or N95's.

Despite these changes the OB floor has adapted. We actually are now in the midst of a mini baby boom, and our labor and delivery floor is up to the task. The entire staff, especially the labor and delivery nurses, have done a wonderful job of working hard and keeping everyone safe.

Here is a picture of them, along with me, on the floor. Here is to hoping that soon in 2021 we can get rid of all the masks and the precautions and get back to normal life! I look forward to the coming year

Healthcare in the US, *from page 16*

booming secondary private insurance industry in most socialized healthcare economies, which has essentially created a two-tier system of "haves" and everyone else.

Self-pay for healthcare in England rises annually by 10% leading to a 50% increase over the last half decade, and this excludes cosmetics or costs paid by the NHS. One result is that nearly all general practices are private now in England, contracting their services out to the government while providing direct-pay services for the affluent.

Another outcome is that 43% of all physicians in England are part time, which usually coincides with the switch to private practice. In Canada, one-third of all healthcare funding is private despite multiple legal challenges to forbid a two-tier system and resultant line-jumping.

All of this is not to say that the American healthcare system is flawless, or that lessons cannot be learned from countries with nationalized care.

Between 1975 and 2010, the number of physicians grew by 150%, while the number of administrators exploded by 3,200%: there are now 10 administrators for every physician in the United States. Administrative costs account for 25% of total hospital expenditures here, while the average among other affluent countries is closer to 10%.

America is also a very litigious society, at great cost to the system. The amount equals 2.5% of total healthcare spending or $60 billion a year, $45 billion of which is "defensive medicine" to avoid lawsuits. One-third of all American physicians have been sued in their lifetime, while that number is 1% for Canadian doctors.

The average malpractice lawsuit in Canada settles for $95,000, compared with close to $500,000 in the United States. And while the adjusted number of uninsured Americans is not the oft-quoted 10% (adjusted meaning those who were not eligible for any aid/coverage, and not offered insurance by any entity) but closer to 1% or around three million, this still should be unacceptable as healthcare is a basic human right.

For generations, the United States has been a shining beacon of healthcare hope, paving the way to healthier, longer living and whose entrepreneurial milieu has led to innovations enjoyed worldwide.

While greater scrutiny over the past few decades have highlighted areas for improvement, the market never lies and recognizes that America is still the best place in the world for healthcare.

Medicolegal Reform in Virginia, and Why It Needs Your Attention

By Jack Craven, MD, JD
Anesthesiology Resident, Virginia Commonwealth University


Dr. Jack Craven

If you imagine yourself as a trial attorney, it is easy to understand the motive behind reducing barriers to filing claims. Trial lawyers are all too familiar with the laws restricting suits and capping damages. It should come as no surprise that they have been seeking to "reform" prior medical malpractice statutes in Virginia. A bill was introduced in the General Assembly this year to remove the cap on damages against physicians, and it is likely a similar bill will be presented in next year's session.

Such constant efforts are predictable, even in light of the generous cap on damages. Yet, one would expect healthcare providers to aggressively fight those proposals. However, unlike lawyers, physician income is not tied to a percentage of claims. Therefore, they do not have the same robust pecuniary interest in following current legislation. This article seeks to bridge that gap. Below you will find a primer on Virginia's current law and a selection of successful efforts in other states– highlighting what can be done to improve the law (for physicians).

BENEFITS OF VIRGINIA LAW:

The cap on damages, Virginia Code Sections 8.01-581.15 and 8.01-38.1

- Starting in 2008, a cap on damages was set at $2 million, with annual increases of $50,000 beginning in 2012. The cap will reach $2.5 million in July 2021.
- Punitive damages are capped at $350,000.
- Why it matters: At common law, it would have been possible for a jury to award any reasonable amount of damages, which could be over $2.5 million.

Medical Review Panel, Virginia Code Section 8.01-581.2

- Either party to a case may submit to the Supreme Court of Virginia for review by a panel. Panels are comprised of two healthcare providers and two attorneys. A circuit court judge conducts the panel. The panel members review written evidence, as well as oral testimony upon request.
- Why it matters: The result is non-binding, however the results can be submitted as evidence in a jury trial. If the panel finds for the physician, it can be very compelling evidence to jurors.

Statute of Limitations, Virginia Code Section 8.01-243

- Typically two years, although certain exceptions apply for minors under 8, those who are incapacitated, and if certain information was concealed (For example: if it was not possible to know malpractice occurred, such as in the case of a retained sponge. In such an example, it would not be possible to know malpractice had occurred until the sponge is discovered). One important exception to the statute of limitations is the continuing treatment rule, whereby an action can be pursued if there was substantially uninterrupted treatment for the condition by the provider. In such a case, the two years toll from the last treatment.
- Why it matters: Actions are barred following the statute of limitations.

Standard of Care (as presented by an expert witness), Virginia Code Section 8.01-581.20

- The standard of care by which any act or omission will be judged is by the "skill and diligence practiced by a reasonably prudent practitioner in the field of practice or specialty". The practitioner must have practiced within one year of the alleged act or omission.
- Why it matters: It helps refine the pool of experts to those who can reasonably testify. In theory, it should also prevent experts from making claims about the standard of care which depart from actual standards of care (The fear being that an expert could impose an unreasonable standard of care on a physician).

Certification of a case at the time of service of process, Virginia Code Section 8.01-20.1

- Service of process is a prerequisite to most actions in court. It requires notifying the defendant (in this case a physician) by serving a copy of the complaint.
- Virginia law requires that at the time of service of process, an expert has been contacted who verifies that the standard of care has not been met and that the deviation from the standard was the proximate cause of the damages.
- Why it matters: If there were no hurdle to filing a claim, it would be possible to file a suit even in the absence of any deviation from the standard of care. This acts as an initial filter, prior to any potential suit.

AREAS FOR IMPROVEMENT IN VIRGINIA LAW:

- Limitation of attorney's fees - Why it matters: Typically attorney's fees are limited by statute or by authority of the state bar. Depending on the state, they are often around 1/3rd of any payout. Due to the large figures involved in a medical malpractice case, that is often a windfall for the plaintiff's attorney. For instance, 1/3 of a $2 million case would be $666,666. It is unlikely that the actual work product of an attorney approaches the number of hours commensurate with such a fee. However, it does incentivize litigation against physicians. As a result,

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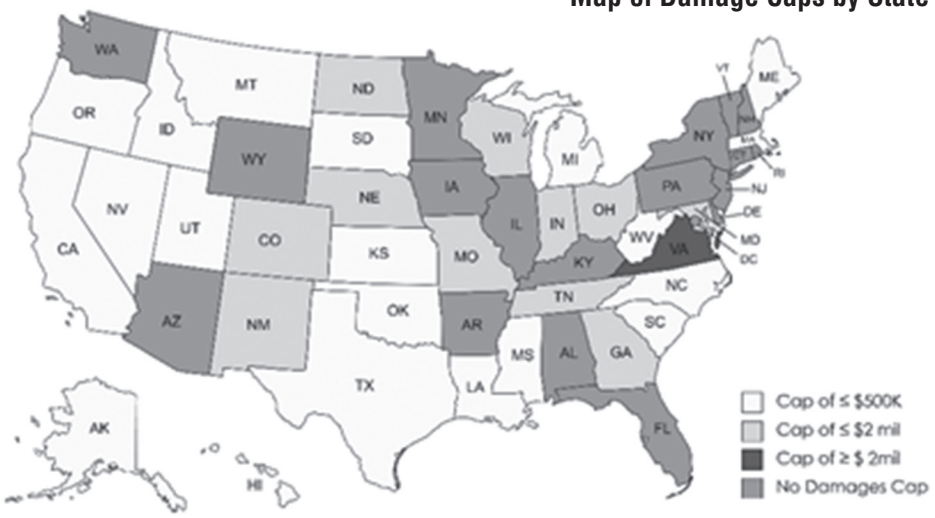
over 10 states have limitations on attorney fees.

- Joint liability reform - What it is: Often two or more physicians treat the same patient. In such a case, if negligence occurs both parties can be at fault—although not to the same degree. For instance, when one anesthesiologist starts a case and another finishes the case—whose fault is it if something goes wrong 5 minutes after handoff? In such an example, it would likely depend on what specifically happened and the individual circumstances. For that reason, fault can be apportioned on a percentage basis by a jury after they examine the facts. - Why joint liability reform matters: Despite fault being apportioned by a jury based on the individual responsibility of the providers involved, the actual collection of the damages can occur in a non-equitable fashion. For instance, a physician who is 10% at fault can be made to pay the entire amount of the damages (if the other party is non-collectable). Such a result skews justice in favor of the plaintiff and against the physician.

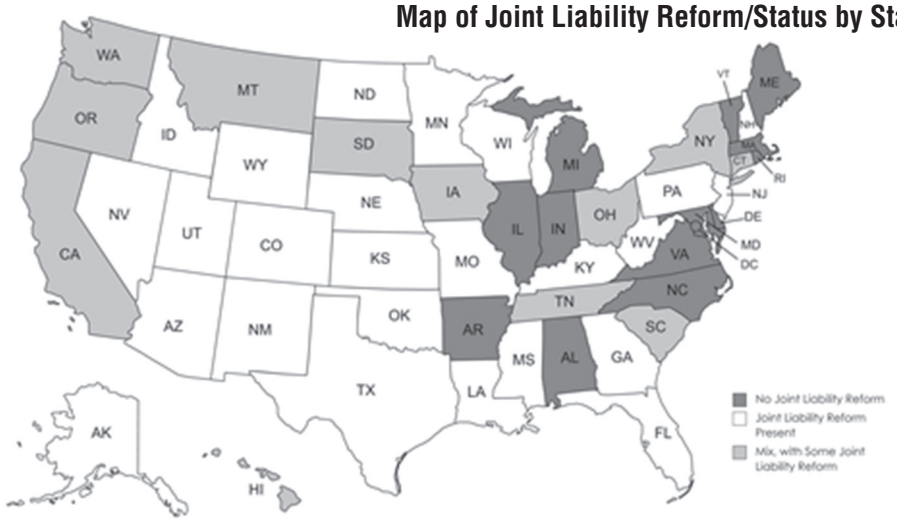
- Collateral Source Reform - What it is: In essence, the collateral source rule allows double payment. As an example, consider a patient who due to malpractice is unable to work. A reasonable calculation of the patient's lost income would first calculate his typical wages, and second subtract any amount paid through social security or long-term disability insurance. Otherwise, the plaintiff would be able to double collect through those models. In Virginia, double payment is the rule. - Why it matters: Lost income should be limited to what is actually lost by the plaintiff. It should not be used to place a patient in a better financial position than if an incident had not occurred. Technically, long and short-term disability insurance are a bit more nuanced than social security, because in practice some of those benefits are paid back to the insurer following a settlement or award in a process called subrogation. Typically, the plaintiff's attorney still receives his share of the amount subrogated. The results of both types of double payment can be substantial if spread over several years (or decades).

Map of Damage Caps by State



Note for the above Map, damages can be separated into non-economic and economic. Therefore, this map is a generalization. Moreover, some damages are indexed to inflation or include annual increases (Virginia for example reaches $2.5 million this year). Those states with caps between $500K and $2 million—have been listed as ≤ $2 million.

Map of Joint Liability Reform/Status by State



Joint liability reform has several nuances, which are often state specific. Note: Although statutes listed are accurate to the authors knowledge, they are intended for educational value and should not be construed as legal advice for any providers facing claims. Each case is unique, and therefore providers should seek advice from counsel when specific issues arise.

Given the very human nature of medicine, errors can only be reduced—never eliminated. As a result, there will always be tension between the law and medicine. The above reforms are certainly not exhaustive, but they do represent ways to ensure providers practice in a fair environment. Ultimately, anesthesiologists work tirelessly to ensure safety. Ensuring a fair legal environment means they can continue to focus on what matters most—the patients.

Anesthesia Care Team Composition: CAA or CRNA, What's the Difference?

By Nicole Cabell
VAAA President
AAAA Legislative Committee Chair


Nicole Cabell

Certified Anesthesiologist Assistants (CAAs) are highly skilled health professionals who work under the medical direction of licensed physician Anesthesiologists to implement anesthesia care plans.

CAAs work exclusively within the Anesthesia Care Team (ACT) model, as described by the American Society of Anesthesiologists (ASA). Also working alongside physician Anesthesiologists in the ACT are Certified Registered Nurse Anesthetists (CRNAs).

So, what's the difference between them? This article will take an in depth look at the education, training, licensure and recertification of CAAs and CRNAs; as well as compare the supervision, practice models, cost, billing and safety between the two providers.

Prior to admission into a CAA program, one must graduate with a Bachelor's degree, take the required prerequisite courses in alignment with a pre-medical school track and take the MCAT or GRE. The prerequisites include higher level biology, chemistry, anatomy and physiology, as well as physics and statistics courses.

One will then attend a 24-28 month Master's level program that is associated with an ACGME accredited medical school and has a physician anesthesiologist as the acting Medical Director.

During the program, the AA student will complete 56-132 didactic hours (program dependent) and a minimum of 2000 (avg. of 2500) clinical hours and 600 cases prior to graduation.

Similarly, CRNAs will complete a minimum of 550 cases, or 1700 hours, (avg. of 2000) and 34-80 didactic hours (program dependent) during their 24-36 month Master's or Doctor program. Prior to entering the CRNA program, one must graduate with a Bachelor's of Nursing and have worked a minimum of one year as a Registered Nurse in the acute care setting.

> *"The specific composition of the anesthesia care team (whether made up of a physician anesthesiologist and an AA or a physician anesthesiologist and a CRNA) was not associated with any significant differences in mortality, length of stay, or inpatient spending."*

Upon graduation from either a CAA or CRNA program, the provider will have been trained in all subspecialties of anesthesia and be allowed to perform invasive line placement and regional anesthesia.

Licensing requirements are comparable for both CAAs and CRNAs. Both must obtain a license for the individual state in which they will be practicing. As of now, CRNAs may practice in all 50 states and the Veteran's Administration, while CAAs may practice in 18 jurisdictions (including the District of Columbia and Guam) and the Veteran's Administration.

In order to obtain a license, a CAA must graduate from a program accredited by the Commission for Accreditation of Allied Health Education Programs (CAAHEP) and Accreditation Review Committee for Anesthesiologist Assistants (ARC-AA) and pass a certifying exam given by the National Commission for Certification of Anesthesiologist Assistants (NCCAA) in collaboration with National Board of Medical Examiners.

CAAs may also practice under delegatory authority in some states; the requirements to practice are the same and both CAA licensure and delegatory authority are overseen by the state medical board. Similarly, CRNAs must graduate from a program accredited by the Council on Accreditation of Nurse Anesthesia Programs and pass a certifying exam given by the Council on Certification of Nurse Anesthetists prior to obtaining a license.

Both CAAs and CRNAs are required to recertify throughout their careers by obtaining Continuing Medical Education Credits (CMEs) and sitting for a recertifying exam. CAAs are required to complete 40 CMEs biannually and sit for a Continued Demonstration of Qualifications (CDQ) exam every six years. CRNAs began a two-part eight-year recertification process in 2016, during which a CRNA must obtain 40 CMES during the first four years and then sit for a recertification exam during the second four years.

Once fully certified and licensed, supervision and practice models between CAAs and CRNAs can differ depending on the practice location. As noted earlier, both are able to practice as part of the ACT under the medical direction of a physician anesthesiologist.

CAAs are recognized by the Centers of Medicare and Medicaid Services (CMS), Tri-care, and all major commercial insurance payors. CMS recognizes CAAs as qualified non-physician anesthesia providers, just like CRNAs. Under medical direction, CAAs and CRNAs are both able to practice with ratios of one physician anesthesiologist supervising four CAAs or CRNAs, according to CMS.

Whether a CAA is practicing with a state license or under delegatory authority, they practice exclusively under the medical direction of a physician anesthesiologist in the ACT model. CRNAs have the ability to practice in other models, including medical supervision by any physician (QZ) and, in some "opt-out" states, independent practice. CMS does not define supervision ratios for medical supervision.

In doing a cost-comparison between CAAs and CRNAs in the ACT, it is found that on average there is no difference because when practicing in the ACT model, billing for CAAs and CRNAs is identical for CMS and other major insurers. Require-

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ments to be met for reimbursement are the same between CAAs and CRNAs in this model. The average annual salaries of new graduate CAAs and CRNAs are comparable at $150,00, but can differ amongst individual states.

Finally, the safety of patients is of the utmost importance and concern. In October of 2018, there was a study published in the reputable journal, *Anesthesiology*, that concluded "The specific composition of the anesthesia care team (whether made up of a physician anesthesiologist and an AA or a physician anesthesiologist and a CRNA) was not associated with any significant differences in mortality, length of stay, or inpatient spending."

Overall, when practicing in the ACT model there is almost no difference between CAAs and CRNAs. In 2017, ASA republished the Statement Comparing Anesthesiologist Assistant and Nurse Anesthetist Education and Practice where they stated, "The Committee concludes that differences do exist between anesthesiologist assistants and nurse anesthetists with regard to the educational program prerequisites, instruction, and requirements for supervision in practice as well as maintenance of certification.

These are the result of the different routes that the two professions took toward development, and the stated preference of anesthesiologist assistants to work exclusively on teams with physician anesthesiologists.

None of these differences, in the opinion of the Committee, results in significant disparity in knowledge base, technical skills, or quality of care."

Although different when broken down, hospitals that employ CAAs and CRNAs use them interchangeably as both are safe and effective members of the ACT.

	Anesthesiologist Assistant	Certified Registered Nurse Anesthetist
Program Admission Requirements	Bachelor's Degree, GPA > 3.0, Pre-medical prerequisite courses, MCAT or GRE	Bachelor's of Nursing Degree, GPA >3.0, 1-year min. as Registered Nurse in acute care setting
Program Length	24 – 28 months	24 – 36 months
Program Education	56 – 132 didactic hours, Min. 600 cases and 2000 clinical hours (avg. > 2500 hours)	34 – 80 didactic hours, Min. 550 cases or 1700 clinical hours (avg. 2000 hours)
Clinical Rotations and Advanced Skills	All anesthesia sub-specialties, Regional anesthesia, Invasive line placement	All anesthesia sub-specialties, Regional anesthesia, Invasive line placement
Certifying Body	National Commission for Certification of Anesthesiologist Assistants in collaboration with National Board of Medical Examiners	Council on Certification of Nurse Anesthetists
Recertification Requirements	40 CME's biannually, CDQ Exam every 6 years	1st 4 year – 40 CME's 2nd 4 years – recertification exam
Practice Locations	18 jurisdictions (including D.C. and Guam), Veteran's Administration	All 50 states, Veteran's Administration
Model of Practice	Anesthesia Care Team	Anesthesia Care Team, Supervision by any physician, Independent practice (opt-out states)
National Organization	American Academy of Anesthesiologist Assistants (AAAA) www.anesthetist.org	American Association of Nurse Anesthetists (AANA) www.aana.com

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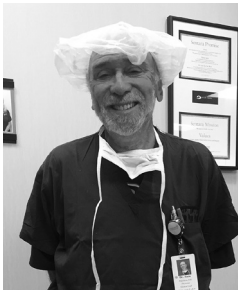
Would I Do It Again?

Paul Rein, DO



Dr. Paul Rein

In 2008 there was a movie made called 'The Curious Case of Benjamin Button'. It was a story of a man who ages in reverse. Interesting movie.

I graduated from Osteopathic Medical School in 1972 with a debt of $20,000. Starting in 1974 I practiced as an old-fashioned general practitioner for six and a half years, including house calls, uncomplicated obstetrics, and minor surgery.

Finally, in 1979, I decided to switch to anesthesiology and, in January of 1980, began my residency at MCV. I stayed on as an assistant professor before leaving in June of 1986 for private practice. In an offshoot of Benjamin Button, I've often imagined, knowing what I know now, would I have chosen the same career path? Have you ever thought about it?

Let me begin by saying I have been very happy with my career decision. I really enjoy being an anesthesiologist and, to this day, still practice two to four days a week, with no weekends, no nights, no call, and no holidays. The majority of my work is as an independent practitioner and occasionally working for a large hospital system as a contract employee. So, what's not to like?

Well….

First, let's go back to the world of medicine in 1986. The choices for an anesthesiologist then were either academic medicine, private practice, government employee/VAH, or military.

Initially I chose academic medicine, but left after four and a half years because of the fear that, because I had no opportunity to do any research, I would not get tenure. I thought I'd explore the private practice opportunities.

I did really enjoy my time at MCV but needed to think about the future for my family and me. When I was offered a private practice job in Newport News in an all "doc" practice, and after discovering that I could live in Williamsburg, off I went.

From 1986 until 2010 I was in private practice at Riverside Regional, and we worked our butts off, but everyone was happy. Initially in our group, we were paid whatever was collected from the insurance company and patient for the work we did, minus expenses.

With the growth of ASC's, we morphed into a modified care team model. If I could pin it to one kind of case, I'd say it was the new technology for cataract surgery. Instead of a 45-minute case, it was a 10-minute case to be done in an ASC.

Instead of a surgeon doing eight cases in a day, an opthamologist could do up to 30 cases in a day. Eventually we morphed into a practice with CRNA's from 7:00 am to 3:00 pm, with 50% of our cases being done by anesthesiologists, including all cardiac, craniotomies, and obstetrics. Our pay was 80% of what you generated and 20% evenly distributed, after practice expenses.

Fast forward to 2010, the beginning of the big changes in how healthcare was going to be provided. Our main hospital decided they would evolve into one that wanted more control over the medical providers. We chose not to do it, and the group stopped covering there.

About 50% of the providers left the group and found work elsewhere. Just thinking about our specialty, we have seen the takeover of practices by national companies and healthcare systems in full force. Yes, there are still some private practices, but as the years move along, we have fewer and fewer.

What has this evolution brought to us? First and foremost, a loss of control over our professional life. We used to be independent service providers with five customers in every case. We had the patient, their family, the surgeon, the staff, and the administrators.

Now the patient remains at the top, but it seems that moving up to second place is the administration and nursing staff, ahead of the surgeon and family. When one becomes an employee, whether of the hospital or a big national company, the game changes.

Instead of being in control of your money, your schedule, and who you must make happy, you are now the middleman between the patient and those making a living off of you.

Think about that for a minute. While they say many things, the bottom line for them is profit. It is well known that there is plenty of money to be made when one does the right thing, but when money comes first, one will do wrong things just to make money.

That 28-year-old MBA, who sometimes walks around with a clipboard and doesn't know anything about real healthcare, is making sure the room runs on time and that you are not holding things up, even though your patient has multiple medical problems that got through the pre-anesthesia office.

They will occasionally justify making money before doing the right thing. You went to school for a minimum of 12 years after high school, and this MBA with far less education, is effectively your boss.

The next big change happening is the gradual takeover of anesthesiology in the United States by CRNA's. Unfortunately, the national companies and hospitals now run medical groups, are moving to a more CRNA dominated model, often times billing with medical supervision instead of medical direction. Where I live in Williamsburg, the main hospital in 2020 disposed of their mostly physician provided anesthesia model, terminating the only group that ever provided anesthesia services there, and now has a national company, instituting a medical supervision model.

The anesthesiologists are supervising, filling out the electronic medical record and rarely providing anesthesia. What message does that send to the surgeons and staff about anesthesiologists? We went to medical school, did a four-year residency, and is this what we want to do? Really? What happens to our skill set?

Finally, is there really job satisfaction in that system? Is there satisfaction when you don't have control? When I began the prac-

Continued on page 23

Medical Marijuana Legislation Update

By James A. Pickral
Partner, Commonwealth Strategy Group

The legalization of recreational marijuana was a major topic of the 2021 Virginia General Assembly. Governor Northam announced that legalization would be a major policy objective of his Administration late in 2020 and subsequently crafted legislation to that effect.

The bill was carried in the House of Delegates by Delegate Charniele Herring and in the Senate by Senator Louise Lucas. The legislation laid out a regulatory framework for the sale, cultivation, and distribution of retail marijuana in the Commonwealth.

Originally, the regulatory authority overseeing all aspects of marijuana, to include hemp and medical cannabis, was the Virginia Alcoholic Beverage Control Authority. However, the General Assembly felt that a new Authority dealing specifically with cannabis was a more prudent option.

This new Authority was added into the legislation along with several other boards and advisory commissions. These additional entities will advise on items such as equity, community reinvestment, education, and health issues. The majority of changes are under various re-enactment clauses. These clauses require that the General Assembly affirmatively act on the various statutes in the 2022 session.

The final bills, as amended by the legislature, passed the General Assembly and were sent to the Governor for his signature.

During the final days of debate on these bills, there were several legislators who expressed concern that not enough had been done around criminal justice reform and, specifically, the legalization of simple possession of small amounts of marijuana, and small-scale cultivation for personal use.

We expect that this issue will be a major topic during the 2022 session as well and that extensive changes will be made. We will keep you informed as the laws around retail marijuana evolve.

During the time between adjournment of the 2021 session and the beginning of the reconvene session, these legislators and various advocacy groups lobbied Governor Northam to amend the bills to address these concerns.

These efforts were successful. The Governor amended both bills and sent them to the General Assembly to act upon during the reconvene session.

In effect the Governor's amendments do the following:

- No penalty for possession of up to 1 oz. of marijuana.
- A $25 civil penalty for possession of more than 1 oz. up to 1 lb. of marijuana.
- The ability to grow up to four cannabis plants for personal use at your primary residence. The plants must not be in view of a public right of way and each plant must be tagged with your name, social security or drivers identification number, and a notation that it is being grown for personal use. Additionally, you must take reasonable precautions to prevent access to persons under two years of age.

These amendments were accepted by the General Assembly. Both the legalization of simple possession and the ability to cultivate plants becomes effective on July 1 of this year. It is important to note, however, that there is no legal means of acquiring marijuana for recreational use. Additionally, there is no legal way to purchase seeds or plants for personal cultivation.

We expect that this issue will be a major topic during the 2022 session as well and that extensive changes will be made. We will keep you informed as the laws around retail marijuana evolve.

Would I Do It Again?, *from page 22*

tice of medicine, the term burnout was used for drug users whose life was burned out. Now we have physicians of all specialties talking about burnout.

Just looking at the percentages of physicians who say they are suffering from burnout, why would I go $300,000 in debt? Why have physicians lost control over the real practice of medicine? There are many reasons, but that is beyond the scope of this essay.

So, would I do it again? Probably not. A lifelong career after all that schooling, just to work for someone with less education than I have, who controls my schedule, controls my income, controls my behavior.

I don't think so. I will continue to do what I do, occasionally in the hospital, but mainly in plastic surgery and GI offices where I can be an independent practitioner, controlling my time and still being a real anesthesiologist.

Sad it has come to this, but true.

Legislative Update

By Lauren Schmitt
Commonwealth Strategy Group

The 2021 Virginia General Assembly session adjourned on March 1 and they returned to Richmond for the one-day "veto session" on April 7. Despite the challenges of a virtual session and not being able to communicate face-to-face with legislators, it was still a very successful legislative session for us. We had a lot of legislative victories and member engagement and participation. Please read below for highlights of this session.

Defeat of Medical Malpractice Repeal

Our biggest victory this session was defeating SB 1107 (Stanley) that would have repealed the current cap on medical malpractice monetary rewards in Virginia. In 2012, Virginia passed a law capping the medical malpractice monetary reward for 20 years. This was an agreement between the Medical Society of Virginia and the Virginia Trial Lawyers Association.

Unfortunately, Senator Bill Stanley introduced legislation this year to undo that cap. We were able to defeat this bill, but the legislators made it clear that they will try again next year and that they believe there are issues with the current system. It will be our top priority over the next year to educate legislators on why the cap is necessary and should not be changed.

Defeat of Licensure for Naturopathic Providers

We were able to once again defeat legislation that would have allowed naturopathic providers to be licensed in Virginia. Despite the bill failing last year and a recommendation from the Department of Health Professions not to require licensure, they still moved forward with legislation. We were pleased to see these bills, SB 1218 (Petersen) and HB 2044 (Rasoul) defeated in committee.

Expiration Date Added to Nurse Practitioners Legislation

We knew going into this session that we would see legislation to allow nurse practitioners to practice independently after only two years of clinical experience (current law is five years). Governor Northam issued

an Executive Order at the beginning of the COVID-19 pandemic changing it to two years. It was set to expire when the state of emergency ends. Delegate Dawn Adams introduced HB 1737, which would have permanently changed the law to match the Executive Order. We strongly advocated against this bill and were very vocal with our opposition.

As a result of the pushback from the physician community, the bill was amended to expire on July 1, 2022. This gives us another chance in the 2022 session to address this issue again- and at that point, we will have a full report from the Department of Health Professions on how independent practice has been working in Virginia.

We will have data on how many are practicing and in which areas they are. The argument for this legislation has always been that it will expand access and NPs will provide care in underserved areas. The DHP report will be able to shed some light on whether that has happened in Virginia.

Amended Insurance Practices Requirements

We were able to amend legislation introduced by Senator Surovell, SB 1289, that made some changes to what health plans can include in their provider contracts. The original version would have required providers to submit claims to the health plan within 30 days. We were able to get that part removed from the bill. The legislation does include "non-discrimination" language that requires health plans to prohibit providers in their contracts from discriminating against a patient because they are a litigant in pending litigation or a potential litigant because they were involved in a motor vehicle accident.

Upcoming Special Session

The legislature will convene sometime this summer for a special legislative session to determine how to spend federal funding received through the American Rescue Plan Act. The dates have not been announced yet, but it will likely be in August.

Upcoming Elections

This November is a big election day for Virginia. The entire House of Delegates is up for re-election and we will elect a new Governor, Lieutenant Governor and Attorney General. The Republican nominees for statewide offices are as follows: Glenn Youngkin for Governor, former Delegate Winsome Sears for Lieutenant Governor, and Delegate Jason Miyares for Attorney General. The Democratic primary took place on June 8 and their statewide candidates are as follows: former Governor Terry McAuliffe for Governor, Delegate Hala Ayala for Lieutenant Governor, and current Attorney General Mark Herring for Attorney General.

VaSAPAC

This is a critical election year in Virginia and a strong and robust PAC is crucial to our advocacy success. Contributions to the PAC will help raise the visibility and profile of anesthesiologists, connect us to new and returning legislators, and continue to build productive relationships with key General Assembly members.

As always, we continue to support members of the legislature who care about issues affecting our profession and our patients. We support both parties and their leadership through individual legislator and caucus events. Please make your contribution to the VaSAPAC today! https://www2.vsahq.org/forms/VaSAPAC.iphtml

Second Chances?

Written by a loving husband, a dedicated father, and an experienced anesthesiologist in Virginia

Just as things were beginning to look more optimistic after a few rough years, I was let go again from a job, despite having an unblemished track record while employed there. My past was back to haunt me.

I had been moonlighting at this hospital for a year and a half and was thrilled when leadership offered for me to come on board full time. My family was happy, healthy, and finally back on sound financial footing...and I had been sober going on 29 months. I was starting to hope that maybe I could finally put the train wreck of the last several years in the rear-view mirror once and for all.

Ironically, the offer of a promotion was what led indirectly to my being fired; it had prompted yet another background check, and even though I had previously disclosed every detail of my past and was initially offered the job after two previous and identical background checks, an H.R. bureaucrat, someone from out of state who had never set foot in our hospital, objected to my continued employment.

The nurses and physicians with whom I worked wrote letters attesting to my professional competence and good nature, and my immediate supervisors all lobbied on my behalf, but the decision stood. I was once again an unemployed physician, fired from another job that I was good at and loved, as a consequence of the fact that I am an addict.

It's taken a while for me to acknowledge it, but yes, I am an addict. I became addicted to opioids after a painful surgery. I'm really not ashamed to admit it anymore; as a matter of fact, I am now completely up front and honest with my colleagues and employers about this.

Addiction is a disease, and until others acknowledge that it is a disease, our society will continue to stigmatize and shame those who suffer from it. I'm well aware of the statistics; that anesthesia professionals suffer from addiction at 3.5 times the rate of other physicians, and that often the presenting symptom of this disease is death. I'm not ready to be another statistic.

Here are a few more statistics:

- Addicted physicians tend to be young, highly talented, very personable, and well liked
- 33% of addicted anesthesia professionals have a family history of addiction (e.g. alcohol, drugs, gambling, etc.)
- Anesthesia residents are over-represented among the anesthesia professionals who suffer from addiction
- There are current studies which have already confirmed that fentanyl has been detected in an aerosolized form in the OR (thereby unknowingly exposing a potentially susceptible individual to a highly addictive drug)

Fortunately for me, I was caught before this disease killed me. I immediately enrolled in a three-month inpatient rehabilitation program, an experience, which was brutal for me. I missed my wife and kids more than I knew was possible. I went to bed every night bummed out and woke up every morning more bummed out.

I've never been profoundly depressed before. I now have a tremendous amount of empathy for folks that suffer from chronic depression. I'm not trying to elicit any undeserved sympathy here; I'm just telling it like it is. And more than just being depressing, rehab was hard. Especially for someone like me who wants instant gratification, who thinks he can do pretty much anything he sets his mind to without help from anyone, thinks the rules don't apply to him, and is used to being able to talk his way out of pretty much any jam.

After spending the first few weeks in rehab in complete denial, I slowly began to realize that I needed to be there, that I really did have a serious problem that I couldn't correct on my own.

I realized I had a lot in common with the other addicts enrolled; extreme narcissism, delusional self-confidence, mixed with unrecognized insecurities and melancholy, an uncanny ability to manipulate others while lying to ourselves, successful careers, and innocent families left behind in the wake of our destructive selfishness. I began to realize that rehab and recovery isn't just about not drinking or using drugs; it's about honestly acknowledging and facing the insidious demons of self-deception that cause us to

Continued on page 26

destroy the things we cherish the most.

It's also about acquiring an appreciation of the biochemical imbalances that make us crave dopamine 'hits' the way a starving dog craves a steak. The end result of actual sobriety from alcohol and drugs is just a fringe benefit of exploring and understanding all this.

When I left rehab, I knew I still had a lot of work to do. I continued with another three months of intensive outpatient therapy, enrolled in Virginia HPMP (with three to six random drug screens per month), and began attending several 12 step meetings every week.

I used to think of AA meetings as being a place where sad, cranky, desperate winos sit around smoking cigarettes and drinking coffee while complaining of their pathetic lives. In my experience this is far from the truth. Recovering addicts are some of the most hopeful, upbeat, supportive, honest, and authentic people I've ever met. Gratitude seems to be the glue that holds this all together. It's something that is discussed at every meeting I've attended.

I now realize that I have so, so many things for which to be grateful. I'm surviving this disease without any major adverse health effects, my family is intact, my wife has been my biggest supporter and our marriage is stronger than it ever has been. I'm grateful for those friends who have stood by me. I'm grateful for my parents and siblings and cousins who have supported and encouraged me. I'm grateful for the nurse that reported my suspicious behavior which led to all this - it very likely saved my life.

Obviously, the journey hasn't been all unicorns and butterflies. I've been fired from two jobs, created incredible hardships for my family, destroyed friendships and professional relationships, and I'm several hundred thousand dollars poorer due to lost salary, lawyer's fees, insurance payments, and cost of rehab. But all that means nothing in light of the newfound focus I have on what's really important to me: God, family, friends, and honest living.

After six months of sobriety, I was cleared by HPMP to return to work. I had planned all along to return to my old job, and it seemed as though my partners were supportive of this. They then fired me via email, without any discussion. This really felt like a kick in the teeth. I had been there 14 years and

I truly loved the hospital and the people I worked with.

It wasn't the firing as much as the indifference with which it was carried out that stung so much. I understand the decision to fire me; I did something inexcusable. I betrayed their trust and I put them in a position they didn't ask to be put in. But I felt as though I had lost something more than just a job; I had lost the respect that I had earned from 14 years of being a solid partner with people I liked and enjoyed working with, and I lost the attendant goodwill that goes with that respect.

I felt like in their eyes, my former self had been erased and, in its place, stood only an addict. I know I have no right to complain, and I bear no resentments towards my former partners; this was 100% my fault. But what if I had been diagnosed with some other awful disease instead? Would the same indifference have been given to my firing? Would I have been judged only by my disease or seen as myself, but now with an illness? That knowledge is something that still plagues me more than the loss of the job itself.

By now, I have come to realize that my past actions will always follow me, and rightfully so-it's legitimately fair to question whether any doctor who has abused opioids should be allowed to return to a job with access to narcotics, even with participation in a recovery program and monitoring. But the addicted are not immoral, evil, crazy, stupid, or weak-willed. We have a disease for which there is no cure, but one that can be successfully treated.

This treatment requires:

- Thorough understanding of the disease
- Long term care and follow-up, including monitoring
- Regular participation in recovery goals

If these principles are strictly adhered to, any addict who is committed to recovery should theoretically be in very little danger of relapse. But just like remembering to take a pill every day, compliance with therapy can be difficult. The statistics for maintaining sobriety for all addicts in recovery are pretty dismal; well over 50% relapse. And for opioids, the presenting symptom for 25% of those that do relapse is death.

The good news is that the statistics for anesthesiologists returning to practice, who are enrolled in a recovery program and who are in monitoring, are much better than those for all addicts. It's hard to find exact numbers, but I've been told by several professional counselors that the success rate for these individuals is north of 90%, and anecdotally I know several addicted anesthesiologists in recovery who have successfully returned to work and continue to have fulfilling careers.

Reentry for anesthesiologists remains a controversial topic, and there is no current consensus on whether opioid abusers in recovery should return to the OR. In general, these decisions are made on a case-by-case

basis.

The Talbot Recovery Program, used by several states as a guideline for determining if and when an anesthesia professional may return to practice, has developed a classification system for reentry into anesthesia, each category having numerous criteria:

- Category I: Return to anesthesia immediately upon successful completion of a treatment program
- Category II: Return to anesthesia after 2 years off
- Category III: Redirect to another specialty

I'm not pretending to have any answers. Strong arguments can be made both ways, but I will give you my opinion. As someone who has made several hiring decisions in the past, I would absolutely hire a physician with a history of addiction; if they have completed inpatient rehab, are actively involved in a recovery program, are monitored, and have maintained sobriety for more than six months.

I would treat them like any other applicant and would be willing to see beyond their tarnished past. I would see them as a physician, and a human, not an addict. As stated above, recovering addicts are some of the most authentic people I know. I would trust them as much, if not more, than many of the physicians I've worked with in the past, some of whom I know have abused alcohol or drugs themselves.

I'm sure some will disagree, and I respect that viewpoint. I base this opinion on my own experiences, my physician acquaintances who are also in recovery, and the overall success rate for physicians in recovery who continue to be monitored.

Addiction is absolutely a disease, and I think that maybe it's time to consider treating addicts as people with a health problem. We didn't ask to become addicts, it's not something to which we aspire, and although we acknowledge that the responsibility for our actions lies solely upon our own shoulders, I think we are at least deserving of the consideration that many of us are pretty decent people.

> *"It wasn't the firing as much as the indifference with which it was carried out that stung so much. I understand the decision to fire me; I did something inexcusable. I betrayed their trust and I put them in a position they didn't ask to be put in. But I felt as though I had lost something more than just a job; I had lost the respect that I had earned from 14 years of being a solid partner with people I liked and enjoyed working with, and I lost the attendant goodwill that goes with that respect."*

Obviously, you can't compare addicts to cancer patients. Pretty much all of us would agree that we aren't deserving of the same degree of sympathy, and I've never heard anyone in recovery use the "disease" explanation as an excuse for their behavior. To the contrary, most of us really struggle with the guilt and shame of the hurt they have caused others, often to an extent that is unhealthy. But anyone can be a drunk or a drug addict. It takes something more to truly be in recovery; honesty, commitment, patience, gratitude.

I'll say it again, the medical professionals I've met in recovery are the most honest, optimistic, grateful and supportive group of people I've ever known. They are genuinely good people. Regardless of one's opinion on whether physician addicts in recovery should be reintegrated, I would hope that we could at least try to understand that addiction doesn't make someone a bad person.

It's not a character flaw, and being in recovery means that someone has been through an intense process of honest self-assessment that the vast majority of people will never undertake or endure.

Links

https://www.aa.org/
https://na.org/
http://caduceusmeeting.blogspot.com/
https://www.idaa.org/11/

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