virginia society of anesthesiologists

UPDATE

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FALL 2023: **FELLOWSHIPS**

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The Future of the ASA Medical Student Council

By Mathew Ciurash
Virginia Commonwealth University
Richmond, VA

Mathew Ciurash

As a first-year medical student, I was attracted to the allure of surgery. I eagerly jumped into OR opportunities and was fascinated with the experience. With more exposure, I found myself gravitating towards the pilots of the operation, the anesthesiology team.

I searched for ways to immerse myself and become more involved with the American Society of Anesthesiologists. I took advantage of leadership opportunities to become the President-Elect of the Medical Student Component of ASA, soon to serve as President this fall.

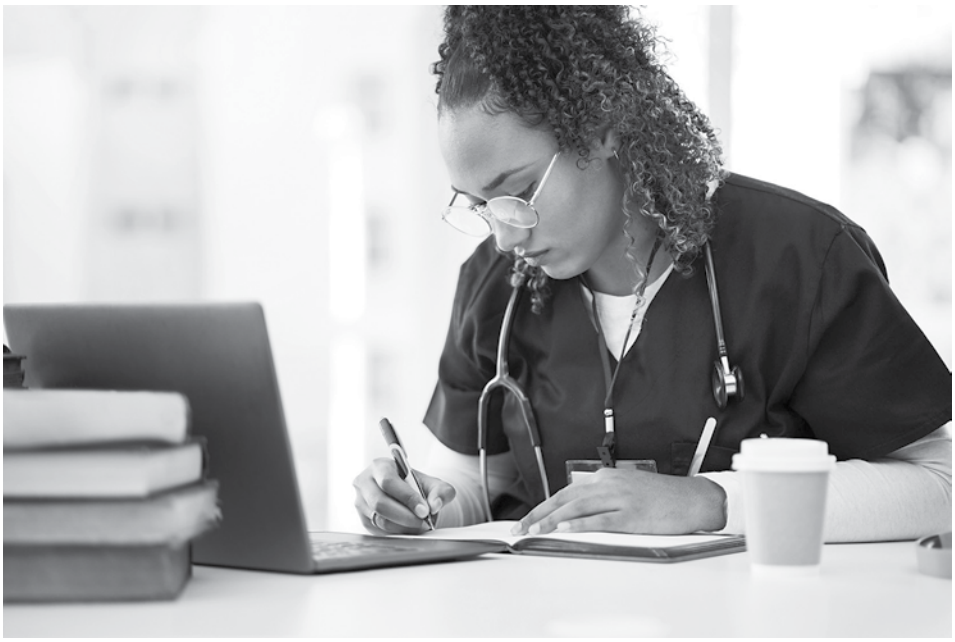
My journey as President-Elect has encompassed a spectrum of impactful experiences, collaborating with fellow physicians, residents, and students, united in our advocacy for the future of anesthesiology. This role has provided a conduit to address national challenges, develop an advocacy interview series and engage political leaders in shaping pivotal legislation.

One of my most impactful experiences within this position has been at the 2023 legislative conference, where I was able to stand in a team and advocate for the field on pivotal issues. These included anesthesiologist-led care, student-loan debt relief and residency position expansion.

Personally, partaking in the conference fortified my belief in advocacy's pivotal

Continued on page 9

Feature Article



Why Fellowships?

By Everett Fox, MD, CA-3
University of Virginia
Charlottesville, VA

Dr. Everett Fox

The thought of applying to fellowship can be a daunting task, especially in the midst of a busy CA-2 year. Many factors and preferences must be considered when pursing a post residency training program, the most important of which I found to be why one would want to continue their training for an additional year.

In today's current job market, anesthesia residents are being offered competitive salaries and benefits in both private practice and academic settings immediately after graduation. A common question along the interview trail was why I wanted to give up a year of attending pay to pursue additional education. In my case, I have found the challenges of caring for critically ill patients undergoing complex cardiac and thoracic surgeries highly rewarding and hope to make these the focus of my future practice.

Should I do a fellowship?

It depends. There has been heavy debate on the value and marketability of fellowship trained anesthesiologists in recent years. While many private practice settings do not require fellowship training to care for pediatric, OB, or cardiac patients, academic hospitals may require additional certification.

Continued on page 4

Inside This Edition: FELLOWSHIPS

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Administrative Office

VSA
2209 Dickens Road
Richmond, VA 23230-2005
Phone: (804) 565-6356
Fax: (804) 282-0090
vsa@societyhq.com • www.vsahq.org

Stewart Hinckley
Executive Director
stewart@societyhq.com

Andrew Mann
Association Executive
andrew@societyhq.com

Angela Puryear
Association Administrator
angela@societyhq.com

Newsletter Editors

Editor
Brooke Trainer, MD, FASA
brooke@vsahq.org

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@vsahq.org.

Get VSA's New Member App!

We are happy to announce the re-release of our VSA Member App.

Use it to learn about upcoming meetings and advocacy efforts, renew your dues, make a VaSAPAC contribution, read the newsletter, and more!

iPhone Instructions

1. Scan the QR code below..
2. Select the forward option (⎋) at the bottom of your screen.
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3. Choose a name for the shortcut, then add it to your home screen.

President's Message

So Long Summer, Hello Fall Review

By Craig Stopa, MD
VSA President
ASA Delegate
President, Atlantic Anesthesia Inc.


Dr. Craig Stopa

So far this year, I have focused on three main topics: workforce shortages, balance billing, and Medicare/Medicaid payment cuts. In this newsletter, I will also write about the upcoming legislative season. Therefore, I will give an update on all three previous topics and stress the importance of giving to the VaSA PAC.

In terms of workforce shortages, this topic remains a priority for the American College of Healthcare Executives (ACHE), the American Hospital Association (AHA), and the Senate HELP (Health, Education, Labor, Pension) Committee. We are still awaiting the results of the request the Senate HELP Committee sent out in March so that they could better understand the views on the drivers of healthcare workforce shortages and hear ideas on potential solutions. I am intrigued to see what comes from this request and remain optimistic. As always, I will stress to take care of yourself, so that you can take care of your patients.

Next up is balance billing/No Surprises Act. In the last newsletter, I summarized The U.S. Department of Health and Human Services data, which highlighted the difficulties of the No Surprises Act. The most recent update on this topic is overall positive.

This month, the federal court ruled in favor of the Texas Medical Association's (TMA) fourth lawsuit. This lawsuit specifically addressed the administrative fee increase implemented on January 1, 2023, and the restrictive batching rules the government had been enforcing. The court found that the government violated existing regulatory processes by raising the IDR administrative fee from $50 to $350 and establishing unworkable batching rules that did not allow physicians to sufficiently batch claims together for the IDR process.

Due to this ruling, the dispute portal will remain closed until its processes are updated. The IDR entities will continue to process claims that have been paid and received prior to August 3. However, claims that lack payment or submitted after that date will need to wait for the new fee structure to be finalized. Please be patient as the process and updates take place.

To follow is Medicare/Medicaid payments. This past April, the House introduced bill H.R. 2474. To review, the bill replaces the separate conversion factors for qualifying APM participants and other physicians with a single conversion factor, and provides for an update that is equal to the annual percentage increase in the Medicare Economic Index, beginning in 2024.

The update is that the bill has now been referred to the Subcommittee on Health. If passed, there would be an annual increase of Medicare payments to physicians.

Also, be on the lookout to join ASA's initiative to block the implementation of a new Centers for Medicare and Medicaid Services (CMS) service code known as G2211. The code is an add-on code intended to provide additional payment for certain work associated with complex Evaluation and Management (E/M) services. However, it is estimated that 90% of the projected 3.3% cuts to anesthesia for 2024 are the result of the implementation of G2211.

The ASA has already engaged with the American College of Surgeons, and other stakeholders negatively impacted by the G2211, to block implementation. Stay tuned and please participate.

Lastly, I would like to address the upcoming legislative season. I cannot overstate how critical these upcoming elections are. At least 15 out of the 40 current Senators are not returning, and approximately a third of the House of Delegates will be all new faces. With all of the new legislators, it is more crucial than ever that we educate them on the importance of the physician-led anesthesia care team and why it is best for patients. A strong and robust VaSA PAC allows us to do this. If you haven't already donated in 2023, please consider contributing today.

I hope everyone enjoyed their summer adventures and are entertained by the newsletter and stories about fellowships. Again, feel free to reach out to me with any questions, concerns, or comments, and thank you for all that you do!

Why Fellowships?, *from page 1*

Furthermore, subspecialty expertise does not always equate to higher pay. Ultimately the choice to complete a fellowship should be based on one's intrinsic desire to grow their knowledge base and skillset for more specialized cases and patient populations.

How do I get started?

Seek out a mentor! Some of the most beneficial experiences I have had in residency came from working with cardiac anesthesia attendings. These individuals are great resources for finding research projects, getting exposure to interesting cases, writing letters of recommendation, and giving behind-the-scenes perspectives and advice on what an attending's work-life balance is really like.

Subspecialty societies tend to be smaller communities, where everyone seems to know one another, and having a great mentor can help connect you with other programs when the time comes to apply. Recent former residents who went into fellowship are also invaluable resources who can help guide you through the application process and provide insight into their experience. Reach out to attendings and former residents to express interest in a fellowship and ask for ways to get involved during residency.

Start early! ERAS, NRMP and SFMatch publish timelines online for applicants to begin preparing. Make an account as early as possible to get a sense of the application requirements and documents you will need to submit to prevent any last-minute scrambling to complete your application.

While there are typically windows of time or target dates for submission, a good rule of thumb is to send your completed application close to the start of the window, so programs have an opportunity to review before being inundated with applications. Get a jump start on your personal statement by jotting down some thoughts throughout the year as you work with interesting patients and cases.

> *Ultimately the choice to complete a fellowship should be based on one's intrinsic desire to grow their knowledge base and skillset for more specialized cases and patient populations.*

When the time comes to put it all together, it will be easier to recall the highlights of your experiences. These thoughts also make excellent talking points during interviews. While some programs emphasize research, it is not required. Ask to help write a case report or present a poster at a national conference early in your training. Begin looking for recommendation letter writers months in advance of your submission deadline. A common delay for a completed application is often a single letter, so allow your writers ample time to prepare a thoughtful recommendation.

What should I look for in a fellowship program?

This answer will differ for nearly every single applicant depending on their personal and professional goals. Ultimately, a year of additional training should prepare a fellow to be competent and confident to independently care for the patients within their subspecialty.

From a personal experience, I focused less on the minutia associated with the program and more on the clinical exposure and education. Geographical location, call schedules, vacation times, educational allowances, etc. held less bearing than case mix and volume, patient acuity, and formalized education structure. My key question was this – Will I finish this program and be confident in my knowledge and skillset to take care of any cardiothoracic patient alone?

To answer this question I looked for a few key aspects in the fellowship. First, how are fellows utilized in the OR? Most programs have a mix of supervision and sit your own cases, while others are skewed to one or the other. Some programs may have fellows cover general OR cases as well.

Second, what types of cases will fellows be involved in, and more importantly are there cases fellows may not get enough exposure to? Third, what formalized education and didactics do fellows receive? It was important to me to find a program where fellows are hands on and heavily involved in a wide breadth of high acuity, educational cases without feeling like a "CA-4".

While I tend to be more of a self-learner outside the OR, having regular didactic sessions led by attendings is a huge benefit. Having gone through this entire process and starting my CA-3 year, I am extremely excited to start cardiothoracic anesthesia fellowship next summer at Emory!

Become a Contributor to the *VSA Update*

Please send your story or feature ideas about your colleagues, your practices, or issues facing anesthesiologists to:

Brooke Trainer, MD, *VSA Update* Editor
at brooke@vsahq.org

Anesthesia Rising: Reflecting on our past to inspire our future

By Melissa Coleman, MD
Associate Professor of Anesthesiology
Penn State College of Medicine

Dr. Melissa Coleman

The Wood Library-Museum of Anesthesiology (WLM)

When most people hear the word history, their eyes glaze over. As a longtime member of the Wood Library-Museum of Anesthesiology (WLM), I'm not one of those people. But there is space for all of us under this history umbrella because accounts of the past are more than names and dates.

The stories comprising our specialty's founding and evolution are empowering and inspiring. They are just the thing to bolster our spirits on long or challenging clinical days. The Wood Library-Museum houses the world's largest known collections of artifacts, books, journals, and archival records dedicated to anesthesia; these powerful vestiges are freely accessible to all ASA members.

The WLM's physical collection, located at the ASA headquarters in Schaumburg, IL, is a stunning exhibition space including a 55-foot timeline "From Darkness to Light" spanning the entrance to the building and "Legacy Hall" which displays early inhalers, general anesthetic equipment, intraoperative monitoring, and regional anesthesia devices. Our overall exhibit honors innovators and innovations in the history of anesthesia, emphasizing North American contributions. Only a short drive away, we have a 10,000-foot facility that houses the remainder of our collection.

Don't worry if you are far from our neighborhood; the WLM's online presence (https://www.woodlibrarymuseum.org/) and social media accounts (@WLMHQ) allow over 100,000 individuals to experience our collection annually. A brief tour of the website begins in the Museum Collection, which features over innovation embedded in our heritage.

> *Learning the inspiring stories of pioneer anesthesiologists may remind residents and attendings alike to look beyond the daily challenges we face and reflect on our significant contribution to medicine and patient care as physician anesthesiologists.*

Anesthesiologists provided frontline support throughout the COVID-19 pandemic, applying their skills to develop creative medical interventions. This online exhibition features the contributions of anesthesiology and anesthesiologists during other historically significant disease outbreaks. These extraordinary discoveries were born of necessity during dire periods and pushed the practice of medicine forward.

From the first public demonstration of ether anesthesia in the 19th century, physicians in the field have risen to challenges during historically formidable disease in other disciplines, historians, and other individuals with a developed interest in the history of anesthesia.

Benefits include round-trip travel to ASA Headquarters in Schaumburg, IL, a $500 grant, and lodging for up to two weeks. Travel and accommodation are for projects requiring access to collections material unavailable online. For further information, please go to the WLM website (https://www.woodlibrarymuseum.org/about/fellowship/).

Greater knowledge about the evolution of anesthesiology develops a nuanced perspective on our role in healthcare. Historical narratives allow practical reflection on lessons learned and inform our relationships and discussions with colleagues and patients, advancing our understanding of the profession. In closing, an appreciation of anesthesia history can bolster personal and professional resiliency. Learning the inspiring stories of pioneer anesthesiologists may remind residents and attendings alike to look beyond the daily challenges we face and reflect on our significant contribution to medicine and patient care as physician anesthesiologists.

In short, learning anesthesia history does not distract you from the practice of being an anesthesiologist; it will make you a BETTER anesthesiologist!

We Don't Know What We Don't Know: A Reason for additional anesthesiology training

By Brooke Trainer, MD, FASA
Anesthesiologist/Intensivist, VCU Health
Central VA HCS, Richmond VA
Editor, VSA Newsletter


Dr. Brooke Albright-Trainer

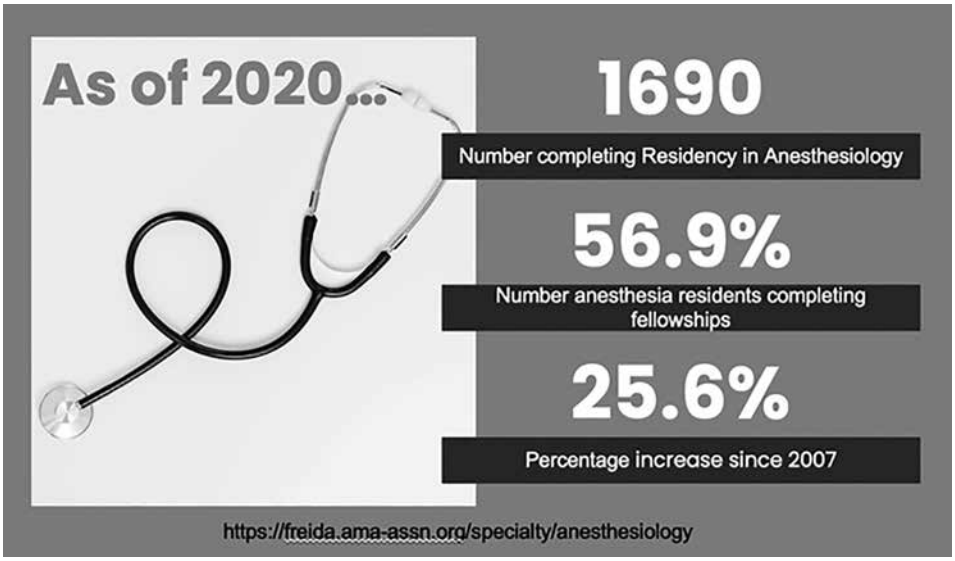
An increasing number of Anesthesiology residents are deciding to pursue fellowships in a growing number of national training concentrations. What is the rationale for wanting to pursue more training? Because we don't know what we don't know, until we learn. Perhaps, rather than seek employment immediately, graduating anesthesia residents decide to pursue fellowship training to expand their knowledge base, and further focus their expertise in order to better care for complex patients. But this sacrifice comes at a great cost, including another year of lost income potential, long work hours resulting in more time spent away from family, and risk of burnout. When one considers the efforts underway to dismantle physician-led anesthesia care teams threatening the future delivery of anesthesia care, are Anesthesiologists needlessly sacrificing lifestyle, money, and time away from family by pursuing fellowships?

The statistics

Out of 1,690 students who completed Anesthesiology Residency in 2020, 56.9% went on to complete additional training. Though this percentage is up 25.6% from 2007, it has fallen 2.4% since 2017. The majority of graduating anesthesia residents (96%) find employment WITHOUT fellowships.

Interestingly, only 85.5% of residents graduating decide to go on after training to practice anesthesia. We will explore the rationale for this later in this article.

Currently, there are 16 major fellowship/subspecialty training concentrations for residents to choose from to further their education beyond anesthesia residency.

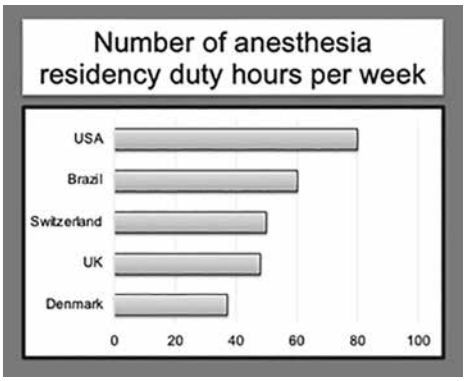


Six anesthesia specialty fellowships are accredited by the Accreditation Council for Graduate Medical Education (ACGME): Pediatric, Cardiac, Pain Management, Intensive Care Medicine, Obstetric, and Regional/Acute Pain.

So why should graduating anesthesia residents pursue a fellowship after residency? Simple. Education matters. Training matters. The fact is, we don't know what we don't know, until we take the time to learn.

Malcom Gladwell popularized the "10,000-hour rule," in his book 'The Story of Success: Outliers', asserting that the key to achieving true expertise in any skill is simply a matter of practicing, albeit in the correct way, for at least 10,000 hours. And plenty of studies support this concept. For example, a population-based cohort study of 8096 pts from 2007- 2013 published in *Jama Surgery* in 2021, supports the notion that higher volume anesthesiologists (ie more experienced anesthesiologists) produce better outcomes in high-risk GI cancer surgeries such as esophagectomy, pancreatectomy, and hepatectomy. They describe the need to perform at least 6/year to qualify as "high volume/experienced". This study supports the "experience" theory that more experience equates to better outcomes.

In the US, anesthesia residents certainly meet the number of education and training hours for mastery of anesthesiology when they graduate. In fact, they work more hours



a week than any other country around the world!

Even if we assume a 60-hour work week, you can see that by number of hours alone, anesthesia residents certainly have the potential to achieve mastery in 4-years-time!

When you consider the relevant clinical hours you achieve in medical school, it's

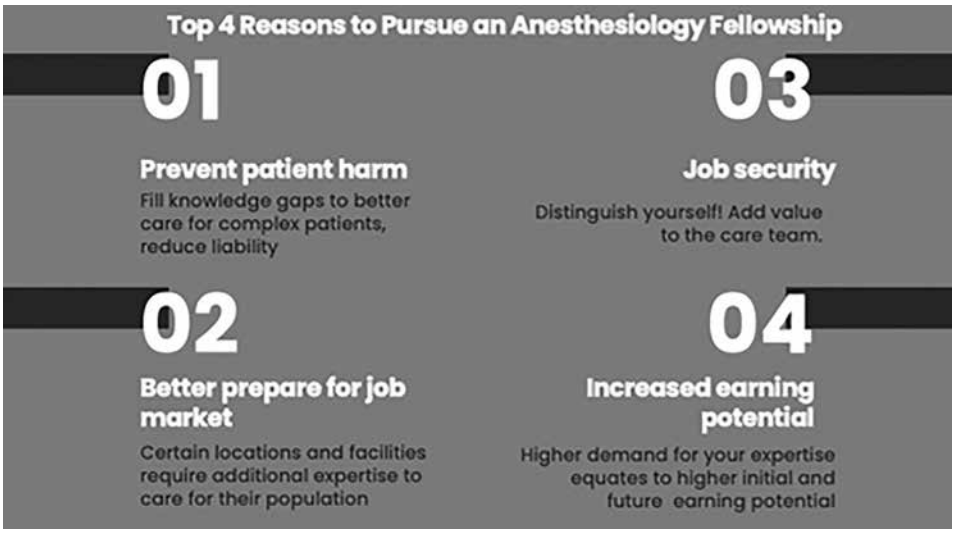
Continued on page 7

possible that anesthesia residents actually amass closer to 16,000 hours of training in 8 years.

The US population is aging, and patient comorbidities are increasing, making management of their anesthetics more complex. Is it possible that increasing patient complexity is the reason why some graduating anesthesia residents (14.5%) decide not to practice anesthesiology upon graduation? Knowing this, is it enough to say that when we graduate anesthesia residency we are "masters of anesthesiology"? Are we truly "experts" in all things related to the practice of anesthesia medicine?

To reiterate, of those more than 10,000 hours achieved in residency training, the only hours that count according to Malcom Gladwell's rule, are the ones performed the "correct way". For the specialty of anesthesiology, there are many areas outside of didactics that must be learned. For example, anesthesia residents must also learn procedures, the use of technology, how to interpret and keep up with evolving evidence, and much more. With the number of rapidly evolving concepts needed to master, it's difficult to say that in 4 years any anesthesia resident has actually achieved "mastery" in the field of anesthesiology.

Most likely, the primary reason driving more than 50% of anesthesia residents to pursue additional fellowship training is the desire to better prepare for unexpected issues which may arise during the care of our patients. This is especially true when one considers the evolving complexity of patients and technologies. For example, those with congenital heart disease are now living long enough to have babies, as well as undergo more common surgical procedures, like colonoscopies and hernias, making low risk procedures more dangerous and complicated. And an increasing number of left ventricular assist device (LVAD) patients are presenting for elective or semi-elective cases. Further complicating our everyday practice are the huge advancements in regional nerve blocks, now performed under ultrasound, the number of new medications incorporated, and the evolving use of point of care ultrasound (POCUS) that we are expected to learn and adopt to aide our ability to rapidly diagnose and treat disease. When one considers these increasing expectations, it is easy to understand how an additional year of fellowship training is needed to improve the comfort levels of new young physicians practicing after graduation.



Medicine is not just about getting the job done, it's about getting the job done right.

Adding to this stress is a generational wave of an aging population affecting the demand portion of the shortage equation and further stressing an already tight market. This older population not only adds to the gross quantity of cases, but also to the complexity of the cases, which contributes to increased production pressures, burnout, and job dissatisfaction, and possibly further explains why only 85% of graduating anesthesia residents go on to practice general anesthesia.

So why argue for more education and training?

To reiterate, it's because education matters. Training matters. Medicine is not just about getting the job done, it's about getting the job done right.

The fact is, we don't know what we don't know, until we take the time to learn. Physician anesthesiologists go on to pursue fellowships to attain additional expertise in managing complex patients. This desire is built out of a healthy fear of not wanting to harm their patients.

Though medical school and anesthesia residency may adequately prepare aspiring anesthesiologists to safely care for patients, some physicians still choose to pursue fellowships after experiencing challenges which have inspired them to expand or focus their knowledge in a particular area.

To break it down, there are 4 primary reasons for anesthesiologists to consider when deciding to pursue an anesthesiology fellowship:

1. Prevent Patient Harm

Delivery of high-quality safe anesthesia care is directly tied to education and training. And an aging population means that the complexity of our patients is increasing, leading to an increase in medical demand. In a specialty such as Anesthesiology or Critical Care, where seconds of decision making can mean the life or death of your patient, there may be no time to second guess your decisions, call for help, or search the literature. It is well known that age and medical, and physical condition of patients are major risk factors for serious critical events.

Statistics show that additional experience and seasoned attendings equates to fewer anesthetic errors. Sakaguchi et al. reported that the most common types of medications associated with the incidence of errors are opioids, cardiac supports, and vasopressors; and interestingly, the responsible anesthesiologist for medical errors were commonly doctors with little experience. Additionally, Cooper et al found the rate of medication error (two-fold increase) were higher by anesthesia-in-training providers compared

Continued on page 8

to an expert doctor, most commonly due to incorrect dose and drug substitution.

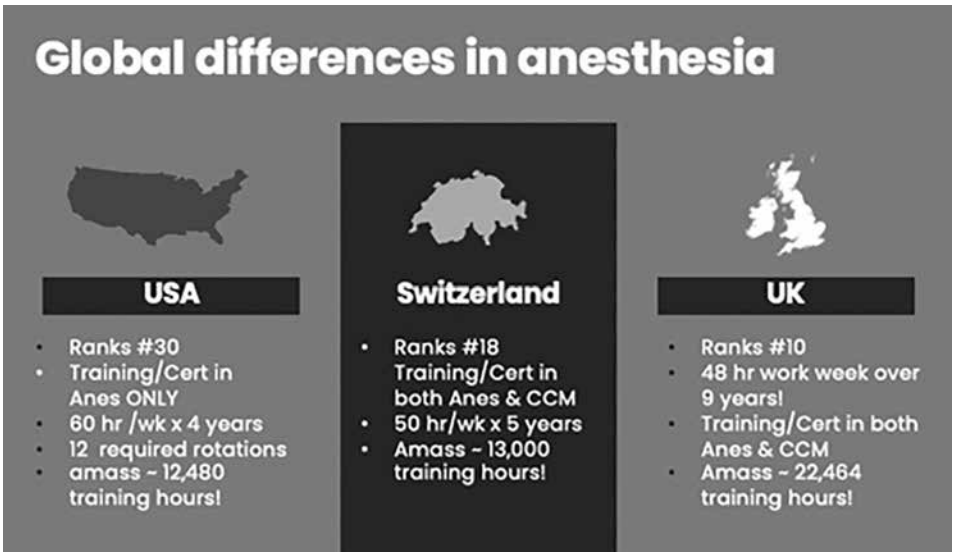
Experience and training are especially vital in the health and safety of our vulnerable populations. The APRICOT study, a prospective multicenter observational study in 261 hospitals in Europe, highlighted the critical role pediatric fellowship trained anesthesiologists play in reducing the incidence of severe critical events in children undergoing anesthesia. This multivariate analysis demonstrated that the beneficial effect of reducing respiratory and cardiovascular critical events was due to years of experience of the anesthesia care team member, rather than the type of health institution. Additionally, a retrospective study from 2013 – 2017 in *Anesthesiology* suggests that OB Specialization (either fellowship training or 5 years of OB 33% of time) leads to decreased use of general anesthesia for cesarean delivery in our laboring mothers. When you consider guidelines published by the American Society of Anesthesiology's task force on obstetric anesthesia explicitly stating anesthesia providers should "consider selecting neuraxial techniques in preference to general anesthesia for most cesarean deliveries", it is possible to see that increasing patient access to obstetric-specialized anesthesiologists represent one route for promoting increased utilization of neuraxial anesthesia, a safer anesthetic modality in many cases.

2. Better prepare for the job market

Sub-specialization facilitates career pathway development. It better prepares you for the job market, making you more marketable, and allowing for more opportunities. The ASA website says about fellowships, "The value of a fellowship extends beyond simply performing cases or procedures; fellowship-trained anesthesiologists can use their expertise to provide consultation or start programs. For example, a regional trained anesthesiologist could set up a nerve block catheter service for an outpatient total joint program, or a pediatric-trained anesthesiologist could advise on anesthesia staffing and hiring for a hospital that is starting a pediatric surgery program".

3. Provide Job Security

For those worried about the political landscape with a fear that physician anesthesiologists will one day be replaced, consider increasing your value to anesthesia care teams by making yourself more competitive and invaluable, thereby further securing your role on the team.



Some have argued that if the future of anesthesia includes nurse anesthetists, with much less experience and fewer years of training, being allowed to practice independently and bill at similar rates, then there is no point extending anesthesiology training periods. However, we know that knowledge is power, and training is necessary to become experts. Therefore, regardless of the political landscape, our focus as physicians should always be to "do no harm". By attaining additional training, it will not only help improve patient outcomes, it widens the gap between physicians and other care team members, leaving no question that physicians are invaluable to the care team and that replacing them would be detrimental to patient outcomes. It is clear, the more you know, the more agile and adaptive you are to handle complex cases, especially when emergencies arise. When seconds matter, mastery of a skill saves lives.

4. Increased earning potential & job satisfaction

In 2021, the Medscape compensation data report showed that most anesthesiologists believe that making good money and being very good at what they do is the most rewarding part of their job. If this is true for general anesthesiologists, then it must also be true for fellowship-trained anesthesiologists. After all, sub-specialization offers an opportunity to increase your salary AND your comfort performing cases, especially complex ones, which in theory should increase your overall job satisfaction.

As we look toward the future of anesthesiology and aim to further distinguish ourselves from other care team members, extending anesthesia training by one additional year offers us the ability to extend our capabilities beyond the OR and into other areas in the hospital, making ourselves more valuable to patients, surgeons, and hospital administrators. It also further aligns us with our European colleagues who routinely cross train as anesthesiologists and critical care intensivists. One Swiss trained anesthesiologist freely admitted that he was taught how to intubate by a CRNA and she was really good at it; however, not once did he ever hear a Swiss CRNA proclaim that they function equivalently to a board-certified Anesthesiologist. Why? Because of critical care, the scope of practice was too different.

Another year of training would also allow residents to expand their knowledge in internal medicine, offering additional expertise in managing patient comorbidities and optimizing their medical conditions preoperatively. Perhaps this additional medical training in residency would build the confidence needed for anesthesiologists to take a more active role in preoperative clearance, thereby helping to reduce the ridiculous number of medical consults required for clearance. This is another "Americanism", which is seen to a much lesser extent in

Continued on page 9

Additional Training, *from page 8*

Europe. How often does a medical consult from a PCP or general internist actually add value to the perioperative care of the patient? These consults are requested on the grounds of legal protection; however, more often than not, they are counterproductive. When an internist writes "avoid hypotension" and the surgeon then loses vascular control and the patient is found to be hypotensive for 15 minutes while we resuscitate, how is that recommendation helpful?

Several arguments can be made opposing the need to pursue additional years of anesthesia training. For one, the additional acquired knowledge does not guarantee mastery. As noted by Hastings and Rickard et al, anesthesiologists need several years of experience after residency to secure a consistently superior level of performance. Continuous deliberate practice in the intended field of practice is vital, and the journey toward expertise depends on the individual's motivation to excel and to pursue lifelong learning. Second, what you learn in fellowship may not necessarily be what you practice. And third, the pursuit of additional training comes at a great sacrifice, including a year of lost salary and time away from family.

In conclusion, the decision to pursue additional anesthesia training beyond residency is dependent on various personal needs and desires. But despite the sacrifice of time and money, as well as the looming threats to the anesthesiologist's role on the care team, an increasing number of residents are continuing to pursue fellowships after residency to seek additional knowledge and specialized training. Regardless of how it happens, the future of our medical specialty depends on skilled, knowledgeable, and competent physicians who are able to master the field of anesthesiology, and fellowship training may be one path towards that goal.

Resources

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Medical Student Council, *from page 1*

role, motivating me to extend this fervor to encourage others in supporting anesthesiologists and the patients affected by legislative decisions. This collective endeavor remains the compass guiding the trajectory of anesthesiology and my goals for impact in 2024.

In this tapestry of collaboration, I have helped to develop a medical student liaison project that will create leadership opportunities for other students and inspire the upcoming generation for much needed advocacy in anesthesiology. Students will serve as representatives in state legislative meetings and be shaped into political leaders in the field starting in medical school.

As these student liaisons forge pathways between their state components and medical schools, they shall also be architects of progress. Their proactive stance in identifying and disseminating opportunities, from research endeavors to community outreach, unveils a vision where anesthesia students are poised to contribute substantively to the field's growth.

> *My journey as President-Elect has encompassed a spectrum of impactful experiences, collaborating with fellow physicians, residents, and students, united in our advocacy for the future of anesthesiology.*

This initiative embodies a juncture where a new generation of anesthesia leaders takes root, skilled not only in the art and science of practice but also fervently advocating for its dynamic development.

In culmination, my tenure as the Anesthesia Medical Student Component President has woven a tapestry of collaboration, advocacy, and shared dedication, extending beyond the boundaries of my initial impression. This journey has unveiled the potential of collective effort and illuminated my goals for the future. Furthermore, it has opened doors within my institution, nurturing connections with my community of anesthesiologists.

As I tread onward, I'm committed to amplifying anesthesiology's narrative and invigorating fellow students to actively shape a brighter future for the field.

Regional Anesthesiology Fellowships: The past, present, and future

By Bryant Tran, MD
Associate Professor of Anesthesiology
Virginia Commonwealth University,
Richmond, VA

Dr. Bryant Tran

Introduction

Regional anesthesiology and acute pain medicine (RAAPM) is a subdiscipline whose history dates back half a century. RAAPM has gained popularity over the past 15 years. Within the context of the Virginia Society of Anesthesiology (VSA) readership, this article delves into the development of RAAPM, outlines the current state of its fellowship training pathway, and discusses how the subdiscipline may evolve in the future.

The Past

Fellowship in RAAPM was once an integration of the last 6-12 months of the core anesthesiology residency. Eventually the curriculum separated into a one-year program. Five programs existed in the 1990s. Currently, we have seen growth to over 80 programs in the United States and Canada. Nerve stimulation technique has been overtaken by the use of ultrasound-guidance, and this transition occurred in the early 2000s. The evolution of intralipid as a rescue agent has revolutionized the safety of performing nerve blocks. Long-acting local anesthetics such as liposomal bupivacaine are now commonplace, as well as the use of adjuncts such as dexamethasone, dexmedetomidine, and buprenorphine.

Two regional fellowship programs exist in Virginia, located at the University of Virginia (UVA) and at Virginia Commonwealth University (VCU). UVA's fellowship program was founded by Dr. Ashley Shilling in 2009 and was formally recognized in 2020 by the Accreditation Council for Graduate Medical Education (ACGME). VCU's program was founded in 2017 by Dr. Bryant Tran, and to date, the program has not yet applied for accreditation. The current fellowship program directors are Dr. Brett Elmore at UVA and Dr. Michael Buxhoeveden at VCU.

The Present

UVA's RAAPM fellowship trains four people per year, while VCU has two positions per year. Since its inception, approximately 45 anesthesiologists have completed a RAAPM fellowship either at UVA or VCU. To place this statistic into context, the VSA currently has 797 members, most of whom are anesthesiologists, who serve a catchment area of 8.642 million people in the state of Virginia. Some practice out of the state upon completion of the regional fellowship program, but most remain in Virginia.

When talking about the present state of regional anesthesia fellowships, it is important to know about the organizational structure which maximizes the extra year that anesthesiologists train to become experts in this trade. In 2017, RAAPM was approved by the ACGME. Initially 7 programs entered this pathway, and over 40 programs are now participating. Programs under ACGME guidance boast standardization of content, consistency, and legitimacy of the subspecialty. Because of applicant demand, a formalized match system was implemented in 2023. Collaboration of programs on a national scale requires organization that a match system has brought to the selection process. A formative regional anesthesia exam is not in place, but collaborative efforts from program directors have created an educational question bank that many fellows use throughout their training year.

The promising landscape of regional anesthesia can be seen through the *Regional Anesthesia and Pain Medicine* (RAPM) journal and through efforts led by the American Society of Regional Anesthesia (ASRA). RAPM now has the highest impact factor of any subspecialty anesthesiology journal. The ASRA Annual Meeting continues to see record numbers of abstract submissions and its participants are diverse. Point-of-care ultrasound (POCUS) is becoming increasingly popular. Lastly, ASRA hosts monthly webinars via virtual platform, which allows for international reach of educational content.

The Future

In Virginia, RAAPM fellowship training is valued in centers with high orthopedic surgery volume. Sports medicine brings in a big referral base for regional anesthesia services, and an aging population requires an exponentially increasing demand for total joint replacement. Acute pain medicine is also valued with complex patients presenting for burn, transplant, and trauma care. The community's need for regional anesthesia services is not currently met by the supply of those fellowship trained in RAAPM. While fellowship training is not required

Continued on page 11

Regional Fellowships, *from page 10*

to perform regional anesthesia procedures, every practice should ideally have at least one fellowship trained person in RAAPM. These individuals have expertise, but they also garner trust across all fields. Academic practices should ideally have multiple people that are fellowship trained. Patients are complex, sometimes having body mass indices approaching triple digits. An increasing number of patients have undergone spine surgery or vascular surgery, while others may have medical or psychological ailments which may lead to difficult pain control during the perisurgical period. These factors account for the difficulty in successfully and safely completing a regional anesthesia procedure.

Because regional anesthesia is now more commonplace, and ultrasound technology is widely available, one may argue that a fellowship year is unnecessary. However, the advancement of this subspecialty extends beyond technical proficiency. We need committed leaders in the field to guide us because there is still evolution in clinical practice, in scientific discovery, and in organizational management. A one-year fellowship is a reliable springboard to fill this role.

Over the past 10 years, plane blocks such as the erector spinae plane (ESP) and the transversus abdominis plane (TAP) block have been in the research spotlight. Enthusiasm in this arena may wane, and future endeavors may focus on practice elements related to transitional pain management. For example, peripheral nerve stimulation, the use of perioperative fluoroscopy for neuraxial procedures, and cryotherapy are recent topics of interest in our field. In the near future, we will see artificial intelligence models that predict block success, and we will have simulation models that will speed up the learning curve for competency.

We need committed leaders in the field to guide us because there is still evolution in clinical practice, in scientific discovery, and in organizational management. A one-year fellowship is a reliable springboard to fill this role.

The future will likely involve multidisciplinary practice in regional anesthesia. The American Society of Regional Anesthesia Annual Meeting has increasing attendance from emergency medicine physicians as well as pain nurse practitioners. With a natural evolution of the subspecialty, a board certification pathway may eventually come to fruition. The goal of this certification would not be to restrict the number of anesthesiologists who regularly offer regional anesthesia to their patients, but rather, set a standard of excellence so that anesthesiologists can remain at the forefront of patient care, continue to be leaders in research, and guide the future direction of the field. Regional anesthesia techniques have greatly diversified in the number of different procedures that can be offered and in the number of different settings in which they are useful. In the current climate, the public would give most credence to the fellowship-trained, board-certified anesthesiologist who could determine the most appropriate regional anesthesia indications.

Conclusion

In conclusion, the RAAPM fellowship has the benefits of career advancement on an individual level, improves patient care at the community level, and is necessary to advance the subspecialty through research. The training programs at UVA and VCU continue to provide anesthesiologists who deliver reliable regional anesthesia services for the state of Virginia.

ASA August Board of Directors Summary

By Jeff Green, MD, MSHA, FASA
ASA Director
Boyan-Keenan Professor of Anesthesia Safety
VCU Medical Center
Richmond, VA

Dr. Jeffrey A. Green

On August 18-20, the ASA Board of Directors (BOD) held a meeting in Rosemont, IL, just a short shuttle ride from Chicago O'Hare International Airport. The BOD meets twice a year with a full agenda, in March and August, and again in a brief session immediately following the conclusion of the House of Delegates (HOD) at the annual meeting.

At each of its full sessions, the board reviews and acts upon reports and statements from ASA's many committees, as well as resolutions from component societies and individuals, and recommendations from the Administrative Council. Our board is unusual in its size, with representation from every state component society which, including directors and alternates, comes to about 130 members in total. One of the items heard by the BOD was a report from ASA's retiring CEO Paul Pomerantz on the challenging financial situation for medical societies and ASA's budget deficit. To balance the budget, the HOD, in addition to significant cuts in expenses, will consider a modest dues increase, in line with other similar organizations, in its October session.

There was no shortage of excellent reports from ASA committees at this meeting. There were several statements moved forward to the HOD which will serve to act as guidance documents for ASA members, once approved by the HOD.

During the BOD, the ASA leadership also presented the annual awards to high-achieving component societies as part of the Component Recognition Program, which was designed to highlight innovative initiatives being done by the state societies. I'm pleased to report that the Virginia Society of Anesthesiologists, won the large component award for our 'Rest Assured' public awareness campaign.

I continue to be honored to serve as your Director for Virginia. As always, if there is anything the VSA or I can do to help with your practice, please do not hesitate to reach out to me at Jeffrey.green@vcuhealth.org.

Discussion on the merit of VCU's Preoperative Outpatient Clinic

Daniel Ratushnyak, MS4
(Co-first author),
Virginia Commonwealth University School of Medicine

Michael Guardado-Montesino, MS4
(Co-first author)
Virginia Commonwealth University School of Medicine

James Henry Wilson II, MD, CA2
Virginia Commonwealth University Health System


Daniel Ratushnyak


Michael Guardado-Montesino


James Henry Wilson II

Preoperative Anesthesia Clinics (PACs) have become more popular in recent years. PACs have been found to benefit both the patient and hospital system through enhanced clinical outcomes, increased patient satisfaction, improvement in OR efficiency by reducing same-day surgical cancellations, reduction in length of stay, and overall improvement in postoperative mortality risk[1,2].

The Preoperative Assessment, Communication, and Education Clinic (PACE) is an outpatient clinic at VCU Health which serves to optimize patients prior to surgery. Referrals to the clinic come from a variety of surgical departments at VCU Health, where patients are expected to benefit from risk stratification and optimization of comorbidities. Patients are typically seen at the newly established Adult Outpatient Pavilion, or, when appropriate, via telephone or virtual encounter.

The primary goal of VCU PACE is to reduce perioperative morbidity and mortality by coordinating medical care with a diverse set of healthcare providers including the surgical, anesthesia, and consulting services. The clinic has also served in a teaching capacity by offering clinical rotations to third-year medical students.

Medical students at VCU have the opportunity to rotate through the PACE Clinic during the ambulatory block of M3 year. Students benefit from the educational value obtained by honing their newly minted clinical skills through evaluating and optimizing a variety of medically complex patients.

VCU is joined by their sister colleges of University of Minnesota, Harvard Medical School, and the University of Michigan in offering exposure to preoperative clinics to clerkship medical students, exposure which has been traditionally limited to resident physicians. By working in close collaboration with attending anesthesiology physicians and senior anesthesia residents, students who rotate through the PACE clinic develop a greater understanding and appreciation of Anesthesiology and its scope of practice as well as principles of Perioperative Medicine.

"Prior to starting this rotation, I really didn't know what to expect of pre-surgery evaluations as my only exposure had usually been from the primary care experience I had in my clerkships. Patients would usually come in for a visit with a form in hand and request the physician to fill in any notable concerns, labs, imaging, or physical exam findings.

"What surprised me the most during my time at the PACE clinic was the access to information and records as most patients were already connected to our EMRs. Our thorough review of patient records and ability to coordinate patient care through our centralized system made these pre-op visits significantly more valuable.

"I'd also be remiss to not include a shout-out to our allied health staff that all play such an important role in maximizing the use of clinic time."

- Daniel Ratushnyak, MS4
VCU School of Medicine

"I found my time at the clinic to be rewarding since it allowed me to utilize the clinical skills and knowledge obtained during my pre-clinical years. Rotating through the PACE clinic also helped me develop a new perspective on the Preanesthesia evaluation process.

"Optimizing patients for surgery can be complex, and assessing a patient's safety to undergo anesthesia isn't always clear cut. Patients visiting the clinic would come in with a variety of medical co-morbidities and other risk factors that could potentially place them at higher risk for surgery.

"After spending four-weeks in the clinic, I became more proficient in discerning pertinent information from my history taking and medical record reviews. Overall, I found my time at the clinic to be a great learning experience. I learned a lot from my interactions with faculty, residents rotating through the service, and through my patient interactions!"

- Michael Guardado-Montesino, MS4
VCU School of Medicine

Appointments at VCU PACE occur days to weeks ahead of the scheduled procedure, providing ample time to optimize each patient. Prior to the in-person visit for patients previously triaged to an in-person visit, there is a phone consultation with a pharmacist who performs a medication history review with the patient. The VCU PACE Clinic has two full-time pharmacists dedicated to these positions. This not only provides PACE staff with accurate and up-to-date information regarding medications but additionally provides an opportunity for pharmacists to address any significant discrepancies by documenting and/or advising the patients of any errors.

Here at VCU from January through November of 2022, our PACE clinic has identified 1,802 high risk medication discrepancies, added 524 allergies, and modified a further 1,162 listed allergies. Patients at PACE undergo a thorough review of prescribed medications and decisions to continue or discontinue a medication prior to surgery is taken after careful consideration of the patient's individual risks factors.

Perioperative medication management is vital since certain high-risk medications (i.e., antiplatelet, anticoagulants, insulin,

Continued on page 13

PACE Clinic, *from page 12*

diuretics) could result in life-threatening operative complications (bleeding, hypoglycemia, or electrolyte abnormalities). As previously studied by Haddad et al[1], the inclusion of pharmacists in the preoperative anesthesia clinic for the purpose of a detailed medication reconciliation has been associated with increased accuracy of medication documentation and interventions to address high risk inconsistencies.

After completion of the medication history appointment, a patient is then scheduled to be seen by a VCU PACE provider via in-person appointment, virtual visit, or a telephone encounter. The appointment type provided to patients is dependent on the risk of procedure scheduled, and patient health status. Patients undergoing low-risk procedures are generally screened via telephone encounter while most others are completed in-person.

In-person visits are conducted by a nurse practitioner, physician assistant, and/or a resident physician under the direct supervision of an attending anesthesiologist. Patients seen in the clinic undergo a comprehensive medical examination including history review, physical exam, and any necessary preoperative workup. During the appointment patients also receive preoperative instructions specific to their scheduled procedure. Any preoperative concerns identified during the appointment are communicated to the surgery team well in advance of the scheduled procedure.

After each visit, a preoperative plan is formulated for every patient in coordination with the surgical team. Any additional workup (consultations, record review, labs, imaging, prophylaxis etc.) deemed necessary prior to the procedure are arranged by the staff at PACE.

Following the in-person pre-operative visit, with a fresh medication reconciliation performed by either clinic staff, or additionally a pharmacist when indicated, changes to medications of interest such as beta blockers or anti-coagulants are conveyed to all staff involved in the surgical care of the patient. This inclusion of surgical and anesthesia staff ahead of time allows for their input, and should any modifications be requested, sufficient time for the patient to begin their adjusted regimen.

The value of this clinic is shared by not only the patients, the staff, or the institution but by learners as well. For the authors of this article, the experiences and insight gained from a rotation in VCU's PACE clinic will have long lasting impressions on the impact that coordinated, patient-centered, and outcome-directed planning have on our patients and highlights our dedication to their wellbeing and best outcomes.

How to contact PACE clinic and inquire for additional information

Olga Suarez-Winowiski, MD, MSc HAS
Medical Director of PACE
olga.suarez-winowiski@vcuhealth.org
PACE Clinic at AOP Building
1001 E Leigh St, Richmond, VA 23219

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VSA POCUS Workshop a Success

By Mike Saccocci, DO, MPH, FASA
Assistant Professor, Department of Surgery
Virginia Tech Carilion SOM
Roanoke, VA

Dr. Mike Saccocci

I'm thrilled to report that the VSA's inaugural POCUS Workshop was a complete and resounding success, as judged by the strongly positive feedback from the participants! We had 29 VSA members participate in the hands-on workshop, which was held September 16-17 at the Hotel Roanoke. Participants were trained in hands-on techniques to better understand and integrate POCUS techniques into their anesthesia practice. The workshop was accredited for a maximum of 13.5 AMA Category 1 CME credits.

Saturday's agenda included training on airway ultrasound, lung ultrasound, focused cardiac ultrasound, gastric ultrasound, and abdominal ultrasound for free fluid. Fujifilm SonoSite provided 9 ultrasound machines, mirroring the variety of new and older ultrasound technologies likely to be found in practice. On Sunday, participants integrated what they learned into real-life case-based scenarios. Intelligent Ultrasound provided an ultrasound simulator, which permitted learners to acquire images of, and recognize, actual pathologies in real-time, via a high-fidelity echocardiography simulator. Karl Storz Endoscopy provided demonstrations and hands on use of equipment during the lunch breaks. A lunch-and-learn virtual discussion on billing for a POCUS service was very well attended. Many participants also took the opportunity to be evaluated by our course faculty, who served as "local mentor" evaluators, allowing participants to log case credit towards optional ASA Diagnostic POCUS Certificate Part 4 requirements!

On behalf of the VSA POCUS Workshop committee, we wish to express our heartfelt thanks for the dedication of our course faculty, VTC and VCOM medical student ultrasound models, our corporate sponsors, and most especially, the tireless efforts of Andrew Mann and Angela Puryear, who were keystones to the success of this VSA event!

We will be surveying the VSA membership soon to gauge interest in future POCUS workshops and look forward to these educational endeavors!

Elevating Your VSA Experience: Welcome to Our Digital Drive

The anesthesiology landscape is in a state of constant evolution, and so too are the ways we connect with one another, our patients, and the broader public. To remain at the forefront, our communication tools must keep pace with these changes.

Under the leadership of Dr. Brooke Trainer, the VSA board has been hard at work adopting digital tools and expanding our social media presence. Our aim is twofold: to enhance our engagement with you and to amplify public awareness about our roles as leaders of the patient care team.

Our successful "Rest Assured" campaign last fall is a testament to the power of unified communication. It underscored the impact of clear communication and a robust digital presence — not only among ourselves but also for the wider public. The positive feedback and lessons we learned propelled us toward this refreshed initiative.

Introducing VSA's Digital Platforms

To bring you a range of channels, we've teamed up with Jason Roop of Springstory, the Richmond-based public relations and content marketing firm that led our Rest Assured campaign:

FACEBOOK

You probably know that we've maintained a private Facebook Group — and you may be a member, we hope. But we realized that we need to establish a more public-facing Facebook Page that represents you and the work that VSA is doing.

LINKEDIN

Connect, network and stay updated through this professional-focused platform. Our new VSA Page primarily will house VSA-centric news, offering insights into member achievements, organizational updates, and the latest on our continued endeavors to advance patient safety and professional excellence.

X

Whether you call it Twitter or X, this platform remains an ideal medium for quick updates. Members of media and public officials remain engaged here. We will continue to share research breakthroughs, legislative updates, member achievements and industry news.

INSTAGRAM

We're following the lead of our ASA colleagues here (@asa_hq) with our new channel, @vsa_hq). This is a more visual experience but we'll attempt to communicate informative content with the public and each other.

What's in It for You

With this integration, our digital revamp aims to offer an enhanced member experience:

1. Real-Time Updates: Stay informed about VSA news, professional opportunities, industry advancements and breakthroughs.
2. Professional Development: Get timely information on member-exclusive events, conferences and seminars tailored to advance your practice and professional growth.
3. Advocacy: Strengthen our collective voice. Help amplify and collaborate on campaigns, contribute to dialogues, and shape the future of our profession.
4. Networking: Build lasting connections with your peers and partner organizations, reinforcing our joint efforts in anesthesiology.

Your Role in This Digital Journey

Our communications upgrade, while facilitated by VSA, is fundamentally about reinforcing our shared community. We invite you to join our new channels at the links provided. Remember, social media thrives on active participation. Whether you follow, like, share, or comment — each interaction enhances our reach and impact.

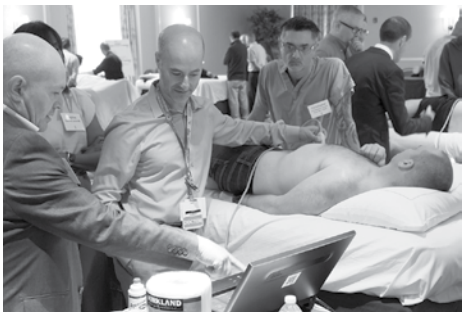
The VSA board is steadfast in its mission to nurture an environment conducive to shared growth, knowledge exchange, and unwavering support. Together, let's ensure Virginia's anesthesiology community remains unparalleled in its excellence.

Rave Reviews for VSA's POCUS Workshop

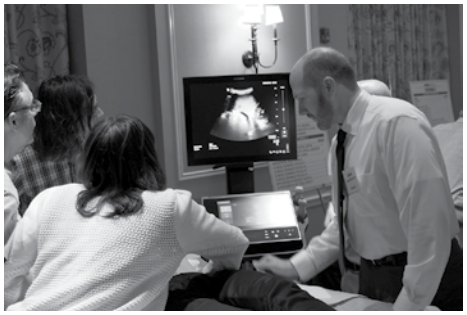
- "I seldom learn new techniques at conferences but the practical portion was very helpful had the most worthwhile techniques that will enhance my clinical practice."
- "Very enjoyable, highly informative and very well presented. Highly recommend to others."
- "The pre-course reading was an excellent primer for the course. The combination of lecture followed by practice followed by reflection on scanning was an effective method to reinforce the information presented."
- "Fantastic workshop and well run, organized with great faculty leadership."
- "The instructors were fantastic, and the models helped out tremendously. It was nice to be able to use different types of ultrasound machines as well."
- "Excellent organization and high value. Excellent equipment and instructors. Live models allows for excellent real-life challenges."
- "Fantastic overall workshop, can't thank the UVA and VCU colleagues enough for coming to Roanoke and donating their time."

Photos From VSA's Point of Care Ultrasound Workshop

September 16-17, 2023 | Hotel Roanoke








For more photos from the workshop, check out the VSA Update online!

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