virginia society of anesthesiologists

UPDATE

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SPRING 2024: **PATIENT SAFETY**

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Virginia Patients Deserve the Best Quality Care - Wherever They Live

Physician anesthesiologists support current state law, which provides for access, safety, and a team-based approach to health care.

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By Robert Shafer, MD
Vice President
Anesthesiology Consultants of Virginia
Roanoke, VA

Dr. Robert Shafer

When I served in the U.S. Navy as a military doctor, I had the opportunity to work alongside some of our country's best and bravest. Whether in friendly waters or the combat zones of Afghanistan, we sounded a unifying refrain: teamwork.

The Navy has no official motto, but one that's stuck around is Non sibi sed patriae — not self, but country. Our goal is to work together under pressure toward a greater mission.

There's a similar feeling in the hospitals and operating rooms of the Roanoke area, where I serve as a physician anesthesiologist alongside some of Virginia's most skilled health care professionals, which include certified registered nurse anesthetists, or CRNAs. Our patients are the focus. Their safety and well-being is our mission. And we achieve the best results for those patients when the health care providers work together as a team.

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Feature Article

Understanding International Anesthetic Practice to Help Guide Safer Care in the United States

By Gavin Brion, MD
Anesthesiology Resident
University of Virginia
Charlottesville, VA

Dr. Gavin Brion

As anesthesiologists, we are tasked with creating an anesthetic plan that is tailored to each of our patients. These plans must take into account a multitude of factors, including the patient's individual preferences and their comorbidities, the type of surgery, as well as economic and environmental considerations. Even with the ever-changing landscape of peri-operative care, patient safety has always been at the forefront of what we do. With the introduction of new technology, advances in the understanding of consciousness, and development of new medications, undergoing general anesthesia has become safer than ever before.

Many of the medications that are administered by an anesthesiologist are extremely dangerous medications and, without proper understanding of their properties, could cause permanent psychological or physical

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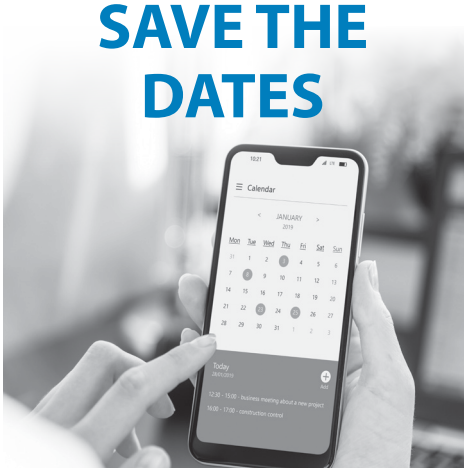
The ***VSA Update*** newsletter is the publication of the Virginia Society of Anesthesiologists, Inc. It is published quarterly. The VSA encourages physicians to submit announcements of changes in professional status including name changes, mergers, retirements, and additions to their groups, as well 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@vsahq.org.

SAVE THE DATES



ASA Legislative Conference
May 13 - 15, 2024
Hyatt Regency Washington
on Capitol Hill
Washington, DC

ASA ANESTHESIOLOGY 2024
October 18 - 22, 2024
Philadelphia Convention Center
Philadelphia, PA

MSV Annual Meeting
October 18 – 20, 2024
The Hilton Norfolk The Main
Norfolk, VA

President's Message

Spring Into Action

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

Dr. Craig Stopa

I cannot believe that my second year as VSA president has begun. It has been a pleasure serving you, and I look forward to another great year. Also, thank you again for entrusting me to represent you and for providing great care to the residents of the Commonwealth.

Last year, I focused on three main topics: workforce shortages, balance billing (No Surprise Act), and Medicare/Medicaid payment cuts. Even though these topics are sadly still an issue, I would like to shift the topic of my message for this newsletter. I am going to focus on the importance of advocacy.

As the calendar turned and the winter season came to an end, the Virginia legislative session heated up. Every year, there are multiple bills introduced in both the House and the Senate that pertain to anesthesiology. However, the last two years have been even more critical as legislation for CRNA independent practice has been the hot topic.

There is a saying that most members have probably heard before: if you do not have a seat at the table, you are likely on the menu. I am a firm believer in this saying and think the way we get a seat is through our collective voice. That is why you received so many action alerts from me these past months, and I appreciate everyone who responded.

Having a seat gives us the opportunity to make sure both the Delegates and Senators better understand our position and profession. Trust me, this call to action did not go unnoticed.

When you use your voice to support our profession, you are also supporting our patients. It has been shown multiple times that physician involvement in anesthesia care leads to better and safer outcomes. The best anesthesia care is given when highly trained and experienced health care professionals work together as a team. This is why VSA believes it is so important to defend the current law regarding anesthesia care and the care team model.

"It has been shown multiple times that physician involvement in anesthesia care leads to better and safer outcomes. The best anesthesia care is given when highly trained and experienced health care professionals work together as a team."

This session, VSA introduced Senate Bill 33, which clarified the current law and maintained the care team model. VSA's bill passed through the Senate on a vote of 34-6.

However, the CRNAs also introduced a bill that passed through the House. Both bills were referred to the Joint Commission on Health Care. This is a bipartisan legislative commission compromised of 18 Senators and Delegates. They review pertinent health-related issues in the interim and make policy recommendations.

The JCHC staff has agreed to take on this issue and will begin their work sometime this summer or early Fall. Their first step will be to engage stakeholders and our lobbyists will absolutely be involved in every part of this process. This is an example of how advocacy can affect patient safety. I would also be remiss to not give a huge thank you to Lauren Schmitt and Catherine Ford of Commonwealth Strategy Group for all the time and effort they put in not only during this session but all year long.

I hope everyone enjoyed the holiday season. This winter's weather has been freezing to this Louisiana boy. Please enjoy this fantastic newsletter focusing on such an important topic, patient safety. Feel free to reach out to me with any questions, concerns, or comments, and thank you for all that you do!

Anesthesiologists Historic Contribution to Safe Anesthesia Care Delivery

By Brooke Trainer, MD, FASA
Editor, VSA Newsletter


Dr. Brooke Albright-Trainer

Anesthesiologists are forethinkers in the realm of patient safety. Although they make up only about 5% of physicians in the United States, anesthesiology is acknowledged as the leading medical specialty in addressing issues of patient safety. We have led the research and innovation in anesthesiology since the safe use of ether as a general anesthetic by Georgia physician, Crawford Williamson Long, in 1846 to remove a tumor from the neck of his patient. From that demonstration, the word "anesthesia" was coined by the physician Oliver Wendell Holmes after the Greek word "anaisthesis", which means "insensibility or loss of sensation". Today, the term anesthesiology continues to be defined by the Oxford and Merriam-Webster dictionary as the branch of medicine or medical science concerned with anesthesia and anesthetics. Over the years, anesthesiologists unwavering commitment to improve the safe delivery of anesthesia care for patients is evident in the technologic advancements achieved, standards implemented, and persistence to remain involved in all aspects of anesthesia care.

As patient complexity continues to increase, so does inherent risk, with administering mind-body altering drugs to keep them unconscious and pain free during surgical procedures, especially life-saving surgical procedures. Continual advancements in technology, research, and innovation are needed to keep up with the evolving complexities of our aging population. Higher caliber clinicians, such as fellowship trained physicians, are needed to better understand and handle challenges associated with caring for sick patients, especially those undergoing huge derangements to their physiology during anesthesia care.

"Since the introduction of the pulse oximeter by Dr. Aoyagi, anesthesiologists have been organizing anesthesia safety conferences to improve upon standardizing implementation of monitoring patients during anesthesia delivery."

Historically, the field of anesthesiology has attracted highly intelligent individuals, some with backgrounds in engineering and aviation, or biomedical chemists who enter the field of anesthesiology and found models for standardizing anesthesia practice and mitigating hazards. Since the introduction of the pulse oximeter by Dr. Aoyagi, anesthesiologists have been organizing anesthesia safety conferences to improve upon standardizing implementation of monitoring patients during anesthesia delivery. The American Society of Anesthesiologists paved the way in 1986 by launching monitoring standards, and anesthesiology societies around the world followed suit.

Over the years, it has been difficult to study the true impact implementation of safety interventions has had on patients undergoing anesthesia. Yet, it is widely believed that anesthesia is much safer today (at least for healthy patients) than it was 25 or 50 years ago.[2] We can get a glimpse at the improvements over time by reviewing ASA closed malpractice claims database; the Australian incident monitoring study (AIMS); the Veterans Affairs Surgical Quality Improvement Program (VASQIP); the private sector National Surgical Quality Improvement Program (NSQIP); and self-auditing research. These databases analyze only a small portion of the events that occur, but glean the maximum amount of useful information and report an overall improvement over the years.

Objectively, improvements in the delivery of safe anesthesia care can be seen by the large reductions in malpractice insurance premiums for anesthesiologists in the United States over time. Prior to the 1980s, when ASA launched the monitoring standards, the cost of malpractice insurance for anesthesiologists in the United States was at an all-time high and at risk of becoming unavailable. The malpractice crisis galvanized the

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profession at all levels, leading to increased work in the development and promotion of protocols, guidelines, and standards aimed to increase safety and reduce harm to patients.

Anesthesiologists' advocacy and grassroots efforts today focus on the preservation of science, education, innovation, and research in the field of anesthesiology, as well as physician involvement in anesthesia care, whenever possible. Safety improvements seen in anesthesia care delivery would not have been possible over the years without the commitment of anesthesiologists to changing how anesthesia was historically practiced. For example, prior to the adoption of monitoring standards in the 1980s, it was common for anesthesia professionals to leave the patient in the room alone on the ventilator, unmonitored, to take a break or retrieve additional equipment or medications. Anesthesiology leaders, however, advocated to change this behavior, requiring an anesthesia care team member to be present at ALL times with the patient in the room while undergoing anesthesia care. The goal of this mandate was to provide the earliest possible warning of untoward dangerous developments during anesthesia that, if unrecognized or left unattended, could injure the patient or lead to long term consequences. The implementation of "continuous safety monitoring" provided time for diagnosis and treatment before injury could occur. Even today, with strict adherence to these safety standards, critical incidents still occur at a ratio of 10-30 per 1000 anesthetic procedures,[10] which is why in many states, including Virginia, a physician is required to be immediately available for all anesthesia being delivered.

Because anesthesia is an adjunct that facilitates the performance of surgery without any direct therapeutic benefit itself, the risks associated with anesthesia must be made as small as possible.[11] Considerable efforts have been made for many years to make anesthetizing patients as safe as possible. Safe delivery of the drugs and monitoring of the patient not only requires knowledge of the pharmacologic and physiologic effects of the drug itself, but also a thorough understanding of how each patients disease process will respond to it at every stage of the anesthetic care. From adequate preoperative evaluations and anesthetic planning, to the safe induction of anesthesia and airway management, the monitoring and maintenance during the procedure, to the emergence from the anesthetic to finally, the postoperative care - every aspect of anesthesia care can profoundly be compromised or improved upon and impact its safe delivery. Nothing has compared to the degree of improvement achieved in patient safety by the ASAs implementation of monitoring standards in the 1980s; yet despite this, errors continue to occur and patients continue to sustain injuries or die as a result of anesthetic mishaps. Until this improves, anesthesiologists must remain committed to improving evidence-based practices, standardizing protocols, reporting incidents for review, and advocating to remain involved in every aspect of a patient's anesthesia care, whenever possible.

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damage, and even death. It is the anesthesiologist's job to administer just the right amount of these medications to allow the patient to undergo procedures that they otherwise would not tolerate. It is an important balance of not giving too much sedation or too little. The overdosing of medications can increase risks of complications from the medications themselves, increased operating room time, or increased PACU length of stay. They must also be mindful to not under sedate patients, which can result in intra-operative awareness or movement during an operation or procedure.

The understanding of pharmacokinetics and pharmacodynamics of medications plays a key role in creating the anesthetic plan for each case. With the advancement of anesthesia machines, many of which now provide a minimum alveolar concentration (MAC) calculation, it is often times easier to opt for a volatile inhalation-based plan for trainees or less experienced providers. However, when a volatile anesthetic is contraindicated, or its side effects are undesirable, opting for a total intravenous anesthetic (TIVA) plan may be chosen. Unlike inhalation anesthetics it can be much more difficult to determine the depth of anesthesia and appropriately titrate the infused medication, especially towards the end of a case. TIVA anesthetics have been associated with higher incidence of intra-operative awareness when compared to inhalation based anesthetics[1]. One piece of equipment that has become more widely available is the use of processed electroencephalogram (pEEG) monitoring to help determine the depth of anesthesia. However, its ability to determine the depth of anesthesia given different pEEG readings, when comparing different medications, has raised concerns about its ability to accurately determine the depth of anesthesia independently[2].

Propofol is one of the many medications that anesthesiologists use for the induction of general anesthesia. It is also commonly used in the maintenance of general anesthesia, thanks to its favorable drug effect profile, relatively short context-sensitive half time, and rapid terminal half-life time[3].

Even with its widespread use for over three decades, research has shown that it is often dosed at much higher concentrations than needed to achieve therapeutic effect. One 36 multi-center study in the United States found that when taking into account both age and ASA status, 64.8% of patients >65 years of age received an induction dose in excess of the recommended dosing[4]. In the same multi-center study, more than 25% of patients that were over the age of 80 and were ASA class 4, received an induction dose of propofol that would be sufficient for a healthy patient 25 years younger.

> *With the introduction of new technology, advances in the understanding of consciousness, and development of new medications, undergoing general anesthesia has become safer than ever before.*

Target-controlled infusion (TCI) pumps have played an important role in anesthetic management in many countries besides the United States due to lack of FDA approval. TCIs were originally developed in the 1990s and rely on the pharmacokinetics of medications, such as propofol. Pharmacokinetic models are a mathematical model used to understand the distribution of a drug in the body and its clearance. These models can further be used to estimate the plasma concentration of a medication and the infusion rate needed to maintain a goal plasma concentration[4]. Closed-loop TCI pumps utilize these mathematical formulas to administer anesthetics at certain rates and dose adjust based on data, such as specific pEEG goals, to eliminate the need for manual provider input[5].

In countries such as the United Kingdom, there has been an increasing shift towards the use of TIVA. According to the National Audit Project 7 (NAP7), there was a three-fold increase in TIVA usage in the UK from 2014 to 2021. During 2014, only 8% of anesthetics were done under TIVA, which increased to 26% by 2021[6]. In 2014 the NAP5 report showed that 63% of all propofol based TIVAs used TCI pumps[7]. While the NAP7 report did not specifically look at the use of TCI pumps, it did show an increase in the use of pEEG from 17% to 76% when using TIVA.

The ultimate goal of an anesthetic plan is to provide a "goldilocks" dosing of medications, for a safe and sufficient anesthetic. One meta-analysis demonstrated that for every 30 minutes of increased operating time, there was a 14% increase in surgical complications[8]. While many factors can influence the time it takes for a patient to awaken from anesthesia, prolonged operating times and ineffective communication between the anesthesiologist and surgeon can lead to redosing of sedatives close to the end of a procedure, resulting in a prolonged time to extubation. The use of closed-loop TCIs guided by pEEG in the UK has been shown to reduce time needed to deep sedation and decreased time to extubation, when compared to manually adjusted TCIs[5].

While devices such as the TCI pump are not commercially available in the United States, anesthesiologists can and should be continuously adjusting infusion dosing based on data and variables such as vitals, pEEG, and time left in a case. They must utilize these continuously changing variables in conjunction with their knowledge of pharmacokinetics and dynamics to help better serve the patient. By being more mindful of their infusion dosaging, anesthesiologists will be providing a more economically and environmentally conscious anesthetic, while also providing a safer anesthetic.

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Virginia Patients Deserve the Best, *from page 1*

But the General Assembly now faces legislation that could break apart this team-based approach to health care, diminish access and weaken patient safety.

The proposal, House Bill 1322, would remove the requirement for a doctor to be present during anesthesia care, and allow any CRNA to provide anesthesia for any procedure to any type of patient. My fellow physicians in the Virginia Society of Anesthesiologists and I consider this proposed change to state law too far-reaching. It fails to consider the complexities of anesthesia care and the highest quality of care for which we all strive.

That's why I join with hundreds of health care colleagues across Virginia in urging legislators to vote against the proposed changes and protect current state law.

If you've ever faced a surgical procedure, you've likely encountered a physician anesthesiologist like me. We're medical doctors who help you fall asleep during general anesthesia before surgery and provide ways to most effectively block and manage pain. We help determine whether surgery can be performed. We lead the team that cares for you before, during and after surgery. We're also there if something goes wrong or there are complications — because anesthesia always carries inherent risk, even with the healthiest patients. CRNAs are indispensable members of this team, and we all share a mission to ensure your comfort and safety.

Virginia state law stands behind this team-based approach, balancing patient safety with the needs of the health care system where you live. We know that a hospital in downtown Richmond differs from a hospital in Southwest Virginia. But we should strive for the highest levels of care for patients wherever they live.

> *In operating rooms and on battlefields, teamwork saves lives. Every team member's expertise is invaluable, and the physician anesthesiologist's role on the team is a crucial component of that.*

That's one reason Virginia's law is among the most lenient of our neighboring states. It allows for nurse anesthetists to practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry or dentistry. This expands the number of professionals who can help patients while ensuring that doctors remain an integral part of that service.

For context, there are more stringent requirements for physician availability in Maryland, where the law requires a doctor to be physically available at all times and prioritizes consultation with an anesthesiologist. In Tennessee, state law requires direct supervision by a physician, requiring them to be physically present in the same building.

Virginia law recognizes the crucial role of physicians in every anesthetic while providing flexibility. It supports hospitals throughout the state by allowing them to adapt their model of care to meet the needs of the facility. Some hospitals might require physician anesthesiologists to supervise nurse anesthetists. Others might allow surgeons to serve as the supervisor.

Either way, the doctor's role provides cohesive service. Even in healthy patients, complications can arise. Patients benefit when everyone works together. Communication and coordination is essential for successful outcomes. Teamwork under pressure.

Patients, too, deserve to choose whether they receive care from a physician or a CRNA, the same way they might decide whether to see a medical doctor or nurse practitioner in primary care, or an OB-GYN or nurse midwife when having a baby.

In operating rooms and on battlefields, teamwork saves lives. Every team member's expertise is invaluable, and the physician anesthesiologist's role on the team is a crucial component of that. The proposed changes in HB 1322 threaten to pull doctors further away from Virginia patients.

The team-based approach to anesthesia care is a model that's proven its worth time and again. Let's continue to support this model — and the Virginia patients who benefit from it. Our patients trust us with their lives. Let's ensure that our laws reflect the highest standards of care, provide access, and keep patients as the focus of our unwavering mission.

Dr. Robert Shafer, who retired from the U.S. Navy after 20 years as a military doctor, serves as vice president of Anesthesiology Consultants of Virginia Inc., and is an assistant professor at the Virginia Tech Carilion School of Medicine.

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)

Ciurash Inspired by Strong Mentorship

By Mathew Ciurash, MS3
Virginia Commonwealth University
Richmond, VA

Mathew Ciurash

I am a product of diverse cultural backgrounds, having been born and raised in Richmond, Virginia, to a mother from California and a father who bravely escaped Communist Romania in the 1980s, seeking refuge and opportunity in America.

At the time of his escape, he was already a practicing physician in Romania but had to restart his medical career in the States. He is now a practicing family medicine doctor, and his path has ignited in me a passion and desire to forge my own path in medicine. My journey thus far has been driven by advocacy and leadership within the field of anesthesiology.

My introduction to anesthesiology can be credited to a mentor whom I met through an advanced curriculum program at my school, Virginia Commonwealth University. The program is called Acute Care and Systems Strengthening in Low Resource Settings, or ACCESS for short.

Part of the program is a journal club where students interested in global medicine meet to discuss varying approaches to healthcare delivery. In this program, I met an anesthesiologist who took me under his wing and allowed me to shadow during my first year of school. From there, I looked for more opportunities and stumbled upon the ASA and their branches for medical student involvement.

I am proud to say I applied and was selected to be the Medical Student President of the ASA, and I have embraced this role as a platform for spreading awareness of the importance of advocacy among medical students.

One of the pivotal initiatives I have spearheaded during my tenure as ASA Medical Student President is the revitalization of the State Delegate Liaison project. Recognizing the indispensable role of student leadership in shaping the future of anesthesiology, this project aims to amplify opportunities for engagement at both local and national levels.

The project was inspired by my firsthand experience at the Annual Legislative Conference in Washington, D.C., where I had the privilege of interfacing with Capitol Hill staffers on pressing issues. Often, the staffers looked to me to speak, as they wanted the youngest opinion in the room.

I had no idea the impact a student could make in directly advocating for patient rights. The medical student government team and I are deeply committed to elevating student voices so they too can share this platform in the future.

Starting with my father's escape, the butterfly effect that has brought me to pursue anesthesiology with a focus on advocacy is remarkable. I often wonder how my path may have been different if I didn't get involved with global care, meet a strong mentor, and discover the field so early in my medical schooling.

With this in mind, I encourage all readers who may have learners under them to go the extra mile in incorporating them into the practice. Offer them the next intubation even if it may be their first. Teach them how to start an IV despite it being faster to do it yourself.

It is impossible to predict the impact your action may have on the impressionable student, but any bit of outreach could be the start of a learner pursuing a career in anesthesiology, as it was for me.

As I embark on the next phase of my career, applying and transitioning into residency, I will continue my efforts in advocacy and strive to be a continued leader in anesthesiology and beyond.

SafeHaven Clinician Well-Being Program

Expanded in the 2024 General Assembly Session

SafeHaven ensures clinicians can seek support for burnout, career fatigue, and mental health reasons without the fear of undue repercussions to their medical license. Before SafeHaven, the belief that seeking help would result in a report to a health regulatory board was a huge impediment for professionals in distress. The program's protections include physicians, PAs, residents, Nurse Practitioners, pharmacists, and medical, nursing, and pharmacy students.

During the 2024 General Assembly session, the SafeHaven program expand in three ways:

- The program was expanded to dental hygienists and dentists
- SafeHaven can now provide outpatient healthcare to healthcare professionals under the SafeHaven umbrella
- Language was added to clarify the mandatory reporting requirements for hospitals when a healthcare professional voluntarily seeks behavioral health services

As SafeHaven continues to grow, the goal is to encourage providers to get help when they need it. With this expansion, a professional can seek voluntary admission to a hospital for up to 30 days so long as the treating physician, PA, or nurse practitioner certifies in writing that the professional is no longer a danger, no report will be required to the health regulatory board. In addition, the outpatient healthcare addition greatly expands SafeHaven's scope of protection. For example, a professional enrolled in in the program and receiving counseling may now be able to pick up their prescription for anxiety medication without fear of mandatory reporting.

This is a win for all healthcare professionals and patients across the Commonwealth!

Are you dealing with burnout symptoms or need additional professional support? See how SafeHaven can help at www.SafeHavenHealth.org.

Patient Safety and the Use of Peripheral Nerve Stimulation Implants for Pain

By Denise Lester, MD, FASAM
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Dr. Denise Lester

Over the past two decades, there has been a notable resurgence in the utilization of peripheral nerve stimulating (PNS) implants for chronic pain management. Initially introduced half a century ago, PNS involved surgically placing electrical leads near nerves to alleviate pain, albeit with several adverse events such as lead migration, nerve fibrosis, and technical challenges, resulting in minimal long-term success. However, recent advancements have transformed PNS into a commonly employed technique, supported by numerous randomized controlled studies demonstrating its long-term efficacy.

One pivotal innovation driving the success of modern PNS is the development of percutaneously placed leads, eliminating the need for invasive surgical procedures. These newer leads boast smaller, more flexible designs, facilitating easier implantation using techniques such as ultrasound or fluoroscopy. They are associated with reduced migration, scar formation, and nerve irritation, marking a significant improvement over previous iteration.

Table 1: A List of PNS Peripheral Nerve Targets
(Adapted from Strand et al, Evidence-Based Clinical Guidelines from the American Society of Pain and Neuroscience for the Use of Implantable Peripheral Nerve Stimulation in the Treatment of Chronic Pain, Journal of Pain Research, 15:, 2483-2504)

Head and Neck	Trunk/Pelvis	Lower Extremity	Upper Extremity
Greater Occipital	Lumbar Medial Branch Nerves	Sciatic Sub Gluteal	Suprascapular
Cervical Medial Branch Nerves	Genitofemoral	Sciatic Popliteal	Axillary
	Ilioinguinal	Femoral	Radial
	Iliohypogastric	Obturator	Median
	Pudendal	Lateral Femoral Cutaneous	Ulnar
	Cluneal	Saphenous Proximal	Brachial Plexus at interscalene
		Saphenous Distal	
		Common Peroneal	
		Tibial	
		Sural	
		Superficial Peroneal	
		Genicular Nerves to Knee	

Technical Considerations for Contraindications to PNS
Lead placement over the heart or across thoracic volume.
Lead placement in the front or side of neck.
Lead placement on the top of the head.
Patients who have a Deep Brain Stimulator system.
Patients who have any other implantable neuro-stimulator whose stimulus current pathway may overlap with that of a Temporary PNS System.
Patients who require Magnetic Resonance Imaging (MRI).
Patients who have epilepsy, if the leads are intended to be placed in the head or neck.
Patients who have a tape or adhesive allergy if using the Temporary PNS System

PNS Applications in Special Populations

Expanding its application, PNS has been employed in various neuropathic chronic pain conditions, including post-traumatic and post-surgical neuropathy, phantom limb pain, occipital neuralgia, hemiplegic shoulder pain, and complex regional pain syndrome (CRPS). Additionally, it has shown efficacy in nociceptive pain states involving the shoulder, knee, lumbar spine, and cervical spine zygapophyseal joints. The advent of more mobile and adaptable PNS leads has facilitated their use in acute and perioperative pain management, spanning procedures like total knee arthrodesis, lower limb amputation, ambulatory foot surgery, and orthopedic traumas. The benefits reported include enhanced pain control, extended duration of pain relief compared to local anesthetic catheters, reduced infection risk, and decreased opioid consumption, promoting earlier mobilization and physical functioning post-surgery.

Moreover, percutaneous PNS has demonstrated efficacy in controlling pain in individuals with underlying painful cancer diagnoses, offering relief in cases where pain management through conventional means, such as oral analgesics or palliative interventions, proves challenging due to multifactorial pain etiology.

Expanding its reach, PNS is being explored for treating various central pain states, including complex regional pain syndromes, fibromyalgia, cluster headaches, and migraines. Mechanistic studies

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suggest potential effects of PNS on higher somatosensory pain centers in the brain, offering insights into its broader therapeutic applications.

Additionally, PNS has garnered interest for managing non-painful conditions, such as overactive bladder syndrome, sleep apnea, and a range of disorders through vagus nerve stimulation (VNS), including depression, Parkinson's disease, anxiety disorders, stroke rehabilitation, and cognitive disorders.

Patient Safety Considerations

In selecting patients for PNS therapy, thorough evaluation is imperative to mitigate risks associated with the procedure. This includes a comprehensive evaluation assessing patient suitability, addressing potential technical challenges, optimizing comorbidities, and ensuring adequate caregiver support. Psychological evaluations may be required in some cases to identify secondary barriers to successful outcomes.

Targets for PNS therapy encompass various peripheral nerves, excluding those innervated by cranial and facial nerves. Diagnostic pre-implant blocks may aid in identifying target nerves, although interpretations should be cautious, as chronic pain syndromes may exhibit differential responses to diagnostic blocks versus PNS therapy.

Image guidance, whether fluoroscopically or ultrasound guided, plays a crucial role in ensuring accurate lead placement during PNS implantation. While there are no definitive studies comparing the efficacy and risks of different guidance methods, considerations exist for both approaches.

Types of PNS Systems

PNS systems are categorized into temporary and permanent devices. Temporary systems, such as the 60-Day Percutaneous PNS System, offer relief for a limited duration before removal, while permanent systems remain implanted for the patient's life. These systems allow patients to stimulate their leads wirelessly via a handheld remote, with contraindications including MRI incompatibility. Several FDA-cleared devices offer varying lead configurations and stimulation options, each tailored to specific pain conditions.

Ultrasound Guidance	Fluoroscopic Guidance
Direct visualization of the nerve	Easy identification of bony landmarks
Dynamic scanning of nerve with movement	Less equipment
Dynamic scanning of the lead being placed	Less skillset needed (ultrasound skills)
Direct visualization of the vasculature	More easily used in some providers (skillset)
Dynamic scanning of drug near target nerve	Radiation exposure
Direct visualization of distance between the PNS lead and the target nerve to ensure tip of lead is close to target	Cost of fluoroscopy machine.
Direct visualization of bony landmarks and target nerve to plan trajectory of lead placement and to ensure depth allows enough lead to be introduced	Availability of fluoroscopy suite.
No radiation exposure	

The Future of PNS

Looking ahead, ongoing research aims to further enhance PNS technology, exploring areas such as waveform comparisons, closed-loop systems, miniature leads for facial structures, and genetic studies to optimize patient selection and outcomes. As PNS continues to evolve, pain physicians will play a vital role in advancing therapeutic interventions and pain research.

In summary, the evolution of PNS therapy has revolutionized chronic pain management, offering safe and effective alternatives to traditional interventions. With ongoing advancements and expanded applications, PNS continues to emerge as a promising modality in pain medicine, providing relief and improving the quality of life for countless individuals suffering from chronic pain and related conditions.

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ASA March 2024 Board of Directors Meeting Report

By Jeffrey Green, MD, MSHA, FASA
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Dr. Jeffrey A. Green

The ASA Board of Directors met in Rosemont, Il on March 9-10. This was the first of the Board's three planned meetings for calendar year 2024, with the remaining two scheduled for August and October. The Board is made up of representatives from each state component as well as a few others, making it a large group. As is done in the House of Delegates, the Board conducts its business by reviewing and voting on reports with recommendations from each ASA Committee, as well as the administrative council and officers. The reports each come before a review committee, where any ASA member can comment on them and make suggestions for changes to the recommendations on the action reports. The formal sessions to deal with each of the reports and the business of the society happened on Saturday and Sunday morning, leaving plenty of time for Board education and strategy sessions.

On Saturday, ASA President Ron Harter briefed the board on his recommendation for a new wellness initiative for member burnout, career fatigue and mental health. The Medical Society of Virginia's Safe-Haven program was among one of those proposed for adoption. The Board approved the funding of a new Board designated fund for this program with lots of discussion and suggestions. Then ASA's new CEO, Brian Reilly, briefed the Board on changes in the ASA staff leadership and his vision for leading ASA into the future. Next the ASA treasurer, assistant treasurer, and first vice president gave updates on the past year financial performance, the new year's budget, and the ASA's strategic revenue initiative to drive new sources of revenue separate from member dues. After lunch, the Board met for interactive strategy sessions and small group breakout sessions for planning for the ASA's strategic priorities.

After conclusion of the formal portion of the board meeting on Sunday, the Board participated in more strategy sessions, including a thought experiment on multiple "what if" scenarios to prepare the organization for possible public policy or regulatory scenarios that could play out in the future. The Board members were heavily engaged, weighing in with their broad experience on each of the scenarios. Overall, the Board meeting was productive and efficient, with lots of great interaction between Board members and active dialog with the leadership. Similar to other physician organizations, the ASA is facing a number of challenges, but the leadership and Board are working hard to find solutions to meet the challenges.

As always, I am honored to be your representative from Virginia to the Board of Directors. If you have any questions about the ASA or the Board of Directors, please reach out to me at Jeffrey.green@vcuhealth.org

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Culture of Safety: The Multidisciplinary Anesthesia Professional Relationship

Reproduced and modified with permission from the APSF. Author(s): Katherine A Meese, PhD; D. Matthew Sherrer, MD, FASA Title. CULTURE OF SAFETY: The Multidisciplinary Anesthesia Professional Relationship | APSF newsletter | June 2021; volume: 36, No. 2

By Katherine A. Meese, PhD and Matthew Sherrer, MD, FASA

Introduction

Healthcare ProfessionalsA recent article in APSF by Jeffrey Cooper, PhD, highlighted the importance of considering the relationship between certain dyads in the operating room, specifically between anesthesia professionals and surgeons.[1] The article discussed implications for patient safety, and the potential for patient harm due to relational degradation in this dyad. However, we suggest that an equally important dyad to consider is that between anesthesia professionals. External pressures have the potential to bleed into our operating rooms, and influence our experiences at the point of care. Therefore, it is most important to create a satisfying work environment for all team members so that collaborative care can translate into improved patient safety.

Optimizing Our Teams

There is a growing body of research that give us insights on how we can promote better team performance which can lead to enhanced patient care.

Collective Intelligence and Teaming

The performance of teams is only moderately connected to the individual intelligence of its members.[2] Woolley et al. found empirical support for a collective intelligence factor (c-factor) that explains a group performance. Specifically, this c-factor is "not strongly correlated with the average or maximum individual intelligence of group members, but is correlated with the average social sensitivity of group members, the equality in distribution of conversational turn-taking, and the proportion of females in the group" (which is likely also related to social sensitivity).[3] Teams with members who can be socially sensitive, encourage all members to participate in the conversation, and value input from all team members may function better as a team.

The nature of the operating room setting requires unique modes of team interaction. Much of the research on teams assumes

stable membership among team members, which allows them to practice and hone their team performance over time. However, in the perioperative context, each case may represent a unique combination of clinicians who have worked together with varying degrees of frequency.

While some teams enjoy stable membership, others have a frequently changing mix of anesthesia professionals, surgeons, and trainees. Researchers have referred to this concept as "teaming" which requires relative strangers to come together quickly to perform challenging tasks with little or no time to practice.

Edmonson describes teaming as "teamwork on the fly," which is apropos for the situations in the perioperative space.[4] A critical component of teaming is psychological safety, which is the belief that the team is a safe place for interpersonal risk-taking, and describes an environment of trust and mutual respect.

In the perioperative context, this risk-taking may include speaking up when a team member has a concern about patient safety or disagrees with a care decision. Successful teaming also requires situational humility, which acknowledges the difficulty of the task ahead, and understands that it cannot be solved alone.[4]

Situational humility leaves room for all members of the team to make a contribution to the end goal. In the face of uncertainty and ambiguity - both central features in the current health care environment - situational humility fosters an environment that encourages teams to engage in more learning behavior. However, if one member within the team retains an authoritarian or dictatorial leadership style, they risk not only suppressing valuable input that might increase patient safety, but also devalue other members of the care team.

The Role of Stereotyping

When a person is dealing with another person who is unknown to them, they often look to cues and stereotypes to try to anticipate how that person will behave. Stereotyping is a mechanism for reducing perceived uncertainty.

For example, if an anesthesia professional is working with a surgeon that they do not know, they may rely on stereotypes about surgeons or specific specialties to try to navigate this new relationship during the case. If these stereotypes or assumptions are incorrect, they can lead to communication errors and threats to patient safety.

Nurses, physicians, and other members of the care team who are familiar with one another within the hospital setting may have built trusting working relationships. However, when the people in those roles are unknown to each other personally (which is common in large organizations) inaccurate stereotypes can be increasingly detrimental. External pressures, intra-organizational power struggles, and professional clashes have the potential to saddle members of the care team with negative stereotypes regardless of the characteristics of the individual.

This stereotyping can create a mistrusting and threatening environment before the case begins. When a threat to safety is perceived, then self-preservation, not collaboration, can become the norm.

Role Ambiguity

As the roles of health care providers evolve and change, they also bring new questions about exactly what functions each team member should fill.

The lack of clarity about how each team member can best contribute or what functions each team member should serve can lead to role ambiguity.

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Role ambiguity is "the extent to which one's work responsibilities and degree of authority are unclear."[5] Role ambiguity is a determinant of occupational stress, and is associated with anxiety, burnout, depression, job dissatisfaction, dissatisfaction with supervision, and dissatisfaction with co-workers among other negative outcomes.[5] High levels of burnout and stress have been reported among both [6] and advance practice providers (APPs).[7]

Therefore, it is imperative that we work to reduce sources of distress such as role ambiguity, and identify the strengths that each type of practitioner can bring to the team and to the bedside. By understanding which team configurations produce the best outcomes, we are better positioned to help each member see the unique value and contribution of the others, thus reducing role ambiguity, and creating an environment of appreciation, mutual respect, and psychological safety. Efforts should be made to clearly identify what functions each clinical professional should serve, in order to reduce friction in areas of possible overlap and maximize team performance. A clear plan that is developed mutually can help the physician, APP, nurses, and technicians understand how their efforts support the team.

The Path Forward

Administering Anesthesia in the Operating RoomThe COVID-19 pandemic has provided incomparable pressure to the perioperative team and has laid bare the underlying nature of the relationships among members of the care team. Under stress, one's ability to disguise and bury relational damage can become more difficult. Teams that were cohesive and trusting beforehand may pull together more, while those that were not, may have a tendency to fracture under the pressure. What shall we do, both in the near-term and as we re-emerge from this pandemic?

First, we need to routinize the concept of micro-empathy with teammates into our daily interactions. The concept of micro-aggressions in the workplace has been a subject of recent focus. Originating in studies of racial discrimination, the concept of micro-aggression has been more broadly applied in the health care setting.[8] The premise is that small acts of disrespect, insults, aggression, or hostility can occur frequently and have the ability to degrade and demoralize employees.

We propose the need to institutionalize the practice of micro-empathy, or small and deliberate acts of consideration, concern, and respect. We suggest that micro-empathy can occur through small acts of listening and concern which have an important cumulative effect over time, building relational capital among team members. Just as we have implemented surgical safety checklists, we need to implement micro-empathy into our routine operations. While showing empathy when a team member experiences an obvious hardship is critical, we need to initiate frequent conversations that allow us to show empathy for the stresses of the day or week before they take a cumulative toll. The Circle Up model9 suggests that this routinization can occur during daily huddles, by asking questions such as:

- "Reactions to today?"
- "What helped your team work well together?"
- "How could our work be 1% better?"
- "How did the shift affect you personally?"

This is likely to be most effective when the team has prioritized building trusting and open relationships.

Additionally, we need to ensure team building early on in professional careers. We should train together. Across the nation, trainees from different disciplines oftentimes do not train together. Health care could be better served by intentional collaborative education, not only on the art and science of care itself, but on the foundations of highly reliable teamwork.

In conclusion, many anesthesia professionals report collegial and rewarding work environments, with mutual respect toward one another. A patient deserves the very best care, and we suggest that this occurs when all members of the care team work together in harmony using their diverse skill sets and training, pooling their collective intelligence to create smart teams that result in the highest quality delivered care. While we unite against the common and formidable enemy of disease, we must take care of each other. It is only then that we will achieve APSF's vision, "That no one shall be harmed by anesthesia care."

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Legislative Update

By Lauren Schmitt
Commonwealth Strategy Group

The 2024 Virginia General Session adjourned as scheduled Saturday, March 9th. With almost 50 new legislators and the Democrats having the majority in both the Senate and House of Delegates, there were a lot of changes and new faces to meet this session. As always, VSA advocated on your behalf for the issues that matter to our members and our patients. This was a pivotal General Assembly session for us, as we faced a very tough legislative battle regarding supervision of Certified Registered Nurse Anesthetists (CRNAs).

HB 1322, carried by Delegate Sickles, was supported by the Virginia Association of Nurse Anesthetists, and would have changed the current law to remove the supervision requirement for CRNAs. Under this bill, they would only be required to "practice in consultation" with a physician, dentist, or podiatrist. Essentially, it would have allowed CRNAs to administer anesthesia without a doctor physically on-site. The VSA strongly opposed this legislation.

The VSA supported other legislation regarding anesthesia care, which was introduced by Senator Mamie Locke. SB 33, would have clarified the current law by defining supervision. It also directed a workgroup of relevant stakeholders to convene over the next year to discuss whether the current law needs to be changed.

VSA fiercely advocated for SB 33 and against HB 1322 through in-person meetings, action alerts, op eds, testimony, etc. VANA was also very engaged, and legislators were constantly hearing from CRNAs in their districts. As a result, these two bills were some of the most contested this session and legislators were very familiar with both. The most common sentiment amongst legislators was frustration that our two groups could not "work this out."

As it turns out, the current legislature is very divided on this issue. For the most part, the Senate is supportive of our position and passed SB 33 on a vote of 34-6. However, the House of Delegates is supportive of CRNA's position and passed HB 1322 on a vote of 71-28. Knowing that after Crossover, the Senate would likely kill HB 1322 and the House would likely kill SB 33, we spoke with the patrons and VANA. We all agreed to let both bills go for the year and to agree to an official study regarding the issue over the next year. Both bills were referred to the Joint Commission on Health Care. This is a bipartisan legislative commission compromised of 18 Senators and Delegates. They review pertinent health-related issues in the interim and make policy recommendations. The JCHC staff has agreed to take on this issue and will begin their work sometime this summer or early Fall. Their first step will be to engage stakeholders and we will absolutely be involved in every part of this process. The JCHC staff will present their findings and policy recommendations to the Commission sometime in November.

VSA Brooke Trainer, MD, FASA testifies in opposition to HB 1322, which would remove the supervision requirement for CRNAs.

At that point, the Commission will decide whether it wants to endorse specific legislation for the upcoming General Assembly session. While not a sure thing, legislation that comes from the JCHC has more credibility and is generally voted upon favorably. We will keep you updated throughout this process. It's important to note that there is serious pressure from the legislature to find a compromise on this issue. They are expecting some type of resolution when we go into the 2025 General Assembly session. If we are not able to find that, we will be back in the same position and fighting the same fight (in a challenging political environment).

One of our biggest accomplishments this session was the defeat of legislation that would have repealed the current medical malpractice cap. SB 493 would have removed the limit on recoveries for medical malpractice acts in which the patient was 10 or younger. Removing or modifying the medical malpractice cap in any way could significantly increase the cost of providing and receiving healthcare in the Commonwealth of Virginia. Medical malpractice insurance costs would increase for all providers, including state hospitals, which would not only cost more General Fund dollars but would also increase the cost of health care for patients. Before Virginia's medical malpractice schedule was enacted in 2012, the costs of medical malpractice insurance plans were exorbitant and only some providers could afford it. Increased costs would impact physicians' considerations to practice medicine in Virginia and stand to decrease medical school student and residency retention.

In 2012, the House of Medicine, the Virginia Trial Lawyers Association, and the General Assembly reached a compromise on a medical malpractice cap, with an agreement that it would be in place for 20 years and no attempts would be made to undo that for at least 20 years. With all the turnover in the legislature the past decade, most of the legislators who agreed to that deal are no longer in office. As a result, we've seen efforts in recent years to repeal the current law. The Virginia Trial Lawyers Association has stayed true to their word and not advocated for these bills. The bill initially passed the Senate Courts committee on a vote of 8-4 with four abstentions. Thankfully, it was later defeated in the Senate Finance committee. The patron, Senator Stanley, has said he will introduce legislation again next year- so we know that this fight is far from over.

The General Assembly also passed HB 971 (Tran), which will allow nurse practitioners to practice independently after three

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VSA Lobby Day 2024: Medical Student Reflection

By Joshua Sison, OMS-II
and Grace Carroll, OMS-II
Edward Via College of Osteopathic Medicine - Virginia

Delegate Joseph P. McNamara (left) meets with Michael Saccocci, DO; Robert Shafer, MD; Joshua Sison, OMS-II; and Grace Carroll, OMS-II

On January 22, 2024, we joined members of the VSA in advocating for maintaining physician-led anesthesia care teams and clarifying the importance of a physician anesthesiologist's role (SB33), and why removing CRNA supervision does not provide patients full equal access to safe anesthesia care (HB1322).

It was a cold, sunny morning when we arrived in downtown Richmond. Along with over a dozen physician anesthesiologists, we were briefed by VSA lobbyist, Lauren Schmitt, on our plan for the day. We went over the details of both bills, split into teams, and made our way to the new Capitol building. We were part of the "Roanoke Team", along with Dr. Michael Saccocci and Dr. Robert Shafer, who led the discussions with each of the four legislators we visited.

Typically, we would be sitting in a lecture hall in Blacksburg learning the science of medicine, but this day, we were sitting in legislators' offices advocating for patients. As we walked from office to office, we observed the hustle and bustle of state legislation at work--advocates from all walks of life, fighting for their causes with legislators, and their staff ready to listen.

It is a challenge, not only to advocate for your cause to legislators, but particularly in medicine when a lot of the issues aren't easily articulated to most people who have only experienced the medical field as a patient. Dr. Shafer expertly navigated this by comparing the anesthesia care team to pilots and co-pilots, and the intricacies of patient care to operating a submarine. These comparisons were much more interesting and easier for legislators to grasp than explaining differentials and the various, ever-changing levels of medical training.

Throughout the day, it became more and more apparent the importance of being involved in medical policy, even at the student level. As the "next generation of anesthesiologists," we represent the future of the field, and these proposed bills will directly affect our practice. Exposure to the legislative side of medicine is an experience that all medical students should try to participate in at some point during medical school.

In our experience at VSA Lobby Day, we both saw the importance of our future as physicians in "primum non nocere", not only in the clinical setting, but in the public health setting. As future physician anesthesiologists, our main role is to protect our patients from harm throughout an individual case, and to society as a whole. It is our collective duty to protect all future patients from negative outcomes that can be prevented by maintaining our role in the anesthesia care team. We are leaders, but also teammates, who are ultimately there to ensure that each patient receives the best care we can provide.

We would like to thank Dr. Michael Saccocci, Dr. Robert Shafer, Dr. Craig Stopa, Dr. Brooke Trainer, Dr. Casey Dowling, Lauren Schmitt, Andrew Mann, and all other VSA members present at Lobby Day for welcoming and encouraging us throughout our time in Richmond.

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years of clinical experience. The current law requires five years and there were multiple bills this year to change it to two years. The Medical Society of Virginia worked with the patrons and the nurse practitioners to reach a compromise of three years, with the understanding this will not change anytime in the near future. This is another example of how supportive the current legislature is toward expanding scope of practice for nurses.

After the General Assembly adjourns, Governor Youngkin will have 30 days to act on all the legislation that was passed. The Governor can either sign, amend, or veto the bill. If he amends it or vetoes it, it will be considered at the "Reconvene Session" on April 17th. This is when the legislature returns to vote on the Governor's actions. In order to overturn a veto, there has to be a 2/3 vote to do so. The legislature can accept or reject amendments on a simple majority vote. We anticipate a record number of vetoes this year, due to the political differences between the legislature and the Executive Office. In particular, the issue of whether to build a sports arena in Alexandria for the Washington Wizards and Washington Capitals is still unresolved and causing a significant amount of conflict. Governor Youngkin strongly supports the proposal, but the Chair of the Senate Finance committee, Senator Louise Lucas, has expressed strong opposition to it. There are rumors that a special legislative session will be called in May or June to address the arena issue.

Thank you to everyone for your advocacy this session and stay tuned for next steps with the Joint Commission on Health Care!

Whenever They Say It's Not About Money, It's About $$$

By Paul Rein, DO

Dr. Paul Rein

I have been a practicing anesthesiologist since January 1, 1982. I spent four and-a-half years at MCV/VCU and the rest in the private practice world, where most of the changes have occurred.

I emphasize that I am an anesthesiologist, not a physician anesthesiologist. I say this because I would like to discuss with y'all the state of affairs of the profession of being an anesthesiologist.

Over the 40 years I have practiced, there have been numerous changes to our specialty. I speak not about pharmacological or monitoring devices, but how we are organized and provide the services of our practice.

I will be discussing the following issues: the loss of control of our practice to non-physicians, the loss of control in the earning of our money, the failure to manage CRNAs, and the lack of physician provided anesthesia care. All this leads to the truth that, for the most part, no one has skin in the game anymore in our practice as physicians.

I have the good fortune of being able to still practice at least 50% of the time doing my own cases in plastic surgery practices. The other 50% I work as a part-time anesthesiologist with Sentara Medical Group, supervising CRNAs.

I am also lucky enough, while in my 70s, to practice with the following benefits: no weekends, no nights, no call, no holidays, and I make my own schedule. Pretty nice, I must say. This has allowed me to work and compare with what was and try to figure out ways to fix our current situation.

The first, and probably most important subject, is the loss of control of our practices to either hospital systems or private equity firms. When this happens, there are non-physicians managing our practices; how it is practiced personnel wise, how we are scheduled daily, how we are scheduled call, how we are paid, and the loss of incentivization.

> *There are seven deadly sins: greed, greed, greed, greed, greed, greed, and envy.*

What anesthesiologists have become in too many practices is a salaried worker. We go to college for four years, medical school for four years, residency for four years and then simply work as an employee without control. We have become physicians for the most part who, during our four-year residency, did our own cases, and then end up in practices where we rarely, if ever, provide physician performed anesthesia, but merely supervise nurse anesthetists.

This leads directly to what has happened to our profession, by the decisions made by the ASA. We have allowed the AANA to gradually take over our profession. There is no better symbol than allowing the use of the term nurse anesthesiologists, not nurse anesthetists.

That is incredibly meaningful, and this symbolism of our lack of strength has led to patients to believe a nurse anesthetist is an anesthesiologist, just with a different degree. We have a double digit number of states that allow nurse anesthetists to practice without physician supervision, and more and more nurse anesthetists throughout the country are continuing to seek states to allow the practice of anesthesia by unsupervised nurses.

We teach CRNA students to do virtually everything we do. What they are not taught is how to medically evaluate patients the way physicians do. Thus, we have become screeners of patients, and individuals who in private practice rarely perform the anesthesia care they learned in four years of residency.

My experience as a private practitioner for 25 years in a private group gave me the experience and the knowledge of how to run a group of physicians and CRNAs. We had 19 physicians and 13 CRNAs in our group. At an ASA practice management meeting I gave a talk about how we practiced and never lost a CRNA to another hospital in the 757-area code.

We had 50% of our cases performed by a physician and the other 50% was by CRNAs being supervised by an anesthesiologist. CRNAs did no hearts, no thoracic, and no OB. Call was taken by physicians.

This may sound crazy now, but of our 19 docs, 13 were with us for 20 years or more, so we must have been doing something right. In 2010, our group left the hospital system as they wanted control of our group, rather than working together as a team. Our group chose to leave.

In the first year, the private equity group went through 64 physicians. A lot of time was spent on credentialing instead of working together with us as care partners. Real partners. This leads me to the reasons why all this has happened, nationwide. CONTROL AND MONEY.

For six years, I was an adjunct Professor at the College of William and Mary teaching a class to pre-med students, called Introduction to Clinical Practice. Amongst the many things we talked about was ethical behavior. One of my messages to them was never forget, there are seven deadly sins: greed, greed, greed, greed, greed, greed, and envy.

Forget about the others. The way the hospital systems and private equity firms demonstrate that is by their desire to have control and make money. Without question that, for the most part, supersedes quality.

Sure, they say they want quality, but control and money certainly come first. Look at your practice and see how much control you have. Simply getting a paycheck by doing what they want may be giving you a nice income, but how much satisfaction do you have?

Like it or not, in any business, people need incentivization, and when you give up control, you aren't incentivized to do anything but be a good follower of the MBA in charge of your practice.

One of the big subjects these days is physician burnout. I must say, back before the mess we are in, I never heard physicians talking about burnout. Perhaps losing control is the major cause.

So, what's next? That is the question and is there an answer? Stay tuned to the next issue of the VSA newsletter for some alternatives.

ASAPAC Needs Your Financial Support

Colleagues,

ASAPAC is your voice in Washington, DC for advocacy on behalf of all anesthesiologists. Whether it be physician-led care, title misappropriation, payment reform or surprise medical bills, the ASAPAC is working to ensure the future viability of the specialty.

ASA has an industry leading lobbying organization in the ASAPAC that is respected in all corners of the beltway, but without financial resources their influence only reaches so far. That's why it is critical to make a donation to ASAPAC today.

The simplest and easiest way to do this is to go to ASAPAC | American Society of Anesthesiologists (ASA) (asahq.org) and select contribute now. Personally, I find setting up a monthly recurring donation that renews continuously is the easy way to "set it and forget it" and that way I don't have to remember whether I've made my donation for the year or whether it is the right time of the year to renew. I use the same feature for VaSAPAC. Dividing up my yearly donation

totals into smaller monthly amounts makes it hardly noticeable to my finances.

The most recent data from the ASAPAC indicates that we are substantially behind in our donations. In fact, as of the end of February, Virginia ASAPAC donors make up a dismal 2.72% of the total Virginia ASA members. We must do better.

Won't you please seriously consider donating a couple of hour's worth of your salary to the improvement and betterment of your specialty? Louisiana, a state with half the number of members of Virginia, has nearly twice the number of donors as us and leads all states with an 8.5% participation rate. Can you imagine how well funded our PAC would be if 20% of the ASA membership donated? What about 100%?

If you feel that you deserve more respect and more reward for the delivery of your services, please step up and fulfill your professional citizenship obligation to ASA by donating to ASAPAC. It is the best path forward to fixing the broken Federal health care system, and every dollar you contribute goes toward leaving the specialty in a more secure financial position for the future.

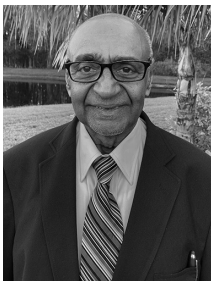
As always, please feel free to contact me at dr.jeffrey.green@gmail.com with any comments or suggestions.

Jeffrey A Green, MD MSHA FASA
Director from Virginia,
ASA Board of Directors

The Arts

Patient Safety

By Jaikumar Rangappa MD, LTC
Retired Anesthesiologist


Dr. Jaikumar Rangappa

Absent a Surgeon Anesthetist Trust is a travesty
Surgeon & Anesthsiologist Trust determines safety
For Pre op comfort, safe surgery and Post op safety
Of every patient for minor or major surgery
With Hippocratic oath to cause no harm any.

A silent or overt animosity in OR hurts patient care
Trusting relationship with OR team is very dear
Surgeon and anesthesiologist cooperation is a must
Caring team helps patient not to be scared and to trust.

APSF has spread message of patient safety overall
To surgeon, techs, anesthesia and nurse team for all
Helps, doctors and hospitals to keep lawyers away from call
"No one shall be harmed by anesthesia"- late Dr. Pierce did enthrall.

APSF set safety standards for all types of Anesthesia
But it did not prevent my open hereditary alopecia
Blame game versus good quality improvement
Brought "root cause analysis" to the forefront.

With no fear of punishment and case review
Replaces hospital holding as peer review
People admit their mistakes and become a student
Improve with safe performance in teaching moment
Anesthesia safety will see fewer adverse event.

With AI, medical technology and microprocessor
Morbidly and mortality is reduced by human error
A safety culture will save unnecessary patient death
Reduction in anesthesia mortality saves every breath.

Anesthesia Consultants of Virginia Simulation Workshop

By Tanner Lydic, OMS-I
ACOS-MSS Anesthesia Chair
Edward Via College of Osteopathic Medicine-Virginia

Tanner Lydic

In March, anesthesiologists from Anesthesiology Consultants of Virginia hosted their annual anesthesia simulation workshop for medical students from Edward Via College of Osteopathic Medicine (VCOM), Liberty University College of Osteopathic Medicine (LUCOM), and Virginia Tech Carilion School of Medicine (VTCSOM). Thank you to Carilion Clinic Center for Simulation for graciously allowing the use of their facility and simulation mannequins for this event.

The workshop began with a talk from the astute Dr. Praveen Prasanna, the Anesthesia Residency Program Director at VCU School of Medicine. Dr. Prasanna spoke about the responsibilities of a practicing anesthesiologist, the variety of practicing directions within the specialty, the lifestyle and outlook of the specialty, and anesthesia residency. He laid out an expectation of anesthesia residency in general and then described his program specifically. Some highlights of his program are their ability to produce anesthesiologists with a mastery level of competence because of their exposure to more sick and unique patients in their training at VCU Health's level one trauma center. Dr. Prasanna also emphasized the major goal of their program to ensure the happiness of their residents by keeping hours at a sustainable level as well as by continual monitoring of the residents' wellbeing. The guest opening remarks ended with a Q&A session where eager medical students were able to ask more focused questions. Dr. Prasanna provided so much educational and inspirational information in his talk, and we were lucky to have him kick off the event.

Following the opening speech, students then rotated through six, 30-minute anesthesia simulations, each led by an anesthesiologist from ACV. Stations included:

VCOM student learning how to perform a fiberoptic intubation from Dr. Maxine Lee

- Intubations and masking, where students learned and performed intubations and visualized associated anatomy.
- Cricothyrotomy station with visualization of gross anatomy on models and on each other using ultrasound, subsequently performing the procedure on mannequins with different styles of kits.
- Standard and nasal fiberoptic intubation station where the indications, contraindications, complications, and technique were learned and the procedure performed.
- Ultrasound anatomy station associated with regional anesthesia procedures including supraclavicular blocks, brachial plexus blocks, popliteal fossa blocks, femoral nerve blocks, and transabdominal plane (TAP) blocks.
- Central line station to learn the anatomy, indications, and workflow of placing central lines through the jugular vein and subclavian vein, subsequently practicing the technique on mannequins.
- Spinal and epidural anesthesia station to learn the differences in anatomy and procedure for performing spinal and epidural anesthesia as well as practice the technique on models.

Edmond Dixon an OMS-I at VCOM-VA said, "As a first-year medical student exploring potential specialties, I am thankful to have had the opportunity to learn from experienced anesthesiologists so early on. Working through their bread-and-butter procedures gave me a great feel for the things I could be doing daily. It also served as an opportunity to review pertinent anatomy, such as when Dr. Michael Sullivan described the difference in medication placement for spinals versus epidurals and how understanding the anatomy is essential for correct placement and desired effect of the drug."

Special thanks to Dr. James Crawford, Dr. Maxine Lee, Dr. Christine Sherman, Dr. Nicholas Wright, Dr. Kevin Vogely, Dr. Neil MacDonald, and Dr. Michael Sullivan from ACV, who donated their Saturday to teach medical students about anesthesiology. Myself and many other attendees gained a further desire to pursue and one day practice anesthesia because of this event, and the knowledge we took away is sure to pay off in the future.

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