virginia society of anesthesiologists

UPDATE

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FALL 2024: **ANESTHESIOLOGY: PAST, PRESENT, FUTURE**

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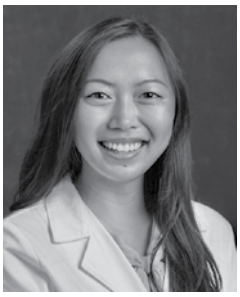
Charles Bell Gibson (1816-1865): Introducing Anesthesiology to Virginia

By Michelle Adema and Joe Ponce
LUCOM
Lynchburg, VA



Michelle Adema

Joe Ponce

It's the 1800s: America has triumphed over Britain, cell phones are still a distant dream, and the field of surgery is just beginning to take shape. Innovation, exploration, and struggle, has been brewing across the nation. Charles Bell Gibson, who became Surgeon General,[1-4] encompassed these ideals throughout his time in the medical field. Not only did Dr. Gibson's work lay important foundations for modern surgical practices and medical education, he was a pioneer for anesthesia in Virginia.

Charles Bell Gibson was the son of Dr. William Gibson, a prominent surgeon who was both a pupil and associate of Sir Charles Bell, the discoverer of cerebral palsy.[1] Charles Bell graduated from the University of Pennsylvania Medical School[2]

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Feature Article

ACCESS Journal Club Session 1: Global Anesthesia

By Panth Doshi, MD
VCU School of Medicine
Richmond, VA

Dr. Panth Doshi

The Acute Care and Systems Strengthening in Low Resource Settings (ACCESS) Program at VCU School of Medicine, is a longitudinal track for students interested in specialties such as Anesthesiology, Critical Care, Emergency Medicine, OBGYN, and Surgery to supplement their educational experience for care in international and low-resource environments.

At the start of their core clinical year, enrolled students pick a specialty track which is comprised of five didactic sessions throughout the year. The first session on Global Anesthesia took place on July 22nd, in the form of a Journal Club focused on "Safe Anesthesia and the Global Burden of Disease: Monitoring, Equipment, and Infrastructure."

The session was open to Anesthesia ACCESS students, residents, and faculty. Students led the conversation on each journal article by giving highlights and teaching points from the article before asking the group questions to further the conversation. Additional input was provided from participants, including faculty members, Dr. Rashid Hussain, Dr. Olga Suarez-Winowiski, and Dr. Rami Maarouf.

The conversation illustrated the unmet global need for surgical intervention and safe anesthesia care. The global burden of disease, which is unmet and growing, can greatly be reduced through surgical inter-

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Inside This Edition:

PAST, PRESENT, FUTURE

vsa virginia society of anesthesiologists UPDATE

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 Coordinator
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.

SAVE THE DATES

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

VSA Annual Meeting Luncheon

Saturday, October 19
Philadelphia Marriott Downtown
RSVP to Angela Puryear at angela@societyhq.com by Wednesday, October 9, 2024

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

President's Message

Did Someone Say Football?

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

Dr. Craig Stopa

I cannot believe that my presidency is on its bell lap.

The last year and a half has gone by way too fast. As the saying goes, time flies when you are having fun, and it has been a pleasure serving you. Also, thank you again for entrusting me to represent you and for providing great care to the residents of the Commonwealth.

So far this year, I have focused on the importance of advocacy. Since the ASA Annual Meeting is coming up this October, I would like to continue to focus on this topic.

I would like to start with an update. The Joint Commission on Health Care (JCHC) has begun conducting interviews with stakeholders who have a vested interest in Virginia's anesthesia workforce. The study will address accessibility, quality, and equity by focusing on the following objectives: describe the anesthesia workforce and how anesthesia services are being delivered in Virginia and review state laws regarding CRNA and CAA practice and their impact on the anesthesia provider workforce.

This is just the beginning. VSA will not stop advocating for quality patient care, patient safety, and the anesthesia care team model. Thank you to everyone who has donated to VaSAPAC as this will be crucial to VSA's success.

As mentioned above, the ASA Annual Meeting will be this October in Philadelphia. I look forward to exploring and discovering Philadelphia, as this will be my first time in the City of Brotherly Love.

The Annual Meeting is a great opportunity to reinforce and learn new practices, catch up with old colleagues, and make new connections in our specialty. Please put a reminder to stop by the VSA luncheon on Saturday for some food and important updates regarding the Commonwealth. See you there.

"The ASA Annual Meeting is a great opportunity to reinforce and learn new practices, catch up with old colleagues, and make new connections in our specialty. Please put a reminder to stop by the October 19 VSA luncheon on Saturday, for some food and important updates regarding the Commonwealth. See you there."

I hope everyone enjoyed summer and was able to take some time off to relish life outside of work. This southern boy made his way up to Maine (no way I was going during winter) to hike the Acadia National Park. Maine is a beautiful state, and my family had a lovely time.

With fall comes football, especially college football. After my alma mater made the national championship game two years ago, they flamed out and did not even make a bowl last year - something Wahoos are familiar with, I hear.

Here's to better seasons for all. Please enjoy this fantastic newsletter and feel free to reach out to me with any questions, concerns, or comments, and thank you for all that you do.

A New Perspective on Anesthesiology's Future

By Brooke Trainer, MD, FASA
Anesthesiologist/Intensivist, VCU Health
Editor, VSA Update

Half Dome in Yosemite National Park

Introduction

Dr. Brooke Trainer

I was recently humbled to receive the honor of speaking at the Texas Society of Anesthesiology's Annual Meeting in San Antonio this year, as a representative of the Dr. Betty Stephenson Award. This award is a tribute to a tireless advocate and pioneer in our field. Her legacy continues to inspire us, particularly women in anesthesiology, to be confident leaders and vocal advocates for our profession.

Dr. Betty Stephenson

Over the last year, I found myself reflecting deeply on the importance of perspective. A transformative experience in Yosemite National Park provided the clarity I needed. During this trip, I realized that time is our most precious commodity, and how we use it determines whether we leave a mark that makes a difference. This moment of clarity helped me reshape how I viewed my role as an anesthesiologist and led me to the topic of my keynote discussion: "Time to Change our Perspective."

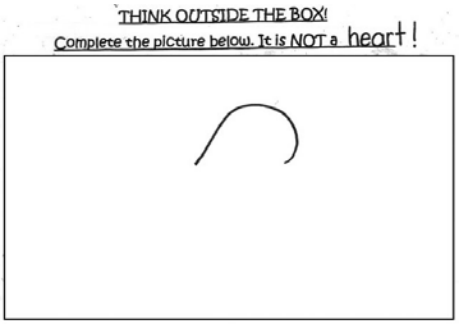
The Power of Perspective

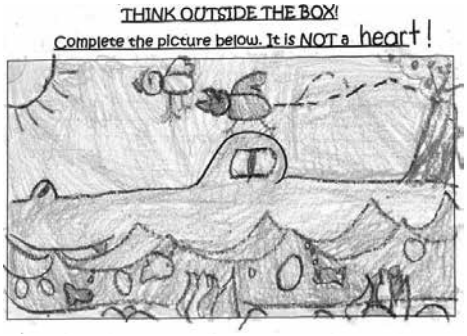
Perspective is the lens through which we view the world. It shapes our decisions, interactions, and even our profession. Just as the glaciers shaped Yosemite's iconic rock formations, our perspectives can be shaped, evolve, and change over time. However, unlike natural forces, we can consciously influence our perspective.

A memorable moment during my Yosemite trip was sitting with friends watching the sunset over Half Dome, and sharing what images we saw in the mountain's face. Our unique interpretations were reflections of our own experiences, highlighting how perspective shapes everything we see and do.

As physicians, our perspectives—whether optimistic or cynical—play a crucial role in how we approach the challenges we face, especially in a profession as dynamic as anesthesiology.

Child vs. Adult Perspectives





Consider the innocent perspective of a child, full of optimism and creativity. My six-year-old daughter, when asked to create a story from a simple squiggly line, saw a crocodile surrounded by flying birds, sunshine, and a sea full of life. It was a reminder that a child's perspective is not yet tainted by life's challenges.

As adults, however, our experiences often cloud our creativity, leading to more cynical or limited worldviews. But we should take a lesson from children and be reminded that creativity and optimism are critical in facing adversity and adapting to change.

The Changing Landscape of Anesthesiology

Our profession has evolved tremendously, and with that evolution comes both challenges and opportunities. When I entered medical school over 20 years ago, I had no idea how much pressure would come from non-physician providers vying to replace us on healthcare teams. Many of us have worked for decades to become the highly trained, experienced physicians we are today. Yet, we now find ourselves facing workforce shortages and a new narrative: that other healthcare professionals, with significantly less training, can do the same job.

The Workforce Shortage: A Problem with Solutions

It's no secret that anesthesiology is facing a workforce shortage, particularly in rural areas. However, the problem isn't the

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shortage itself—every field has workforce issues—but rather the potential solutions being proposed. Certified Registered Nurse Anesthetists (CRNAs) are advocating for the right to practice independently, without physician involvement, claiming they are capable of providing equal care.

This two-tiered system, where some patients receive care from physicians and others from nurses, harks back to a time before physicians and nurses teamed up to improve patient care. It's a step backward, and it raises significant questions about who decides which patients see physicians and which do not. Patients rarely choose the professional administering their anesthesia, making this model rife with potential inequities.

Addressing the Shortage with Creative Solutions

The solutions to this crisis must be thoughtful, systemic, and maintain high standards of patient care. For example, here are a few key proposals:

Incentivize Anesthesiologists to Work in Rural Areas

Offering financial incentives, such as higher reimbursement rates and loan forgiveness, can encourage anesthesiologists to work in underserved communities. Additionally, we can support legislation like the Support Medicare Access to Rural Anesthesiology Act, which allows rural hospitals to hire anesthesiologists using Medicare pass-through payments, a benefit currently limited to CRNAs.

Expand Anesthesia Residency Programs

The Rural Residency Planning and Development (RRPD) Program provides a practical solution to increase the number of anesthesiologists practicing in rural areas. By supporting residency programs in these areas, we can create a pipeline of professionals more likely to stay in underserved regions after completing their training.

Abbreviate Training Programs for Rural Anesthesiology Residents

A creative and unique proposal aimed to attract residents to apply to rural residency programs is to abbreviate anesthesiology training program for residents who commit to staying in rural areas for a set number of years post-graduation. These residents could be allowed to graduate early and serve as attending anesthesiologists in their final year, helping alleviate the shortage while earning an attending-level salary.

> *By addressing the workforce shortage with thoughtful, creative solutions, and advocating for physician-led teams, we can ensure that both physicians and nurses continue to play their vital, distinct roles in healthcare.*

Merge Anesthesiology Fellowship and Residency Training

More than 50% of anesthesia residents now choose to pursue fellowships, adding another year of training to an already extensive process. One creative solution could be to integrate anesthesiology fellowship training into residency programs, allowing residents to specialize without extending their total training time. This would shorten the timeline to workforce entry by at least one year while maintaining the same level of specialization.

This model already exists in countries like the UK, Switzerland, and Australia, where anesthesia residents graduate with subspecialty certifications in areas like critical care. It's a model we should carefully consider to ensure we continue to meet the growing demand for anesthesia providers.

Lessons from the Military: Physician-Led Teams

Having served as an Air Force Officer and Critical Care Air Transport Team (CCATT) Physician, I've witnessed firsthand the importance of physician-led teams, particularly in high-risk environments. In the military, CRNAs follow strict protocols and are supported with physician involvement. They are not left to practice solo in combat zones, contrary to some claims made. And for their sickest patients, those requiring the most complex care, the military reserves this care for physician-led teams only.

The military understands the importance of comprehensive training, protocols, and standards before sending CRNAs into challenging situations without physicians at their side. The military minimizes the risk of harm by ensuring mission readiness through regularly scheduled drills and simulations, and by having every service member train together as a team before deployment.

The idea of solo practice is not supported by the military, where safety protocols and physician involvement are paramount. This ensures that even in the most remote environments, patients receive the safest possible care.

A Pathway for CRNAs to Become Physician Anesthesiologists?

Finally, one intriguing solution to the workforce shortage could be offering CRNAs a specialized pathway to becoming physician anesthesiologists, similar to the airline industry's model of junior pilots working toward senior pilot status. By requiring additional training and certification for CRNAs interested in practicing independently like anesthesiologists, we could create a fair and safe pathway that ensures the highest standard of care for all patients.

Optimism for the Future

In conclusion, I want to emphasize the importance of optimism and resilience. The challenges we face—workforce shortages, competition from non-physicians, and the complexities of modern healthcare—are real. The future of anesthesiology depends on our ability to adapt, innovate, and maintain the highest standards of care. By addressing the workforce shortage with thoughtful, creative solutions, and advocating for physician-led teams, we can ensure that both physicians and nurses continue to play their vital, distinct roles in healthcare.

The pendulum may swing with the times, but with the right perspective, we can guide it back to where it belongs: a model of healthcare that prioritizes patient safety and teamwork.

and soon after began making a name for himself. Aside from his medical career, Charles built a large family; after marrying Ellen Eyre in 1838, they had at least eleven children together: Sarah, Charlotte, William Eyre, Mary Elizabeth, James Cheston, Charles Bell, Beverley Tucker, Anna Louisa, Charles Bell, Ellen Eyre, and Manual Eyre.2 Through the naming of his two sons, both by the name of Charles Bell, one can see the influence that his father's teacher had on his life and family.

Part of Dr. Gibson's early career as a surgeon was spent advancing the medical field through literature. In December of 1842, Charles wrote a detailed account of an operation he performed on Moses Lee, an enslaved blacksmith who presented with a growing tumor of his chin and jaw. In his account, Charles Gibson recalls the history of Mr. Lee's symptoms, the morphological appearance of the tumor, and his impression of the lesion upon his examination, which was later recognized as an osteosarcoma of the lower jaw.

He went on to write about his technique in excising the lesion from the patient in detail, which included him stating, "I now took a position directly behind the patient, his head resting on my breast, and the flap on the left side being held out of the way, sawed from above downwards through the bone on that side, cutting through the cavity occupied by the roots of the extracted molar". Following the procedure, Dr. Gibson documented the course of Moses Lee's successful recovery and rehabilitation, narrating that "a thick line down the middle of his chin is the only evidence of his having submitted to an operation".[5]

After studying under his father in Pennsylvania he moved to Baltimore in 1843 and became a professor of surgery at Washington Medical College.[2] After four years, he moved to Virginia where he was chosen as the second professor and chief of surgery at Hampden-Sydney College, renamed Medical College of Virginia.[2,3,6] While at Medical College of Virginia, he instructed students in a variety of surgical procedures that used chloroform, the prevalent anesthesia at the time. He delivered an annual lecture series on anatomy and surgical techniques to students at Medical of Virginia,[7,8,9] where he also taught a range of procedures including lithotomy, lower jaw surgeries, and tumor resections.

In 1848 he conducted the first surgery using anesthesia in Virginia and then was elected Surgeon General at the start of the Civil War.[1,3,4] From 1861-1864, he was commissioned as the surgeon-in-charge for the Confederate State Army's first General Hospital in Richmond, Virginia, called Alm's Hospital, later known as the Officer's Hospital.[4] This hospital treated both Confederate and Union Soliders.[3]

At the end of a life of teaching, innovation, and advancement, Dr. Charles Bell Gibson succumbed to heart disease following a severe case of pneumonia in April of 1865. As a surgeon, Dr. Gibson was recognized with high reputation for his practice in Baltimore and Maryland and, for his work in introducing anesthesia to the state of Virginia, was noted for his teaching at the Medical College of Virginia.[6,10] In 1968, the Medical College of Virginia merged with Richmond Professional Institute to form the Virginia Commonwealth University, where Dr. Charles Bell Gibson is now highlighted as part of the history of the Department of Anesthesiology.[10] While this is so, there is much to be sought in the recognition that Dr. Gibson receives for his skillful practice as a physician and his initiative in utilizing anesthesia in surgery.

References

1 Fiske, John, Joint Ed. Appletons' cyclopædia of American biography. editeds by Wilson, James Grant New York, D. Appleton and company, -<1895 >, 1894. Pdf. https://www.loc.gov/item/tmp96003927/.

2 Burden, Jeffry. "Dr. Charles Bell Gibson." . Accessed July 28, 2024. https://www.findagrave.com/memorial/16521831/charles_bell-gibson

3 "Our History," last modified Dec 6, accessed July 28, 2024, https://anesthesiology.vcu.edu/about/#d.en.333653.

4 Alexandria gazette. Vol XLII. (Alexandria, D.C.), 18 April 1842. Chronicling America: Historic American Newspapers. Lib. of Congress. <https://chroniclingamerica.loc.gov/lccn/sn85025007/1842-04-18/ed-1/seq-3/>

5 Gibson, Charles. "Art. I.—OsteoSarcoma of Lower Jaw—Amputation—Cure." American Journal of the Medical Sciences - AMER J MED SCI 25, (1842): 277-280. doi:10.1097/00000441-184204080-00001.

6 Richmond Whig. Vol 1-No. 18 (Richmond, Va.), 24 April 1865. Chronicling America: Historic American Newspapers. Lib. of Congress. <https://chroniclingamerica.loc.gov/lccn/sn84024669/1865-04-24/ed-1/seq-5/>

7 Alexandria gazette. Vol LXXI. (Alexandria, D.C.), 24 Aug. 1865. Chronicling America: Historic American Newspapers. Lib. of Congress.<https://chroniclingamerica.loc.gov/lccn/sn85025007/1865-08-24/ed-1/seq-2/>

8 "Confederate States Medical & Surgical Journal." Confederate States Medical & Surgical Journal 1, no. 1 (January 1864).

9 Richmond Enquirer. (Richmond, VA), Jan. 28 1848. https://www.loc.gov/item/sn84024735/1848-01-28/ed-1/.

10 Virginia Commonwealth University Department of Anesthesiology. "Our History." . Accessed July 28, 2024. https://anesthesiology.vcu.edu/about/#d.en.333653.

Global Anesthesia, *from page 1*

vention, of which safe anesthesia is a critical component. The differences in perioperative care and outcomes, such as the type of anesthesia available, anesthesia-related mortality, and available resources, were outlined.

Of particular interest was the topic of resource scarcity. Participants discussed how safe anesthesia practice relies on physical resources, such as equipment and monitors, human resources such as trained providers, and infrastructure, such as the physical space in which to deliver care.

In resource-rich countries, the anesthesia scene looks very different. There are plenty of available personnel with appropriate levels of supervision. There is ample equipment and medicine, often to the point of wasteful use.

However, in resource-limited settings, there may not be a dedicated anesthesia team. Rather the responsibility may lie in the hands of a different practitioner, who is often multitasking. There isn't necessarily the convenience of pre-mixed medications, neatly packaged into a single-use syringe. Oftentimes, there isn't a dedicated OR space for these critical procedures, necessitating bedside service instead.

It takes an entirely different set of skills to be able to care for patients in those types of environments. That difference often isn't seen until providers from resource-rich countries travel to resource-limited areas on medical mission trips.

To mitigate that shock, facilitate clinical knowledge and skills, and spread awareness, Dr. Suarez-Winowiski has helped to coordinate residency exchange with facilities in Tuloca, Mexico. Residents from VCU spend time in Toluca, while residents from three programs in Toluca come to VCU.

> *Global health opportunities in medical education, at all levels of training, have greatly risen in recent years. As students enrolled in this longitudinal program focused on the globalization of these acute care specialties, M3 learners also discussed appropriate etiquette for mission trips and five principles of avoiding unethical altruism.*

Global health opportunities in medical education, at all levels of training, have greatly risen in recent years. As students enrolled in this longitudinal program focused on the globalization of these acute care specialties, M3 learners also discussed appropriate etiquette for mission trips and five principles of avoiding unethical altruism.

How can we help minimize the impact of hosting trainees for these institutions which may already be resource strained? The participants discussed having a pure learning attitude and acknowledging limitations. Learners can easily be placed in situations with less supervision, but it is critical to be cognizant of your abilities. More autonomy doesn't justify practicing out of scope or in a manner different from the home institution.

The lack of human resources due to the "brain drain" phenomenon was also discussed. Brain drain refers to the emigration of highly educated and skilled individuals from resource-limited areas to resource-rich areas. Oftentimes, the education of these individuals has been subsidized by their countries of origin to meet their existing needs. However, this investment doesn't always yield results, as the beneficiaries may leave the country in search of better opportunities. Thus, the lack of resources, both funding and personnel, is perpetuated.

Overall, the conversation was highly productive and allowed for an effective introductory session, in comparing and contrasting systems-level challenges for safe anesthesia practice internationally, when compared to the United States.

The other component of this first ACCESS session for anesthesia is an in-person OR simulation, led by Dr. Hussain. These students will have four more sessions this year before they transition to working on capstone projects with their faculty mentors. To improve safe anesthesia practice worldwide, these conversations on global health are critical. Students in this program have the benefit of this education early in their careers and can be future leaders in safer and more equitable global anesthesia.

Legislative Update

By Lauren Schmitt
Commonwealth Strategy Group

It's been a busy summer for VSA as we continue to advocate to protect Virginia's current supervision requirements. We've met with key legislators and participated in multiple informational interviews for the Joint Commission on Health Cares' study on anesthesia care.

We also recently chose both Senator Mamie Locke and Senator Todd Pillion for our 2024 Legislators of the Year award. We are incredibly grateful to their bipartisan leadership and support in protecting the physician-led anesthesia care team.

Some of the highlights from the last few months include working with medical students at Liberty University to set up a meeting with their local legislators. We were thrilled to have Joseph Ponce, a medical student at the Liberty University

College of Medicine, who is interested in choosing anesthesia as his specialty, join us for a meeting with Senator Mark Peake and Delegate Wendell Walker. Joseph was able to give a unique perspective from a medical student still deciding which specialty they will choose. He was able to share with the legislators the negative impact the CRNA's legislation would have on recruiting anesthesiologists.

We also were able to give Senator Todd Pillion his "VSA 2024 Legislator of the Year" award in person at his annual event in Bristol. Thank you to the physicians at Virginia Highlands Anesthesia who attended the event and showed their support to Senator Pillion. We are looking forward to presenting Senator Locke with her award next month.

Thank you to everyone who has contributed to the VSA PAC this year. We have definitely seen an increase in the number of people giving contributions. Unfortunately, we are still significantly behind the Virginia Association of Nurse Anesthetists when it comes to PAC giving.

We need every member of VSA to contribute to our PAC so we can support legislators like Senator Pillion and Senator Locke. If you want to help us keep the current law in place, it is critical that you contribute to the PAC.

Virginia Highlands Anesthesia

By Lauren Schmitt
Commonwealth Strategy Group

We want to give the physicians of Virginia Highlands Anesthesia a special shoutout for their exceptional advocacy!

Lauren Schmitt (VSA lobbyist) presenting Senator Todd Pillion with the VSA 2024 Legislator of the Year award with physicians from Virginia Highlands Anesthesia.

Drs. Mark Simcox and Jeff McCraw attended Senator Todd Pillion's annual fundraiser on Sunday, August 25. They were able to present Sen. Pillion his "VSA 2024 Legislator of the Year" award.

Dr. Brandon Nave, Dr. Tommy Sutton, Dr. Cedric Regelin, Senator Todd Pillion, Dr. Mark Simcox, and Dr. Jeff McCraw

It was great to have such a strong presence of anesthesiologists at this event. In addition to Senator Pillion, they were able to meet and speak with several legislators who were there.

Virginia Highlands Anesthesia has developed a strong relationship with Senator Pillion, and he knows and truly values the care they provide in his district. Their practice exemplifies the importance of meeting and developing relationships with your local legislators.

Thank you to this fantastic group of anesthesiologists for taking the time to advocate for their profession and patients!

Reauthorizing and Funding the Dr. Lorna Breen Health Care Provider Protection Act

Legislation supports health workers' mental health and well-being

Dr. Lorna Breen, Dr. Matt Gall, Dr. Mo Brown, and Dr. Scott Jolley are four of the hundreds of physicians who die by suicide every year. Like Lorna, Matt, Mo, and Scott, physicians, and all health workers, suffer from a critically high degree of burnout and poor mental health. The rate of burnout among health workers continues to rise, along with their rates of depression and other mental health conditions. The suicide rate among physicians and nurses is also twice that of the general population.

To avoid professional repercussions, health workers often feel trapped taking care of patients with little to no relief. It is not surprising that the quality of patient care suffers in parallel. Without immediate action, the added stress they continue to experience will put more pressure on our caregivers, resulting in more loss of life and a further decline in patient care.

The Dr. Lorna Breen Health Care Provider Protection Act is a landmark, first-of-its-kind legislation, supporting health workers' mental health and well-being. Since passage in 2022, the Lorna Breen Act has funded $103 million across 45 organizations to implement evidence-informed strategies that reduce and prevent suicide, burnout, mental health conditions, and substance use disorders.

It has also established the Impact Wellbeing™ campaign, which gives hospital leaders evidence-informed solutions to reduce health worker burnout, sustain well-being, and build a system where health workers thrive. But this is only scratching the surface of caring for our caregivers - less than 1% of the 6,120 hospitals in our country received grants, and it doesn't consider the 200,000+ other types of healthcare settings, such as Federally Qualified Health Centers (FQHC).

The pressures on health workers over the past few years finally shined a bright light on the immense strain they face – but this strain is deeply rooted in how our healthcare system operates.

> *The Dr. Lorna Breen Health Care Provider Protection Act is a landmark, first-of-its-kind legislation, supporting health workers' mental health and wellbeing. Since passage in 2022, the Lorna Breen Act has funded $103 million across 45 organizations to implement evidence-informed strategies that reduce and prevent suicide, burnout, mental health conditions, and substance use disorders.*

We must call on our legislators to reauthorize and renew funding for the Dr. Lorna Breen Health Care Provider Protection Act (HR 7153/S 3679). In addition to widening its reach to more hospitals, the reauthorization of the Lorna Breen Act also focuses on reducing the administrative burden for health workers everywhere.

The Act is a lifeline for health workers, offering support and resources to address the mental health challenges they face. This critical legislation is not just a matter of policy; it's a critical piece of the health delivery supply chain that benefits not only health workers, but every patient, every caregiver, every person that will require medical care in their lifetime.

It's time to act for the future of healthcare in our country. Contact your legislators at https://drlornabreen.org/reauthorizelba/.

SafeHaven: A New Support System for Virginia Anesthesiologists

The American Society of Anesthesiologists (ASA) is proud to announce its partnership with a nationally recognized well-being program, SafeHaven. ASA is offering anesthesiologists the opportunity to enroll in this program for only $149, half of its regular price.

The SafeHaven legislation and program was created in Virginia for physicians by physicians through the lobbying efforts of The Medical Society of Virginia.

Across the nation, advanced clinicians operate in high-pressure, fast-paced environments where the highest quality of care and accuracy are the only options, making SafeHaven a necessity.

This national movement has earned recognition and support from hospital administrations, medical schools, and elected officials across the country. As physician burnout becomes increasingly recognized as a national issue and a crucial quality-of-care concern, SafeHaven steps in to provide essential support.

SafeHaven offers confidential counseling sessions that are protected by Virginia law, ensuring that healthcare professionals can seek help without fear of repercussions to their medical license. This program is specially designed for advanced practitioners, including doctors, PAs, nurses, and pharmacists.

Key Offerings of SafeHaven

- Counseling Sessions: Support when you need it most.
- Peer Coaching: Connect with someone who understands your everyday challenges.
- WorkLife Concierge: Your virtual assistant to help manage your time.
- WorkLife App: Easy access to resources at your fingertips.

This partnership with SafeHaven underscores the ASA's commitment to the well-being of its members. We encourage all anesthesiologists to take advantage of this valuable resource at a reduced cost and invest in their mental health and professional sustainability.

There are only a limited number of discount enrollments available.

safe haven™ CONFIDENTIAL SUPPORT

The SafeHaven legislation and program was created in Virginia for physicians by physicians through the lobbying efforts of The Medical Society of Virginia.

Website for more information

https://safehavenhealth.org

SafeHaven Video

https://www.youtube.com/watch?v=e3I7xDWxS8g

ASA Enrollment Link

https://safehavenhealth.org/enroll/asa/

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

Reflecting on My Journey: Why Anesthesiology Became My Chosen Path

By Mohammad Hasan
MD Candidate
Virginia Commonwealth University
Richmond, VA


Mohammad Hasan

As a fourth-year medical student working through my application for the upcoming Match cycle, with the hope of securing a position in an anesthesiology program, I've been reflecting on what drew me to this specialty.

Born and raised in Kuwait, I am the first person in my family to enter the field of medicine. When I started medical school I had no clear idea of what specialty I wanted to pursue. My exposure to medicine was limited. By the time I started medical school, I had only lived in the USA for six years and had a very limited understanding of the complex healthcare system here.

As I began my medical education, I found myself fascinated by the field and loved the vast majority of subjects I had to learn. During my preclinical years, many of my beliefs and assumptions were challenged, and needed to be corrected. Fortunately, I had advisors who provided invaluable input and answered my numerous questions, guiding me through the first two years.

Transitioning to clinical years, I noticed a significant shift in my role from being a "student" to becoming more of a "worker." I began to understand and experience the hierarchical nature of medicine. I had to quickly adapt to the nature of clinical rotations, which involved constantly joining preformed teams and integrating within their dynamics every few weeks.

> *Anesthesiology, to me, epitomizes the essence of being a doctor. However, many other specialties share these characteristics. Upon reflection, I realized that the differentiating factor was the positive interactions and mentoring I received during my anesthesiology rotation.*

Throughout these rotations, the attendings and residents across various specialties were understanding of my evolving role. However, it wasn't until I started my anesthesiology rotation midway through my third year that I experienced truly meaningful relationships with the residents and attendings. These interactions made me feel mentored and guided in the clinical setting, and in many instances, I felt I was treated as an equal. It was these positive experiences that sparked my interest in anesthesiology, an interest that has only grown since.

As I am preparing my application and engaging in internal dialogue, I delved into why anesthesiology was so compelling to me. The specialty's procedural nature, its emphasis on the practice of medicine, being an active member of a multidisciplinary team, and the significant patient interactions it encompasses were all intriguing aspects.

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Medical school can be a challenging and, at times, brutal environment, especially given the position of students within the team hierarchy. This journey has given me a profound understanding of how power imbalances manifest and the crucial importance of mentoring and forming meaningful relationships with team members. Choosing a specialty in such a fascinating and diverse field was not easy, but my experiences with anesthesiology faculty and residents over the past two years have solidified my decision.

I am immensely grateful to everyone who has supported me throughout this journey, especially within the field of anesthesiology. Their guidance and the examples they set have been instrumental in shaping my aspirations. As I move forward in my career, I aspire to embody the qualities of the mentors who have influenced me.

One day, I will hold a position of power over others, and I hope to always remember how it felt to be in a less powerful position. I aim to fulfill my moral responsibilities with compassion and respect, ensuring that I provide the same level of support and mentorship that I was fortunate to receive.

Considerations for Anesthesiologists in Caring for Sexual Violence Survivors

By Luke M. Johnson
VCU School of Medicine
Richmond, VA

Luke Johnson

Sexual violence is a pervasive societal plague with devastating effects. In the United States, 44% of women and 25% of men experience sexual violence in their lifetime (1), and rates of sexual assault are higher among lesbian, gay, bisexual, transgender and gender-diverse individuals (2).

These survivors suffer from suicidality, post-traumatic stress disorder (PTSD), and major depressive disorder at increased rates (3).

Anesthesiologists play a critical role in the care of sexual violence survivors, not only in their medical treatment, but also in the broader context of understanding the use of common anesthetics in drug-facilitated sexual violence. Drugs commonly used by anesthesiologists, such as ketamine, benzodiazepines, and various opioids are frequently misused to incapacitate individuals before they are sexually assaulted (4).

For example, ketamine is a common date rape drug, due to its ability to cause dissociative, trance-like anesthesia, and properties which allow it to be diluted and imperceptible in drinks. As experts on these medications, anesthesiologists should be involved in developing and disseminating guidelines on the safe handling and administration of these drugs to prevent this misuse.

Another important way that anesthesiologists can care for sexual violence survivors is during perioperative care. During the preoperative phase, anesthesiologists should consider appropriately assessing the patient's history of violence and trauma, as many survivors of sexual assault have specific triggers that the surgical environment may exacerbate (5). In a notable case example, one adolescent patient with a history of sexual trauma expressed that she did not want anything placed on her face during surgery. This careful, detailed preoperative communication allowed the anesthesia team to respond with trauma-informed care.

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Additionally, anesthesiologists must be aware that for many survivors, general anesthesia is frightening because of the total loss of control. For survivors, one of the most scarring aspects can be the memory of being robbed of their freedom to choose what happens to their body. Understanding this is essential for anesthesiologists because general anesthesia involves a total loss of control and extreme vulnerability which can be very triggering for survivors. It is crucial for anesthesiologists to address this during the preoperative phase by communicating clearly with patients about what to expect, what will happen to them, and steps taken to ensure their safety. Further, it may be helpful to offer patients choices about the method of induction, (e.g. IV vs mask) as this can help patients feel in control, which is invaluable for survivors.

Fears that survivors may have about being put to sleep are worsened by macabre anesthesia history. Grievously, pelvic examinations have been performed on women without consent under general anesthesia for learning purposes (6, 7). Though many states have outlawed such violations by requiring written or verbal consent, this happened and may sometimes still happen due to "presumed consent." Anesthesiologists must be aware of this horrific history and always stand as patient advocates to ensure this does not continue to happen.

Postoperative care is equally important. Emergence from anesthesia can lead to potential flashbacks of past trauma, especially in survivors with PTSD (8). Ensuring a calm and gentle emergence, preferably in a less stimulating environment, can help dampen these effects. For increased emotional sup-

Continued on page 13

port during anesthesia emergence, the presence of a trusted support person, if allowed by hospital policy, can provide immense comfort to the survivor. Additionally, communicating the patient's history and needs to the postoperative care team is essential to maintain continuity of care and provide a safe recovery environment.

Regarding pain management, studies reveal that sexual violence survivors generally experience higher pain levels in response to painful stimuli (9). This hyperalgesia experienced by many survivors may help explain the well-established link between sexual violence and chronic pain (10, 11). Sexual violence survivors experience chronic pelvic, back, and abdominal pain at increased levels (12, 13). Also, the emotional modulation of pain, which typically helps in pain regulation, is often disrupted in survivors. For example, in most people, positive emotions may reduce the amount of pain experienced, and negative emotions may augment the pain. However, in survivors, research shows that pain levels may be heightened regardless. These pain nuances are critical factors for anesthesiologists to consider when managing pain in these patients.

Doctor Julie Valentine, a lead sexual violence prevention researcher, authored this beautiful analogy of hope for survivors: after cold, dark winters, the crocus flower is the first to bloom, often sprouting through the snow. Similarly, it is also possible for sexual violence survivors to bloom despite the brutal circumstances they have endured. Multidisciplinary efforts play a major role in enabling survivors to bloom, including those of anesthesiologists. Empathetic, competent care from anesthesiologists plays a crucial role in promoting healing and minimizing the trauma experienced by sexual violence survivors.

References

1 Smith, S.G., Zhang, X., Basile, K.C., Merrick, M.T., Wang, J., Kresnow, M., & Chen, J. (2018). The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 Data Brief - Updated Release. National Center for Injury Prevention Control, Centers for Disease Control and Prevention. Retrieved on January 30, 2024, from https://www.cdc.gov/violenceprevention/pdf/2015data-brief508.pdf

2 James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). The Report of the 2015 U.S. Transgender Survey. National Center for Transgender Equality. Retrieved on January 30, 2024, from https://transequality.org/sites/default/files/docs/usts/USTS-Full-Report-Dec17.pdf

3 https://www.ptsd.va.gov/professional/treat/type/sexual_assault_adult.asp

4 de Souza Costa, Y. R., Lavorato, S. N., & de Campos, J. J. C. M. (2020). Violence against women and drug-facilitated sexual assault (DFSA): a review of the main drugs. Journal of forensic and legal medicine, 74, 102020.

5 Troutman, M., Chacko, S., Petras, L., & Laufer, M. R. (2022). Informed care for the gynecologic day surgical patient with a history of sexual trauma. Journal of Pediatric and Adolescent Gynecology, 35(1), 3-6.

6 Cundall, H. L., MacPhedran, S. E., & Arora, K. S. (2019). Consent for pelvic examinations under anesthesia by medical students: historical arguments and steps forward. Obstetrics & Gynecology, 134(6), 1298-1302.

7 Tillman, S. (2023). Presumed consent for pelvic exams under anesthesia is medical sexual assault. IJFAB: International Journal of Feminist Approaches to Bioethics, 16(1), 1-20.

8 Huang, J., Chopra, N., Yepuri, N., & Kinthala, S. (2023). Emergence agitation and anesthetic considerations in the management of patients with post-traumatic stress disorder: a report of two cases and a review of the literature. Cureus, 15(1).

9 Hellman, N., Kuhn, B. L., Lannon, E. W., Payne, M. F., Sturycz, C. A., Palit, S., ... & Rhudy, J. L. (2018). Emotional modulation of pain and spinal nociception in sexual assault survivors. Psychosomatic medicine, 80(9), 861-868

10 Leserman, J., Zolnoun, D., Meltzer-Brody, S., Lamvu, G., & Steege, J. F. (2006). Identification of diagnostic subtypes of chronic pelvic pain and how subtypes differ in health status and trauma history. American journal of obstetrics and gynecology, 195(2), 554-560.

11 Wuest, J., Ford-Gilboe, M., Merritt-Gray, M., Varcoe, C., Lent, B., Wilk, P., & Campbell, J. (2009). Abuse-related injury and symptoms of posttraumatic stress disorder as mechanisms of chronic pain in survivors of intimate partner violence. Pain medicine, 10(4), 739-747.

12 Tesarz, J., Gerhardt, A., Leisner, S., Janke, S., Treede, R. D., & Eich, W. (2015). Distinct quantitative sensory testing profiles in nonspecific chronic back pain subjects with and without psychological trauma. Pain, 156(4), 577-586.

13 Walker, E. A., & Stenchever, M. A. (1993). Sexual victimization and chronic pelvic pain. Obstetrics and gynecology clinics of North America, 20(4), 795-807.

My Why: Mike Saccocci and Joseph Walch

DR. MIKE SACCOCCI

What Led You to Anesthesiology?

One of the things that really led me to anesthesiology is how critical decisions could make a big impact on patient care very quickly. In anesthesiology, there are so many ways we impact patients — whether it be through a preoperative clinic, intraoperative care, pain management procedures, critical care.

How About Your Subspecialty?

One of the areas that I found I'm most interested in is cardiac anesthesia. I play a role not only in keeping the patients safe and comfortable, and guiding them through a massive surgery on their cardiovascular system, but increasingly we play a role in the surgery itself. We do echo navigation for procedures so that cardiologists and surgeons can see where they're going and we can help direct them in ways to fix the heart or cardiovascular system.

Why Did You Join VSA?

When I initially came to Virginia, it was an automatic thing. But I've been out for 15 years now, and in the last few years I felt like something's been missing from my career. And that's been impactful networking — a way to make a difference for everyone in my state, for all the anesthesiologists. For example, I formed a committee that created a new, novel educational program for point-of-care ultrasound. Anesthesiologists were early leaders in this, but it's evolved a lot further from there. The VSA played a key role in this. This is a collegial group, very welcoming. Come on out! It's very fulfilling.

DR. JOSEPH WALCH

What Led You to Anesthesiology?

The interaction between the physiology and the procedural part of it — to be active in intervening on a moment-to-moment and day-to-day basis. Having a real impact on patients' care, and affecting the quality of their recovery from surgery and their pain control.

What Made It a Good Match for You?

I went into medical school thinking I would do internal medicine cardiology. And I did a dual-degree program. So in the middle of med school, I was doing my Ph.D. graduate work, and I discovered anesthesia as a way to combine the science of pharmacology and physiology and medication dosaging in a way that was really interesting for me. It also kept me really busy, and interested every single day. And also, being able to monitor cardiac function, and do echos, and be able to see real-time results from my intervention.

Why Would You Encourage a Colleague to Join VSA?

Membership in a professional society allows you to have community, belonging, and to really have greater capacity to influence the direction of the future of our specialty — long after all of us retire. There's going to be a need to take care of patients perioperatively. Anesthesia's going to be one of those core specialties that's not going away anytime soon. And it's important that we not just consume but also give back. That we add to the giants that have come before, try to add our little piece to the puzzle, and help those who come after us.

ASA Board of Directors Report

By Jeff Green, MD, MSHA, FASA
VSA/ASA Director

Dr. Jeffrey A. Green VSA ASA PAC Director

The ASA Board of Directors met Aug 16-18 in Rosemont, Illinois for the second of three scheduled board meetings this year. On Friday, there are closed Section meetings for Fiscal Affairs, Administrative Affairs, Professional Affairs and Scientific Affairs, as well as a meeting of the resident component governing council, and the ASA-PAC executive board. Starting on Saturday, the caucuses, including our own mid-atlantic caucus, meet before the first formal session of the board. During the first session of the official meeting, the ASA President, CEO, and finance team each give updates to the board on their progress for this year. President Ronald Harter, MD, spoke about the threat of CRNA expansion of scope of practice, highlighting the recent experience in Modesto, California at Stanislaus Surgical Hospital, where an investigation by the California Department of Health on behalf of CMS found serious deficiencies leading to patient harm and the removal of CRNAs privileges from the hospital. New ASA CEO, Brian Reilly, updated the board on his vision for increasing ASA's "relevance and revenue", and the finance team, led by treasurer Dr. Jay Mesrobian, gave an update on the 2024 and 2025 budgets. ASA membership has been holding steady but with rising inflation and expenses, ASA is looking for ways to increase non-member, non-dues revenues to strengthen the financial position of the organization.

After the updates, the Board members presented testimony to the four reference committees on the various reports submitted to each section. Items of interest receiving significant testimony included a proposal to shorten the governance structure of the ASA annual meeting to 4 days, from the traditional length of 5, and approval of board designated funds to increase member and customer relations with ASA through an ASA app, ASA insurance offerings, and other frequently requested services. As usual, there was thoughtful and passionate, but always respectful and engaging, testimony from the board members.

Much of the afternoon session was spent in the candidates' forum, where the board heard from the three candidates running in a contested election for ASA 1st VP in October. Drs. Michael Lewis, Jay Mesrobian and Jeff Mueller each eloquently presented their plans and vision for the future of ASA. The Board then heard from new Anesthesiology journal editor, Dr. Jim Rathmell, on his plans for the journal, and Dr. Matt Hatch, from the committee on communications, on ASA's social media strategy. Finally, Dr. David Martin gave an update from the ad hoc committee on board engagement. The afternoon concluded with a reception in honor of President Harter.

On Sunday, the Board again formally met to approve all the reference committee reports and any respective budgetary adjustments. This was followed by a legislative and regulatory update from ASA's Manny Bonilla and Matt Popovich. Considering the amount of business for the board, the meeting ran smoothly and efficiently.

I continue to be honored to serve as your representative to the Board of Directors and lead the delegation to the House of Delegates in October. I remain always available to you regarding anything to do with the ASA and would be happy to have you reach out to me with any of your questions or concerns at dr.jeffrey.green@gmail.com

In Memoriam: Cosmo DiFazio

September 10, 1933 - August 21, 2024

Cosmo DiFazio

Cosmo Americo DiFazio, Sr., age 91, passed on August 21, 2024, in Palmyra, VA.

He was born in Rumford, ME in 1932. After graduating from Rutgers University, with a B.S. in Pharmacy, he went to graduate school at the University of North Carolina, receiving a Ph.D. and M.D.

He served his residency program in Anesthesiology at the University of Virginia Medical Center, and served as a clinical Anesthesiologist and Professor in the Department of Anesthesiology at the University of Virginia for nearly 40 years. He was also a pioneer in the field of regional anesthesia, conducting research on the medications that are now regularly used for epidural blocks in obstetric procedures.

During the Vietnam era, he also served in the Army Reserves as a Major, attached to the Army's 56th Station Hospital in Richmond, VA.

His professional successes were secondary to his most cherished accomplishment, his family. While a student at Rutgers University, he met the love of his life, Connie, also a pharmacy student. They were married for 62 years, before her death in 2017. He credited her as the reason behind all of his professional successes.

They had five children, Cosmo Jr., Michael, Charlie, Maria and Patrick. They also enjoyed spending time with their daughter-in-laws, Faye, Bonnie, Diane, and Cathy; their 13 grandchildren, Cosmo, Michael, Emma, Ryan, Cody, Melissa, Kevin, Arielle, Greg, Kyle, Andrew, Bella and Francie; and three great-grandchildren, Jaclyn, Wyatt and Dean.

Cosmo is preceded in death by his parents, Cosmo and Maria; his beloved wife, Connie; and his older brother, Anthony. He is survived by his five children; 13 grandchildren; and three great-grandchildren. He is also survived by brother, Louis DiFazio; and sister, Mary Peterson. He is also survived by a host of colleagues and friends who he considered part of his family.

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VSA Annual Meeting Luncheon

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