virginia society of anesthesiologists

# UPDATE

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WINTER 2025: **CARDIAC ANESTHESIA**

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## Save the Date for POCUS 2025!

**By Mike Saccocci, DO, MPH, FASA**
*Co-Director, VSA Region 5 – Southwest*
*Partner, Anesthesiology Consultants of Virginia (ACV), Inc.*
*Roanoke, VA*

*Dr. Mike Saccocci*

Did you know that diagnostic Point of Care Ultrasound (POCUS) training is among the hottest and most requested workshop topics among attendees at recent national anesthesiology conferences? In fact, a recent survey of the VSA membership in May of 2022 revealed that 53% of VSA members had "little to no experience with POCUS", 55% agreed that they were "very likely to attend a regional POCUS workshop", and 51% would travel "50 to 150 miles" to attend a POCUS workshop.

POCUS techniques have been successfully applied to clinical/rescue situations in Pre-Op, ORs, the PACU, and ICUs, where rapid answers to a diagnostic dilemma can allow focused treatments to occur. When seconds count, why guess when you can just "look in and see"?

With this information in mind, an ad hoc committee of VSA leaders and educators formed in 2023 to develop a POCUS workshop designed to meet the needs of anesthesiologists in practice across the Commonwealth. We assembled a team of experienced POCUS educators and volunteer models to provide an exceptional hands-on

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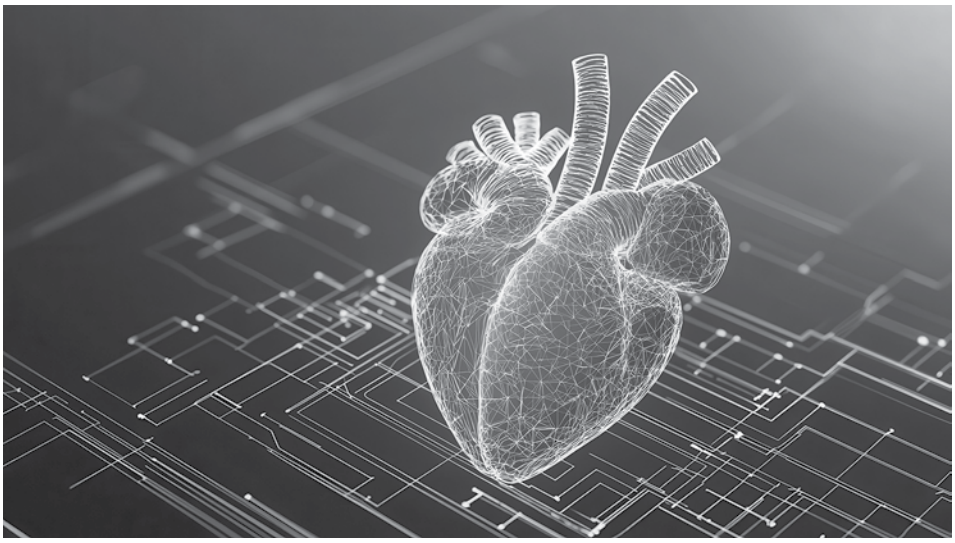
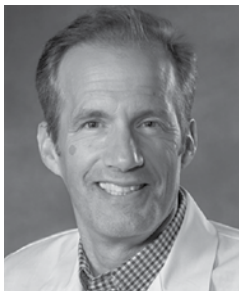
*Feature Article*



## ASA's New Cardiac Implantable Electronic Device Practice Management Aid

**By Mark T. Nelson, MD, MEd**
*Associate Professor*
*Chief Division of Cardiac Anesthesiology*
*Virginia Commonwealth University*
*Richmond Virginia*



*Dr. Mark Nelson*

This year the ASA released a new document which provides a step-by-step approach to the perioperative management of cardiac implantable electronic devices (CIEDs).

The document is a practice aid, written by the ASA Cardiothoracic Committee and endorsed by the Heart Rhythm Society (HRS) as well as all five device manufacturers. It is an adjunct to the 2011 ASA/HRS Expert Consensus and 2020 ASA Expert Consensus Update and is on the ASA's website under Research and Guidelines. The document addresses two main areas: magnet response of all CIEDs by manufacturer and specific step by step algorithms for perioperative device management.

At the time of this writing, the practice aid includes all commercially available devices as well as devices currently in situ except for the Medtronic EV-ICD which is addressed later in this article.

Since its pioneering by William T. Bovie and use in neurosurgery by Harvey Cushing

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*Inside This Edition:*

# CARDIAC ANESTHESIA



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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

## Membership Meeting & Legislative Update

Monday, January 13, 2025
Sam Miller's Restaurant
1210 E. Cary St.
Richmond, VA 23219

## VSA Whitecoats on Call

Tuesday, January 14, 2025
Commonwealth Strategy Group
118 N 8th Street, Richmond, VA
Capture the code below to register.

If attending Lobby Day ONLY, contact Angela Puryear at angela@societyhq.com.

## VSA POCUS Workshop

September 12-14, 2025
Delta Hotel
Richmond, VA 23219

*President's Message*

# Saving The Best for Last

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

*Dr. Craig Stopa*

My presidency is coming to an end soon, therefore, this will be my last President's update. Don't worry though. It's not goodbye, just see you later. The last two years have truly been a pleasure serving you. As always, 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 and will end by continuing to focus on this topic.

First, an update. The Joint Commission on Health Care (JCHC) has been conducting a study to address accessibility, quality, and equity of anesthesia services and the workforce. Their report was presented at their meeting on Tuesday, November 26. The Commission accepted written public comment up until their December 17th meeting. At that meeting recommendations were voted on by the Commission.

The Legislative Update article in this newsletter more fully explains their findings. 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.

Second, the ASA Annual Meeting concluded in Philadelphia this past October. What a wonderful city. We were blessed with great weather, which allowed me to explore all the fascinating historical sites and landmarks. The food and the people were fantastic. It was great seeing everyone from the Commonwealth at the VSA luncheon; it was the largest turnout I can remember since I've been going.

I also enjoyed catching up with old friends and colleagues from across the country. Reestablishing old and creating new connections is just one of the strengths of the Annual Meeting.

Third, the VSA Annual Membership Meeting will be January 13 at Sam Miller's restaurant in Richmond starting at 5:30 pm. This is a great opportunity for those who could not make it to the ASA to get caught up on everything going on at the ASA, as well as the VSA. Dinner and drinks will follow, and who can pass up a free meal. I hope to see everyone there.

I hope everyone had a happy holiday season and cheers to 2025! 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!

*Members in the News*

# Dr. Mark Simcox Appointed to Virginia Board of Medicine

We congratulate VSA member Dr. Mark Simcox on his recent appointment to the Virginia Board of Medicine by Gov. Glenn Youngkin.

Dr. Simcox, a seasoned anesthesiologist based in Abingdon, has been with Virginia Highlands Anesthesia since 1994 and currently serves as its president.

He brings decades of experience in patient care and leadership to this important regulatory body, which oversees the professions practicing the healing arts in the Commonwealth.

Dr. Simcox is a graduate of the University of Tennessee Medical School who completed his residency at the University of Virginia. His ties to the community and expertise in anesthesiology make him a valuable addition to the Board of Medicine.

Dr. Simcox will represent Virginia's 9th Congressional District during his four-year term. For more information about the Virginia Board of Medicine, visit dhp.virginia.gov/medicine.

# Mastering Leadership and Communication in Anesthesia: A Pathway to Excellence for the Anesthesiology Resident

**By Brooke Trainer, MD FASA**
*Editor, VSA Newsletter*


Dr. Brooke Albright-Trainer


Leadership and effective communication are essential competencies for anesthesiology residents, particularly as they transition from supervised learners to independent practitioners.

The Accreditation Council for Graduate Medical Education (ACGME) program requirements emphasize the principles of graded supervision, team leadership, and effective communication, underscoring the importance of these skills in improving patient outcomes and fostering trust in the perioperative environment.

Mastering these skills are paramount to fostering resident's professional development, thereby progressively allowing them to graduate from training with confidence to assume leadership roles and managing other team members, such as CRNAs and CAAs, while ensuring patient safety.

Clear communication of team roles fosters trust and satisfaction among patients and enhances workflow efficiency within the care team. Additionally, navigating challenging conversations with patients, families, and colleagues is vital for maintaining professionalism, empathy, and team cohesion. By mastering these skills, residents can confidently lead perioperative care teams, improve patient outcomes, and create a collaborative clinical environment. This article offers practical guidance and best practices to prepare residents for the leadership and communication demands in the high-stakes setting of independent anesthesiology practice.

**Understanding and Applying Graded Supervision**

Graded supervision is at the core of ACGME requirements, enabling residents to progressively develop independence. Residents start under close supervision and transition to taking on supervisory roles themselves, overseeing junior residents, Certified Registered Nurse Anesthetists (CRNAs), CAAs, or other team members.

This process requires not only clinical competence but also an understanding of team dynamics and delegation. The ability to guide team members, ensure patient safety, and make clinical decisions independently are hallmarks of readiness for unsupervised practice.

For example, a senior resident might oversee a junior resident performing a regional block while simultaneously coordinating with a CRNA to manage a patient's intraoperative care. In such scenarios, the senior resident must balance clinical oversight with mentorship, ensuring that tasks are completed safely while fostering the junior team member's growth.

**Key Tips for Graded Supervision Success:**

1. Know Your Team - Understand the skill levels and roles of each team member to delegate tasks appropriately.
2. Provide Constructive Feedback - Offer real-time guidance and post-procedure debriefs to help team members improve.
3. Maintain Oversight - Always prioritize patient safety while empowering others to contribute to care delivery.

**Communicating Leadership Roles to Patients and Staff**

An essential aspect of leadership in anesthesiology is the ability to clearly articulate the roles of the anesthesia care team to both patients and staff. Patients often have limited understanding of the anesthesiologists' role in their care, leading to confusion or mistrust. Effective communication not only clarifies roles but also builds confidence and satisfaction.

For instance, a resident might explain to a patient, "I am a resident anesthesiologist who is part of your anesthesia care team, working closely with our attending anesthesiologist and nurse anesthetist to ensure your safety and comfort during surgery. I will monitor you closely and make adjustments as needed to keep you safe." Such transparency helps patients feel informed and secure.

Similarly, within the care team, role clarity reduces redundancy and ensures smooth workflow. Clearly defining who handles

***Continued on page 5***

preoperative assessments, intraoperative management, or postoperative pain control avoids miscommunication and enhances efficiency.

**Strategies for Effective Communication of Roles:**

1. Patient-Centered Language - Use clear, non-technical terms to explain roles and responsibilities.
2. Team Briefings - Before procedures, clarify each team member's role to ensure alignment and accountability.
3. Reassurance Through Explanation - Help patients understand how the team works collaboratively to prioritize their safety.

Navigating Difficult Conversations with Patients, Families, and Team Members

In the high-pressure environment of anesthesiology, residents frequently face challenging conversations. These can range from explaining unexpected outcomes to addressing conflicts within the care team. Mastering such interactions is critical to maintaining professionalism, empathy, and patient-centered care.

**Handling Difficult Patient or Family Conversations**

When communicating adverse events or complications, honesty and empathy are key. For example, if a patient experiences a prolonged recovery from anesthesia, a resident might say, "We encountered some challenges during your procedure that caused a delay in waking you up fully. However, I want to assure you that we managed it safely, and we're closely monitoring your recovery."

Such conversations should be grounded in transparency, focusing on what happened, what was done to address it, and next steps. Always validate the patient or family's emotions, allowing space for their concerns or questions.

**Managing Team Conflicts**

In situations of team conflict, a leader must address the issue promptly and constructively. Suppose a disagreement arises over an anesthetic plan between a CRNA and a resident. The resident can de-escalate by acknowledging the CRNA's input and saying, "I hear your concerns about this approach. Let's review the patient's status and ensure we're aligned on the safest plan moving forward."

Addressing conflicts with professionalism strengthens team cohesion and ensures that patient care remains the priority.

**Best Practices for Navigating Challenging Conversations:**

1. Active Listening - Show genuine interest in understanding concerns, whether from patients, families, or colleagues.
2. Empathy and Validation - Acknowledge emotions and show that you care about their perspective.
3. Focus on Solutions - Move conversations toward actionable steps and resolutions.

**Preparing for Leadership and Communication Challenges**

As residents progress in their training, they must prepare for the leadership and communication demands of independent practice. The ACGME requirements highlight the need for residents to develop the skills to lead perioperative care teams, communicate effectively across healthcare systems, and handle diverse clinical situations with sound judgment.

**Steps to Prepare for Leadership Roles:**

1. Engage in Mentorship - Seek feedback from attending physicians and senior colleagues to refine leadership skills.
2. Simulate Team Leadership - Practice leading mock scenarios, such as crisis management or multidisciplinary rounds, to build confidence.
3. Educate Yourself - Stay informed about best practices in team leadership and communication through workshops, reading, and professional development opportunities.

**Enhancing Communication Skills:**

1. Practice Scenarios - Role-play challenging conversations with peers to hone your approach.
2. Solicit Feedback - Ask colleagues and patients for input on your communication style and make adjustments as needed.
3. Be Self-Aware - Reflect on your tone, body language, and word choice to ensure you're conveying confidence and empathy.

**The Path to Mastery**

Leadership and communication are not innate traits but skills that can be cultivated through practice, feedback, and intentional effort. By understanding graded supervision, clearly articulating roles, and mastering difficult conversations, anesthesiology residents can confidently step into leadership roles and positively impact patient care and team dynamics.

Incorporating these skills into daily practice will not only meet ACGME requirements but also prepare residents to become effective, trusted, and empathetic leaders in the field of anesthesiology. As healthcare continues to evolve, these competencies will remain central to delivering safe, high-quality care, and fostering collaboration across teams.

Master these skills, and you'll be well on your way to excelling as a leader in anesthesiology.

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in 1926, electrosurgery has become increasingly popular for cutting and cauterizing tissues with a very low complication rate. Three decades later, at the Buffalo Veterans Administration Hospital, Drs. William Chardack and Andrew Gage teamed up with an engineer, Wilson Greatbatch, and placed the first pacing electrode in the heart of a dog. In 1960, the first pacing device was implanted in a human.

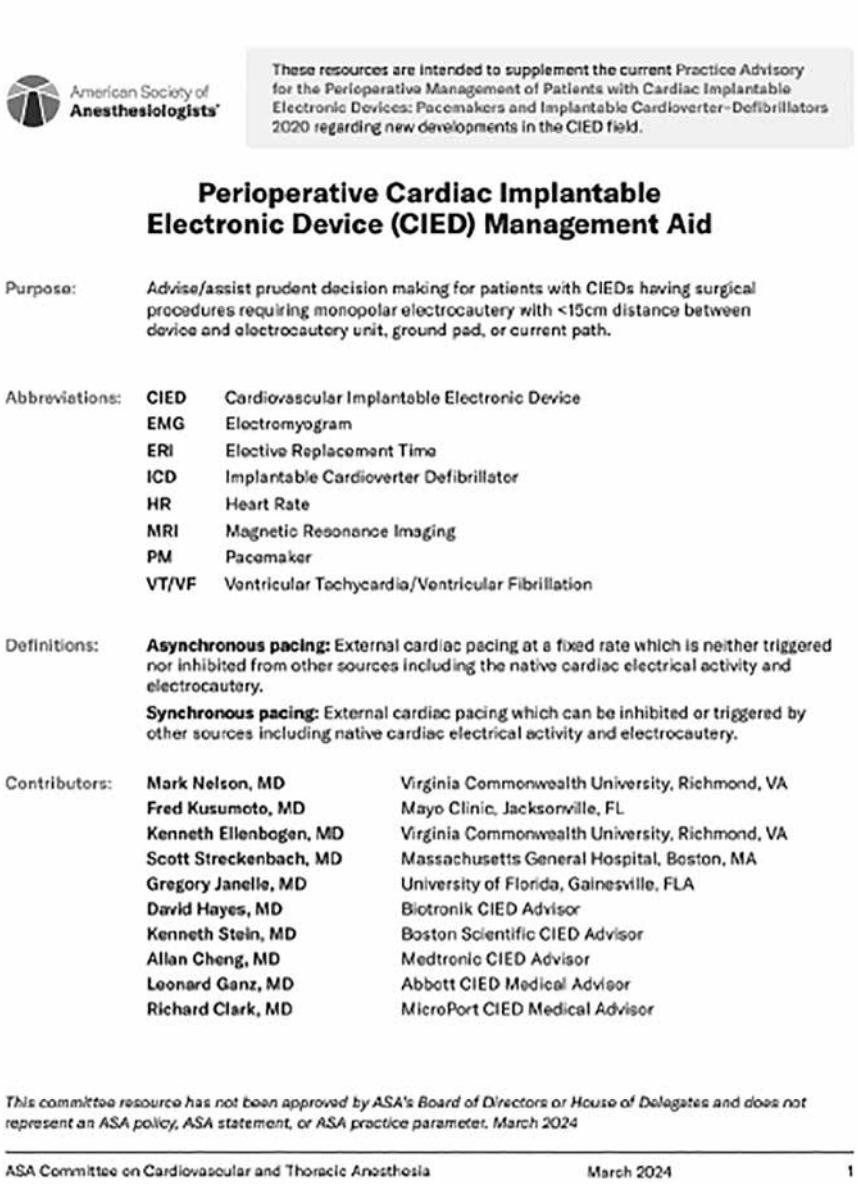
Since then, CIEDs have become smaller with ever increasing programming options. Central to their function is their ability to sense intrinsic electrical currents produced by the heart. The absence of these currents can be an impetus for pacing for pacemakers (PM), while detection of currents consistent with ventricular tachycardia (VT) or ventricular fibrillation (VF), can serve as impetus to deliver tachytherapies for ICDs.

Oversensing by PMs occurs when the device mistakes currents not produced by the heart, such as electrosurgical currents, as intrinsic cardiac activity and therefore withholds pacing. Oversensing for ICDs occurs when these extracardiac currents are interpreted as malignant arrythmias and tachytherapies are delivered.

Placing a magnet over the CIED or formally reprogramming it will enable all CIEDs ignore these extraneous currents. The practice aid addresses surgical procedures above the umbilicus, since currents produced by electrosurgery below the umbilicus do not result in CIED oversensing as they are too weak. The electrosurgical grounding pad should be placed on either the buttock or thigh, well below the umbilicus as is indicated for all patients undergoing electrosurgery with CIEDs.

ICD magnet responses have become less variable in the modern era. Despite some devices having programmable magnet options, it can be safely assumed that all ICDs respond to magnet placement with suspension of tachytherapies. There are no case reports of ICDs magnet responses programmed otherwise.

In addition, providers may be reassured that ICD tachytherapies are disabled if an audible tone is heard when a magnet is applied to the device. However, the absence of a tone does not rule out ICD deactivation as many ICDs do not emit a tone with magnet deactivation. Thus, listening for an audible tone with magnet application to assure device deactivation is not included in the practice aid.



American Society of Anesthesiologists

These resources are intended to supplement the current Practice Advisory for the Perioperative Management of Patients with Cardiac Implantable Electronic Devices: Pacemakers and Implantable Cardioverter-Defibrillators 2020 regarding new developments in the CIED field.

**Perioperative Cardiac Implantable Electronic Device (CIED) Management Aid**

Purpose: Advise/assist prudent decision making for patients with CIEDs having surgical procedures requiring monopolar electrocautery with <15cm distance between device and electrocautery unit, ground pad, or current path.

Abbreviations:

| | |
|---|---|
| CIED | Cardiovascular Implantable Electronic Device |
| EMG | Electromyogram |
| ERI | Elective Replacement Time |
| ICD | Implantable Cardioverter Defibrillator |
| HR | Heart Rate |
| MRI | Magnetic Resonance Imaging |
| PM | Pacemaker |
| VT/VF | Ventricular Tachycardia/Ventricular Fibrillation |

Definitions:

**Asynchronous pacing:** External cardiac pacing at a fixed rate which is neither triggered nor inhibited from other sources including the native cardiac electrical activity and electrocautery.

**Synchronous pacing:** External cardiac pacing which can be inhibited or triggered by other sources including native cardiac electrical activity and electrocautery.

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*This committee resource has not been approved by ASA's Board of Directors or House of Delegates and does not represent an ASA policy, ASA statement, or ASA practice parameter. March 2024*

ASA Committee on Cardiovascular and Thoracic Anesthesia March 2024 1

It is noteworthy that for ICDs to remain inactivated, the magnet must remain fixed over the device. If a magnet is loosely attached and allowed to move off the device either due to body habitus, patient positioning or both, device tachytherapies will be reactivated. ICDs are easily differentiated from PM due to the presence of shocking coils noted on CXR. The practice aid includes an adjunct document showing CXR examples of ICDs.

The Boston Scientific Subcutaneous ICD (S-ICD) responds to magnet placement similarly with suspension of tachytherapies while the Medtronic Subcutaneous ICD (EV-ICD) has a programmable magnet response. The default or nominal magnet response for the EV-ICDs is suspension of tachytherapies. The programming of device to ignore the magnet (magnet placement does not inactivate tachytherapies) would be very uncommon.

The document advises against relying on ICDs to deliver tachytherapies for VT or VF occurring intraoperatively. It recommends leaving the magnet in place over the device and managing the arrhythmia with standard ACLS protocols.

There are several reasons for this. If the VT rate fails to reach device therapy zone,

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the device will not provide tachytherapies regardless of the hemodynamic consequences of the arrhythmia. Other reasons include that the device may be programmed with extensive tachytherapy delays and/or multiple rounds of anti-tachycardia pacing (ATP) for patients who when awake, have self-terminating and non-syncopal VT.

However, the same patient under anesthesia, experiencing the sympatholytic effects of anesthesia, with volume, acid/base/electrolyte anomalies, with positive pressure ventilation and undergoing surgery may have VT that is no longer self-terminating and hemodynamically stable. For this reason, the authors opt for leaving the magnet over the device and providing therapies guided by ACLS (shocks) if intraoperative VT/VF is encountered.

PM magnet response has become much more consistent as well. Excluding some leadless pacing devices, magnet placement triggers asynchronous pacing in all devices. PM are typically programmed by electrophysiologists to pace synchronously with native cardiac conduction being inhibited by intrinsic cardiac activity.

Electrocautery can be interpreted as intrinsic cardiac activity by the device resulting in suspension of device pacing. Profound bradycardia or asystole can result in patients with pacemaker dependency or minimal native conduction. With magnet placement, all PMs revert to asynchronous pacing.

The device paces at a rate between 85-100bpm (device magnet rates differ between manufacturers) while ignoring intrinsic cardiac electrical activity and currents produced by electrocautery. Some devices produced by Boston Scientific have a magnet programming option which instructs the device to record an EMG rather than pace asynchronously. This function is uncommonly utilized and can be easily defeated by removing the magnet for three seconds and replacing it a second time to enable asynchronous pacing.

As well, some Biotronik devices can be invertedly left in "auto mode" at the time of implantation. In auto mode, the device will pace asynchronously for ten beats, reverting to synchronous pacing after. Due to this possibility, the guideline recommends monitoring ECG or plethysmography, to be certain continuous asynchronous pacing is occurring with the Biotronik PMs.

> *The practice aid dispels the myth that CIEDs require formal interrogation prior to discharge from a monitored area. In the current era, nearly all devices have remote monitoring. Remote monitoring utilizes the patient's cell phone or a free-standing cellular based device to interrogate the patient's CIED daily.*

The new algorithm stresses that magnet placement on PM should only be utilized when "unacceptable bradycardia" is encountered with electrocautery. Unacceptable bradycardia is defined as bradycardia that results in hemodynamic instability. This is easily recognized by observing the plethysmography or ECG tracing during periods of electrocautery. The indiscriminate use magnets on PMs is discouraged, as it can produce competing and disorganized rhythms as well as an "R on T" resulting in VF in patients with native heart rates above the magnet response rate.

Leadless PM are being utilized more commonly. They are associated with reduced risks of infection and lead malfunction as well as possibly increased battery life.

The Medtronic Micra and Abbott Aveir are leadless PMs currently on the market. The Micra has no magnet response thus the device must be formally reprogrammed to asynchronous pacing for patients with little native conduction undergoing electrosurgical procedures above the umbilicus. The Aveir has a programmable magnet response with the nominal or default response of asynchronous pacing.

It would be very uncommon for the device magnet response to be programmed off, where by the device would not respond to magnet placement with asynchronous pacing.

Lastly, the practice aid dispels the myth that CIEDs require formal interrogation prior to discharge from a monitored area. In the current era, nearly all devices have remote monitoring. Remote monitoring utilizes the patient's cell phone or a free-standing cellular based device to interrogate the patient's CIED daily. Lead impedances, pacing thresholds, battery life, and any tachyarrhythmias are noted and an electronic report is forwarded to the device clinic of the implanting or managing hospital.

These reports are read daily by electrophysiologists. Thus, unless there is suspicion of mechanical device disruption, i.e. chest compressions, thoracic surgery, trauma, ionizing radiation, or external cardioversion or defibrillation, postoperative device interrogation prior to discharge from a monitored unit is not indicated.

An exception is that a small percent of patients do not have remote monitoring because some medical insurances do not cover this service. In this case, the patient can still be discharged from a monitored environment but must follow up with their device clinic or cardiologist within 30 days of the procedure for formal device interrogation.

In conclusion, the ASA practice aid provides clear and unambiguous direction for perioperative CIED management. It addresses PM, ICDs, leadless PM, subcutaneous ICDs, and provides a management algorithm for patients with unidentified devices undergoing emergency surgery without adequate time for device identification. PMs react to magnet placement with asynchronous pacing and ICDs with suspension of tachytherapies.

ASA Practice Aid located at: https://www.asahq.org/standards-and-practice-parameters/resources-from-asa-committees#cied

# My Why: Casey Dowling and Brooke Trainer

## DR. CASEY DOWLING


**What Led You to Anesthesiology?**

Anesthesiology is just really amazing. I first thought that I wanted to do internal medicine. And then I found anesthesia, where you can do things, and then see the fruits of your labor. People are awake, they're asleep. They're in pain, then they're not in pain. You can't ask for a more immediate impact on patient care than that. I was in my fourth year and had to change my progress to get into anesthesia, but I did.

**How long have you been in practice?**

I've been doing this now for 30 years — 22 in the state of Virginia. I'm cardiac fellowship trained, so I also do anesthesiology for open heart.

**Why Did You Join VSA?**

To tell people about anesthesiologists' involvement in their care. Because if I've done my job well, they don't even know. Because most of the action happened while they were asleep and in my care. I also wanted legislators to know. We are the voice of anesthesiologists in this state. And we are integral. The surgeons need us, the patients need us. And we take care of that patient from the beginning to the end of their perioperative period.

## DR. BROOKE TRAINER


**What Led You to Anesthesiology?**

I found a new path and interest in surgery. It was something I'd never really seen before in medical school, behind the curtain. I saw anesthesia as an option because it's still very procedural-oriented, but it also encompasses all of medicine. It's not just focused on one system, you focus on all the systems. So you're well-rounded in that sense.

**Mid-Career, You Got a Critical Care Fellowship — Why?**

I really enjoyed getting to learn the disease processes, especially with complex patients. It kept me interested and challenged, and I wanted to learn more. The more you know, the more you want to know. So that spawned my interest in critical care medicine. Getting that additional training really helped solidify that interest, that knowledge, that thirst for wanting to continue that care in the post-operative period.

**Do You Have any Advice for a Medical Student Curious About Anesthesiology?**

Keep an open mind, because it's a journey. Every part of what you learn is a new opportunity for you to improve your knowledge, but also expand your horizon in medicine. There's no set path, and you can change paths. Getting a critical care fellowship later in life made me that much better of an anesthesiologist in the operating room. You're a lifelong learner. Don't have fear that you're going to make the wrong decision, and that you're not going to be able to change later in life.

**What's the Future of Anesthesiology?**

Where we end up expanding our presence in the hospital. We have to add value to the hospitals. So we need to expand our presence in preoperative clinics, optimizing patients. We know them best, we know the inherent risks of anesthesia better than any primary care physician that you'd be able to send them to. So we need to be the ones putting ourselves in that clinic. Furthermore, we also need to be the ones caring for these patients after the anesthesia. Whether that's in the recovery room, step-down unit, or even the ICU. We do a lot of critical care training as it is, but we can do more. We can prove to be more valuable to the surgical care team at the hospital levels and surgeons by being the person who continues on that anesthetic care in the ICU, and being that intensivist for that patient in their recovery.

# MSV Annual Meeting Review

**By Alice A Tolbert Coombs MD MPA FCCP**
*MSV Former President, 2024*
*Chair and Professor*
*Department of Anesthesiology*
*Virginia Commonwealth University*
*VCU Health*


*Dr. Alice Coombs*

Prior to the Annual Meeting, the MSV hosted a series of roundtable discussions.

The Physician Burnout Roundtable began with a thoughtful discussion on posttraumatic stress disorder. The MSV hosted the Polish delegation for dinner where a productive, solution-oriented conversation continued.

The Roundtable reconvened the following day with dialogue on the development, implementation and growth of the MSV's Virginia Mental Health Access Program (VMAP) as well as the first-in-the-nation SafeHaven program. The Polish delegation engaged with the MSV membership to learn about the positive impacts of these programs first-hand.

The MSV advocacy committee convened to discuss legislative objectives and goals, followed by an orientation and reference committee training. An open forum was hosted immediately after the orientation which allowed members to learn about the evolving medical malpractice landscape in Virginia and ask questions about how the landscape may change in the upcoming legislative session.

The MSV Annual Meeting convened on Friday, October 17, where the House of Delegates assembled for its first session. Delegates accepted 25 resolutions as the business of the House for consideration. This session was immediately followed by a CME session focused on behavioral health, with a robust discussion on adapting a culture of psychological safety for physicians, PAs, and other healthcare providers.

Reference Committees met consecutively to give each of the 25 resolutions a fair and robust hearing. Conversation was collegial, productive, and insightful, with many different perspectives having an opportunity to be heard in full.

The President's Reception was well attended by physicians, PAs, residents, medical students, and guests. The evening was also highlighted by a medical student social with the Virginia Health Workforce Development Authority, sponsored by members of MSV.

Saturday morning's CME sessions continued the mental health discussion with a presentation on applying the principles of VMAP across specialties, and a panel focused on integrating available resources into the primary care setting. The speakers for all three CME sessions represented a wide range of practice types and faced a variety of challenges which gave us a well-rounded faculty perspective.

District caucuses met during lunch to focus on the reference committee reports and recommendations. The reference committee recommendations further solidified our ability to advocate for physicians, PAs, and patients and decrease barriers to practice.

Saturday evening was highlighted by the Inaugural ceremony for Dr. Joel Bundy, as well as the Presidents' and Physician receptions. Receptions were followed by the MSV Foundation gala, one of the most well-attended celebrations in the last 10 years.

The next morning featured a celebration of MSV's membership with remarks by its CEO and EVP Melina Davis, followed by the President's presentation to the House of Delegates. The House of Delegates then considered extractions and amendments to the Reference Committee reports. Due to lengthy deliberation of Reference Committee report one, extractions from Reference Committee report 2 are to be carried over as business of the 2025 House of Delegates.

## POCUS Workshop, *from page 1*

workshop in Roanoke.

The 2023 workshop was also accredited for 13.5 AMA PRA Category I credits. We are very excited to build on the success of our inaugural 2023 VSA POCUS hands-on workshop and announce our upcoming 2025 program, which will be held in Richmond over the weekend of September 12-14, 2025, at the Delta Hotel.

The overwhelming success of our inaugural 2023 workshop was evident by the sheer volume of positive comments we received from the 34 VSA member attendees on our inaugural program. Here are just a sample of what attendees shared with us: "Well organized conference", "Excellent workshop!", "Loved it", "Great workshop – would recommend to others!", "Very knowledgeable and well-prepared faculty", "Excellent meeting – appreciate the efforts to train anesthesiologists in Virginia", "Excellent organization and high value. Excellent equipment and instructors. Live models allow for excellent real-life simulation", "As a private practice anesthesiologist, it is hard to fulfill the requirements for the ASA POCUS certification. The workshop helped greatly with this. Thank you for the opportunity!", "Groundbreaking", and "Please put this on again in future years!".

The 2025 VSA POCUS hands-on workshop will build on this success and introduce participants to the hands-on techniques needed to allow them to acquire and interpret bedside POCUS in their practice. Topics such as Focused Cardiac Ultrasound, Lung Ultrasound, Gastric Ultrasound, and Focused Abdominal Ultrasound will be introduced. Rotating small group instruction will maximize participants hands-on opportunities. A unique value to VSA members, on completion, this workshop will also enable the participant to meet requirements for Parts 2 and 4 of the ASA's Diagnostic POCUS Certificate Program as well!

So, save the date and look for future announcements as registration opens on the VSA web portal: https://vsahq.org/meetings/. See you there!

# ASA Annual Meeting House of Delegates Report

**By Jeff Green, MD, MSHA, FASA**
*Academic Chair and Program Director*
*Mary Washington Healthcare*
*Anesthesiology*
*Fredericksburg, VA*

*Dr. Jeffrey A. Green*
*VSA ASA PAC Director*

The ASA House of Delegates (HOD) met in Philadelphia at the Annual Meeting in October. All items of business for ASA are eventually ratified or rejected by the House of Delegates. This year the House reviewed hundreds of reports and recommendations by the ASA's committees, components, officers and Board of Directors. These items are first presented to reference committees for member testimony and review. The reference committees then present the reports to the HOD for disposition.

The Virginia delegation includes 8 delegates and the ASA Director. Delegate numbers are determined by membership. We are proud to represent the interests of all the anesthesiologists in the Commonwealth and dutifully look out for items of interest or concern for all of our practices. At this year's meeting, there was one item that dominated the discussions. Although the educational content at the annual meeting has been shortened to 4 days, the governance portion of the meeting lasts 5 days. There was a recommendation from the Committee on Governance Effectiveness and Efficiencies (CGEE) to shorten the governance portion to 4 days to align with educational meeting by consolidating the House of Delegates from 2 sessions to 1. The merits of the proposal, including less time for delegates away from their practices and lower cost, were compared with the disadvantages including a compressed meeting timeline and decreased access to CME content for the delegates. Ultimately the House voted to shorten the meeting, and the new format will go into effect no sooner than 2026.

There was also a contested election for ASA first vice president. Although contested elections are not rare, a three-way race is unusual. Jeff Mueller, MD former ASA Vice President for Professional Affairs from Mayo Clinic in Scottsdale, Arizona prevailed over Jay Mesrobian, MD, MBA and Michael Lewis, MD, MPH, MBA in a competitive and respectful election.

In addition, the House approved many new statements including:

- "Statement on 21st Century Cures Act Final Rule Information Blocking Compliance" (Committee on Informatics and Information Technology)
- "Statement on Anesthesiologist Head Injuries in Anesthetizing Locations" (Committee on Occupational Health)
- "Statement on the Use of Adjuvant Medications and Management of Intraoperative Pain During Cesarean Delivery" (Committee on Obstetric Anesthesia)
- "Statement on Support of in Vitro Fertilization" (Committee on Obstetric Anesthesia)
- "Statement on Providing Psychological Support for Obstetric Patients" (Committee on Obstetric Anesthesia)
- "Statement on Anesthesia Support of Postpartum Sterilization" (Committee on Obstetric Anesthesia)
- "Statement on Resuming Breastfeeding after Anesthesia" (revised) (Committee on Obstetric Anesthesia)
- "Statement on Harassment, Incivility, and Disrespect" (Ad Hoc Committee on Harassment, Incivility, and Disrespect)

As your Director, I was honored to lead the very talented and enthusiastic Virginia delegation to the HOD representing your interests in the ASA.

Your delegation represents a wide range of practice types and locations across the Commonwealth and is dedicated to making sure that the business in the HOD aligns with our practices in Virginia.

As always, if there is anything I can do to support your practice or answer any questions about the ASA, please don't hesitate to reach out to me at Jeffrey.green@mwhc.com.

*The Arts*

# Laughter

Laughter is the best medicine
If all can laugh their heart out
At oneself and stress jettison
Hearty laugh will surely rout
All daily problems, aches, pain.

Organize a society of laughter
With friends, family and other
To include a mother and father
Laugh at own follies, not another.

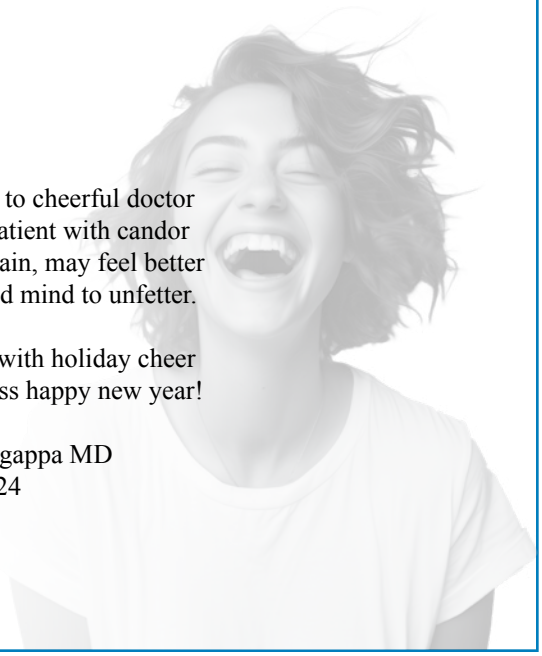
Ancient Kings had court jester
His jokes got peals of laughter
Caught enemies who did pester
King, with no stress ruled better.

*Dr. Jaikumar Rangappa*

When sick go to cheerful doctor
Joking with patient with candor
Will lighten pain, may feel better
Opens a closed mind to unfetter.

Good wishes with holiday cheer
May Lord bless happy new year!

Jaikumar Rangappa MD
December 2024



# Legislative Update

**By Lauren Schmitt**
*Commonwealth Strategy Group*

The 2025 Virginia General Assembly session will begin on January 8th and is scheduled to adjourn February 22nd. It's an odd year so it'll be a "short session" and only 45 days. However, there will be a lot to get done in those 45 days!

VSA has been busy the last few months lobbying for CRNA supervision requirements to remain in the law. We've met with every legislator on the key committees to advocate for the physician-led anesthesia care team.

We also participated in several informational interviews with the Joint Commission on Health Care regarding their anesthesia workforce report. This report was presented to the Joint Commission at the end of November and can be found here: https://jchc.virginia.gov/documents/CRNA%20Briefing.pdf

Overall, we were pleased with the findings of the report. They confirmed that there is no evidence showing that loosening supervision requirements will increase access. This has been one of the CRNA's major arguments for why we need to change the law. We are glad to see this myth dispelled.

Unfortunately, there were some parts of the report in which we do strongly disagree regarding patient outcomes. The report stated there is no evidence showing a difference in quality of care or patient outcomes with physician anesthesiologists vs. CRNAs.

We all know very well there is a difference and patient care will suffer if the standard of care is lowered. We are communicating with the members of the Commission to ensure they understand the recent events in California regarding CRNAs practicing outside their scope.

We are grateful to have legislative champions from both sides of the aisle on the Joint Commission, including Senator Mamie Locke and Senator Todd Pillion. We awarded them the 2024 VSA Legislators of the Year award. We were able to present the award to Sen. Pillion in August and most recently to Senator Locke in October.

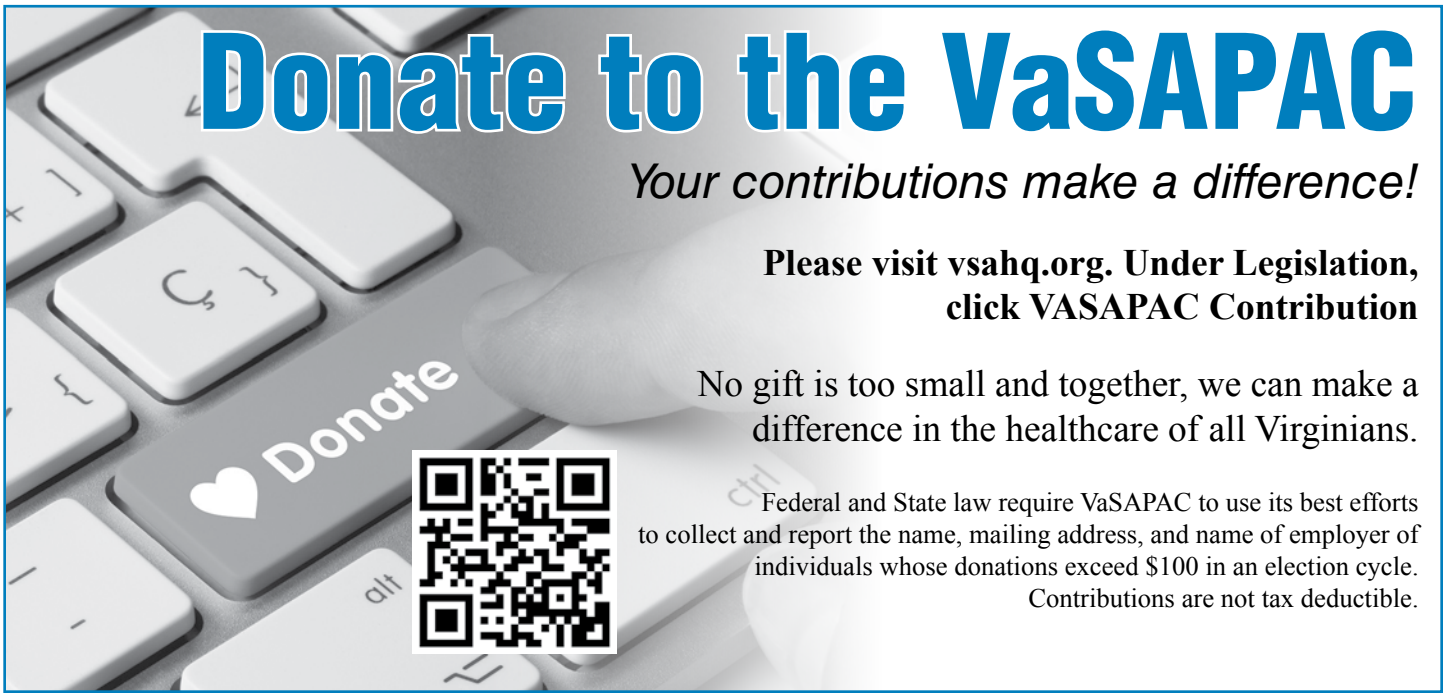
Dr. Alice Coombs, an anesthesiologist and immediate past-president of MSV, presented the award to her. We are incredibly grateful for both Senators' support and advocacy for Virginia patients.

VSA will be working with legislators to introduce two bills this upcoming session that maintain the current supervision requirements and would allow for Certified Anesthesiology Assistants to be licensed in Virginia.

We anticipate that legislation will be introduced for the third year in a row by the nurse anesthetists' that would grant them independent practice. We will keep you updated on how you can contact your legislators and express your position on these bills.

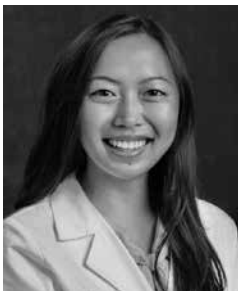
And finally, thank you to everyone who has contributed to the VSA PAC this cycle. We've had a record number of contributions this year. If you haven't contributed yet this year, you have a few weeks left! We cannot give political contributions once the General Assembly session starts January 8th.

Please make sure to contribute so we can show our support to legislators who stand up for our patients and profession. Make a contribution



# Bridging the Gap: The LUCOM Medical Student Experience at ANESTHESIOLOGY 2024

**By Michelle Adema and Joseph Ponce**
*Liberty University College of Medicine*
*Lynchburg, VA*



*Michelle Adema*

*Joseph Ponce*

The American Society of Anesthesiologists (ASA) hosts an annual conference that serves as a yearly opportunity to share innovations and updates that influence the world of anesthesiology. This year, ANESTHESIOLOGY 2024 was hosted in Philadelphia, PA, where anesthesiologists, residents, medical students, and clinicians had the chance to meet, collaborate, and connect for a weekend full of networking and education. A highlight of the schedule is the medical student track, which we were able to explore as first-time attendees. Let us walk you through some of the highlights of the conference as medical students!

The first day of the conference is the perfect opportunity to warm up your social skills and to start making connections.

Upon arrival, we headed straight to the registration desk to pick up our badges. While waiting in line, we struck up a conversation with a charming anesthesiology couple from Switzerland. This encounter reminded us of the importance of being open to meeting new people. By the time we had our badges, they had invited us to visit them for an away rotation. Afterward, we took a stroll around the convention center to get our bearings.

With a busy schedule ahead, we decided to explore Philadelphia. We grabbed some delicious food, visited the iconic Liberty Bell, and wandered through the bustling Reading Terminal Market. It's essential to take advantage of any downtime to experience what the city has to offer, as the conference itself is packed with activities and opportunities.

The welcome reception was a fantastic opportunity to meet a diverse group of residents, medical students, and physicians. We reconnected with friends from VCU and Virginia Tech Carilion, and it was heartwarming to see familiar faces. The community here is incredibly welcoming, making it easy to strike up conversations and form new connections. We had the chance to meet members of the PAC, women specializing in cardiothoracic anesthesiology, and future anesthesiology residents. The variety of people and the shared passion for the field made for an inspiring and enjoyable evening.


*Joseph Ponce (OMS-II), Shua Jeong (OMS-II), Karen Frieswyk (OMS-III), Michelle Adema (OMS-II), & Alexander Lalovic (OMS-III), first-time attendees from Liberty University College of Osteopathic Medicine (LUCOM).*

We kicked off Day 2 with an insightful keynote address by Sam Quinones, who delved into a pressing medical issue: "The Opioid Crisis in America." His talk was both enlightening and timely, highlighting the critical role that anesthesiologists and pain physicians play in combating this epidemic.

We were particularly engaged in this topic, as it aligns with our interest in preventative medicine and our dedication to advocating for our future patients. Quinones' insights and book provided valuable perspectives and actionable strategies that we can incorporate into our practice to better serve those affected by the opioid crisis.

As much as we've strived to engage anesthesiology on a national level, we believe that it is just as important to get involved at the state level. On Day 2, the Virginia Society of Anesthesiologists hosted its annual luncheon at the conference hotel, where our state leaders in anesthesiology were able to present for elections, discuss updates in practice, and share a meal as a community. The luncheon also served as a great opportunity for our state's student representatives to reconnect from each program.

Widely recognized as the hallmark and most demanded event of the conference for medical students, the Residency Programs Open House session was held on Day 2. Each of us registered for an hour-long session held in a large conference hall of the hotel, where various residency programs hosted tables to quickly chat with residents, administrators, and program directors.

In addition to picking up some free swag, this session provided a critical networking opportunity to learn about and connect with anesthesiology programs from across the country. We learned that, for this session, it's important to come in with a plan and to move quickly, as an hour is much shorter than you think. With limited tickets for participation, this session is a MUST-DO for medical students registering for the conference.

Within the ASA emails leading up to the

***Continued on page 13***

conference, we found the chance to register for a social event held by the Society for Pediatric Anesthesia at a local Lucky Strike restaurant in Philadelphia.

Through this event, we were able to meet and receive advice for pediatric anesthesiologists from across the country, hopping between small tables covering topics including various advanced fellowship options, research, and comparisons between pediatric and adult anesthesiology. This social served as an important lesson to check your emails from ASA-affiliates leading up to the conference, as you never know what opportunities may arise at the weekend. Also, as medical students, we couldn't pass up the free food and refreshments!

As it came time for the ASA Medical Student Component to host its annual meeting, we took this day to make the most out of the remaining events on the medical student track.

Another hallmark event of the ASA annual conference for medical students is the ASA Medical Student Component House of Delegates session, which comprised most of our Day 3 of ANESTHESIOLOGY 2024. This annual event provides an opportunity for medical students and aspiring anesthesiologists to gather from across the country and represent their respective programs in discussion of our growth in the field as students.

We heard from keynote speaker Dr. Stephen Estime, Assistant Professor of Anesthesiology & Critical Care at the University of Chicago, who discussed the importance of authenticity, adaptability, resilience, and wellness on our paths of training. We also received updates from the MSC governing council about growing opportunities for student engagement and, as voting and alternate voting delegates from LUCOM, we were part of the vote that elected the council's newest governing members. Overall, this session brought all our favorite things about the conference together.

As we left the House of Delegates session inspired and impassioned, we decided to stop by the Scientific and Educational Exhibits portion of the conference, where numerous clinician and research teams were displaying their newest innovations in practice.

We found ourselves captivated by a presentation from Dr. Ellen Wang and the Stanford Chariot Program from Stanford

*Medical students from Liberty University College of Osteopathic Medicine, Edward Via College of Osteopathic Medicine-Virginia, Virginia Tech Carilion School of Medicine, and Virginia Commonwealth University School of Medicine at the Virginia Society of Anesthesiologists Annual Luncheon.*


*Michelle Adema, OMS-II, and Joseph Ponce, OMS-II, posing with the iconic Propofol bottle at the exhibit hall of ANESTHESIOLOGY 2024.*

University, learning about their research and clinical implementation of virtual and augmented reality headsets for pediatric perioperative care. We gained first-hand experience of its utility for distraction and placation by trying these headsets on ourselves, which was only one of many innovations on display at the scientific & educational exhibit hall.

As the medical student track of the conference came to an end, the last days of the conference provided the opportunity for further didactic, workshop, and panel presentations.

While the student-dedicated sessions had finished for the weekend, we decided to use the final days to explore the huge exhibit hall of the conference. The hall was essentially a maze of stalls that varied in appeal, ranging from intubation and ultrasound devices to clinician recruitment groups and even a live-recorded conference podcast. There were also different sections of the hall that were dedicated to poster presentations and medically challenging case discussions. The exhibit hall alone offered enough excitement for the entirety of the conference duration, but we were happy to make the most of it over our last few days. And of course, we had to snap a quick picture with the iconic Propofol bottle.

Unfortunately, due to travel and schedule restrictions, we found ourselves unable to attend the annual ASA House of Delegates session, which is typically held at the end of its yearly conference. After hearing about how unique of a learning opportunity it is for students to observe policy discussions from leaders in anesthesiology from across the nation, we were particularly sad that we had to miss it. It does, however, remain an important part of the conference and we would recommend that students consider the opportunity to attend when able. We look forward to observing this session at future meetings!

ASA stands for the American Society of Anesthesiology, but after attending their conference, we believe it should stand for the Absolutely Sensational Association. As first-time attendees at a specialty-specific conference, we were blown away by the experience.

Everything exceeded our expectations, and the connections we made were invaluable. Whether you're already involved in anesthesiology or looking to enter the field, there's something for everyone. We hope to see you at the ASA annual meeting in San Antonio in 2025!

# Dr. Michael Kazior Wins FAER Grant to Close a Life-Saving Knowledge Gap

*Dr. Michael Kazior*

Dr. Michael Kazior's work starts where medical training can fall short — gaining and maintaining the knowledge required for defibrillator competence. That recognition, and his potential solution, led to a spring Research in Education Grant from The Foundation for Anesthesia Education and Research (FAER).

Kazior attended medical school at Virginia Commonwealth University, where he graduated in 2013. Then he headed to his anesthesia residency at The University of North Carolina at Chapel Hill.

That's where he learned about the FAER grant. "My residency program at UNC was very heavily involved in educational research," he says, citing his now primary grant mentor, Dr. Susan Martinelli. A previous FAER grant recipient, she's been instrumental in his project along with another Ph.D. researcher at UNC, Fei Chen.

Kazior's idea centers on a critical device that restarts a patient's heart or stabilizes its rhythm — the external manual defibrillator. But for students and health care providers, he says, there's a knowledge gap.

Despite mandatory Advanced Cardiovascular Life Support certifications, he says, "most people don't use ACLS every day." That means when an emergency arises, the reflex to use a manual defibrillator may not be as effective as it could be.

"Most providers don't practice these skills on a frequent basis," says Kazior, whose subspecialty is critical care medicine. "Because the training is so intermittent, there's a large knowledge gap."

What makes that gap wider is that a lot of hospitals, including the VA, have moved to RQI, an online ACLS refresher course, he says: "There's no longer any hands-on defibrillator training for these [Resuscitation Quality Improvement] providers."

Kazior, who works in the surgical ICU at the Richmond VA Medical Center and in the ICU at VCU, went to work developing an Electronic Learning Module through the VHA (Veterans Health Administration) Innovation Spark-Seed-Spread Program.

With initial funding from that innovation program, he reached out to The Center for Safety, Simulation and Advanced Learning Technologies (CSSALT) at University of Florida Health. He provided an outline to its software engineers and coders, who helped him design, build and develop a finished product.

"We have created a novel, interactive E-Learning module to teach ACLS providers how to place defibrillator pads and use the three main functions of the defibrillator (cardioversion, defibrillation, and pacing)," he writes in his abstract.

With funding from the Foundation for Anesthesia Education and Research (FAER), Dr. Kazior is testing a solution: a virtual training module designed to teach ACLS providers how to use manual defibrillators.

The program, developed with the University of Florida's simulation center, aims to provide a flexible, accessible alternative to traditional hands-on training. "This module allows providers to refresh their skills anytime, without having to schedule an in-person training session in a simulation lab".

His research project focuses on testing the online simulation against in-person instruction for novice anesthesia residents. During the next few months, they will test the online simulation in several anesthesia residency programs across the country.

The goal is to create a simulation as effective as the classical gold standard of hands-on training.

"We want to validate this new simulation as an educational tool for ACLS providers to help maintain their knowledge," Kazior says. "The vision is having this resource out there will complement the current online training through the American Heart Association with ACLS providers".

*In the Digital Edition of the VSA Update*

# Introducing the Virgina Student Anesthesiology Group (VSAG)

**By Grace Carroll, OMS-III**
*VCOM-Virginia*

*Grace Carroll*

The Virginia Student Anesthesiology Group (VSAG) is led by seven medical students from five of the six medical schools in Virginia. Our mission is to increase medical student involvement in the VSA and ASA as well as promote collaboration between the schools. Over the past year, we have held several events virtually given the distance between schools, so of course, we were super excited for the opportunity to all meet in person at ASA 2024 in Philadelphia.

VSAG Leadership includes Karen Frieswyk, Jacob Grondin, Joshua Sison, Brandon Raquet, Matthew McCarron, Grace Carroll, and Mathew Ciurash.

The conference kicked off on Friday night with the medical student reception which gave us the opportunity to connect with other students around the country. It was great to see old faces, new faces, and those that we had only ever been able to see over Zoom.

Saturday was a packed day of lectures, workshops, and finally, the residency open house that most students were looking forward to the most.

***Read more in the digital edition!***

# VCOM Experience at the ASA Conference

**By Grace Carroll, Tanner Lydic, and Josh Sison**
*Via College of Osteopathic Medicine*
*Blacksburg, VA*

*VCOM students at the ASA Annual Meeting*

Over 30 VCOM-Virginia students from the second, third, and fourth year classes attended the 2024 ASA conference in Philadelphia. For almost all students, it was our first time attending ASA.

Our students had the opportunity to engage in a variety of valuable sessions, including a medical student reception, a program director panel on successful matching, a networking lunch with the Virginia Society of Anesthesiologists and Virginia program directors, subspecialty and career pathway sessions, a residency open house featuring program directors and resident booths from across the country, and much more.

The conference proved to be immensely valuable for all of us, whether still in didactics, currently on rotations, or those who had already applied. For the second year medical students, their biggest takeaways involved the anesthesia residency application process as a whole, ranging from steps to take to become a competitive applicant to the intricacies of applying through the online central application service.

Many feel more prepared for the process because they now have a better understanding of how to better themselves early in the medical school journey to be the strongest applicant possible.

One of the most important pieces of advice from the conference was during the program director panel where the "signaling" process was explained in more detail. It was stated that there is a 2.8% chance of receiving an interview from a school that you did not "signal to" in your application, and that this number has been decreasing year-by-year since the introduction of "signaling."

The residency directors were in agreement across the board that most programs do not even have time to interview the "non-signaled" applicants. It was also stated that the signaling process is beneficial for both students and programs because it allows students to put an emphasis on the programs that better suit them.

By focusing efforts on a more select number of programs, students are able to save a significant amount of time and fees on fewer applications.

The third and fourth years especially appreciated the residency open house, which gave them an inside look at various programs throughout the country. The meet and greet was conveniently set up by region so students could make the most of the hour by targeting the area where they hope to end up.

Being able to talk to program directors and current residents one-on-one allowed students to introduce themselves and inquire about program details that may only be available by these in-person conversations. Some fourth years even had the opportunity to follow up on their current application to strengthen their connection and hopefully secure an interview.

Most programs had QR codes to scan so there is a record of each student showing interest in their residency. Even these small interactions can prove crucial to expressing commitment and interest to a residency program when the time comes for applications and interviews.

In addition to these educational and professional activities, we also took time to explore the city. We enjoyed the culinary delights of Reading Terminal Market, visited the historic Liberty Bell and other landmarks, indulged in some top-notch shopping, and experienced the vibrant nightlife.

It was a very educational and fun experience for all of us and something that we look forward to attending again next year in San Antonio. We encourage all students to attend ASA in the future as it certainly proved to be valuable for our journey of learning about and applying to anesthesiology residency.

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