virginia society of anesthesiologists

UPDATE

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SPRING 2025: **AI TECHNOLOGY AND ETHICS IN ANESTHESIA**

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Certified Anesthesiologist Assistants Licensure in Virginia: Decades in the Making

By Robert B. Goldstein, MD
UVA Health System
Charlottesville, VA

Dr. Robert B. Goldstein

Thanks to the effort of the VSA leadership, lobbyists, staff and physicians, licensure of Certified Anesthesiologist Assistants (CAAs) in Virginia is near at hand.

At the time of this update, the bill to establish licensure for CAAs in Virginia has passed the Virginia House of Delegates and the Virginia Senate. The next step is signature by the Governor in late March.

The licensure of CAAs in Virginia will help with the existing shortage of anesthesia team members in our state. CAAs only work in the anesthesia team model under the supervision of an Anesthesiologist. They do not practice independently nor under the supervision of a surgeon.

CAAs presently practice in 26 states and the District of Columbia. Many of them live in Northern Virginia, which is why this potential legislative change is particularly pertinent.

Many practices have both AAs and CRNAs who work at hospitals and ambulatory surgery centers, sharing similar clinical responsibilities.

This legislative accomplishment is personal to me. As some of you may know, I trained as an AA at Case Western Reserve in Cleveland, back in the 70s. I worked at

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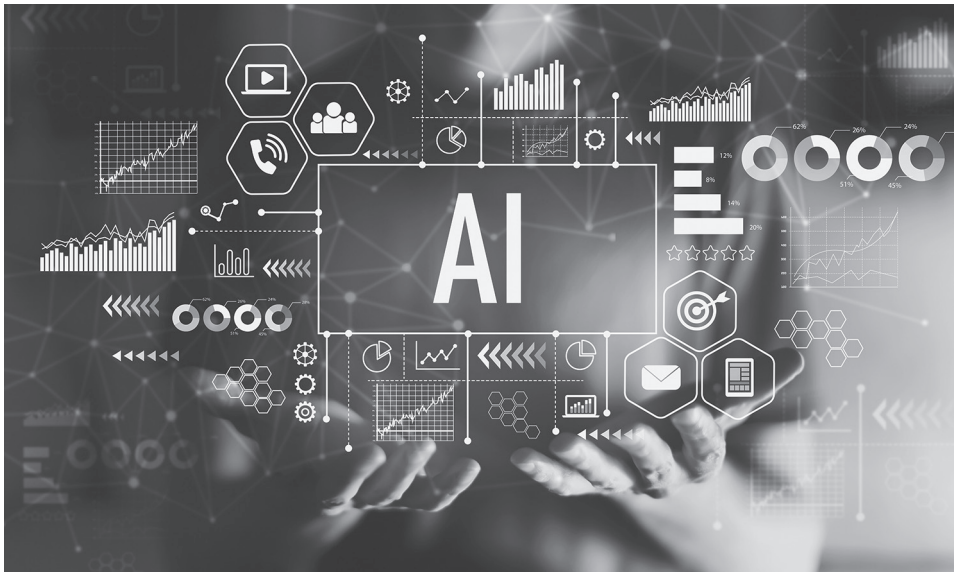
Feature Article



Revolutionizing Healthcare: The Power of Strategic AI Implementation

By Iyabo Muse, MD, FASA
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Dr. Iyabo Muse

Artificial Intelligence (AI) is a scientific tool that uses engineering and algorithms to translate patterns from large datasets to learn and solve problems mimicking human cognitive function. The use of AI has been evolving over decades, shaped by the contributions of various people such as Dr. Alan Turing, a computer scientist in 1950 who published "Computer Machinery and Intelligence," to Dr. John McCarthy coining the term "Artificial intelligence" in 1955, to broader industry innovations such as Windows releasing the first speech recognition software in 1997 that eventually led to the development of virtual assistants such as Apple's Siri and Amazon's Alexa in the 2000's.[1] Today, AI is transforming healthcare by automating time consuming tasks, accelerating drug discovery, enhancing health monitoring, virtual clinical consultation, and improving disease diagnosis and treatment options.[2]

Integrating AI into healthcare has the potential for improving diagnostic accuracy and minimizing human errors. For example, AI-utilized diagnosis was more sensitive for diagnosing breast cancer with mass

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AI TECHNOLOGY AND ETHICS IN ANESTHESIA

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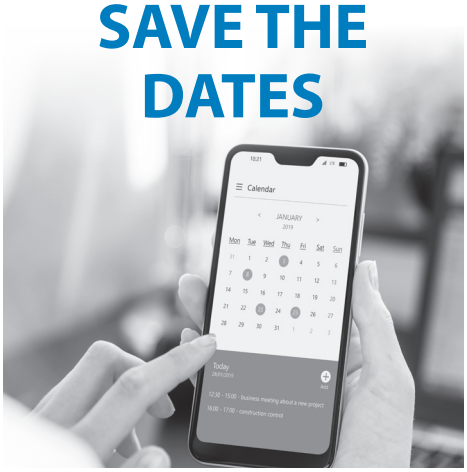
The ***VSA Update*** newsletter is the publication of the Virginia Society of Anesthesiologists, Inc. It is published quarterly. The VSA encourages physicians to submit announcements of changes in professional status including name changes, mergers, retirements, and additions to their groups, as well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



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President's Message

A Message From the VSA President

By Casey Dowling, DO, FASA
VSA President
Winchester Anesthesiologists
Winchester, VA

Hello VSA Members,

Dr. Casey Dowling

I'm Casey Dowling, a private practice anesthesiologist from Winchester, and I'm deeply honored to serve as your President of the Virginia Society of Anesthesiologists (VSA). Today, I'd like to take a moment to reflect on the journey that brought me here and share a few thoughts on the importance of our collective efforts.

How I Got Here: A Grateful Reflection

First and foremost, I must thank my husband, Jay Dowling, who has always been my greatest supporter and enabler. Without his unwavering encouragement, I would not have been able to take on leadership roles such as this one. His belief in me has been a constant source of strength.

Next, my path to this position has been shaped by the incredible mentors and role models I've encountered throughout my career. While I can't name everyone for fear of leaving someone out, I encourage you to look at the past presidents, current board members, and active members of the VSA. The leadership and wisdom they offer have been invaluable to me, and they represent the excellence we strive for as a profession.

Finally, there's a simple yet powerful principle that has guided me: Show up and do. It's easy to be passive, but the real impact comes from being an active participant. As we often hear, there are "doers," "not doers," and "undoers." I encourage you to be the one who shows up and makes a difference. That's how you'll go far.

The Power of Membership: Why It Matters

I know I'm preaching to the choir here – you wouldn't be reading this newsletter if you weren't already a committed "doer" in our field. However, I ask that you take a moment to help others understand the value of being part of the VSA. We've seen tremendous success over the past two years in protecting anesthesia care in Virginia, but these accomplishments don't happen in a vacuum. They're the result of strong relationships with legislators and a united voice from our society.

Unfortunately, many of our fellow anesthesiologists may not fully realize the importance of their VSA membership. That's where you come in. I'm asking you to share this message and help spread the word about the critical role the VSA plays in our profession.

What is the VSA?

At its core, the VSA serves as a forum for networking—both within our specialty and with other medical professionals. Through the VSA, we have access to role models and mentors who guide us, and we participate in the Medical Society of Virginia, where we can advocate for policies that impact our profession.

The VSA is also a key educational resource. It provides opportunities for us to learn, from events like the POCUS conference to this very newsletter. Additionally, we are committed to educating our patients, utilizing social media and our website to share vital information about the value of anesthesia care.

Finally, the VSA is a powerful advocate for both us as professionals and for the patients we serve. When we speak with one unified voice, our collective influence becomes stronger, and our impact more profound.

Take Action: Spread the Word

So, I urge you all to take an active role in spreading the word about the importance of the VSA. Speak to your colleagues, share our content on social media, and encourage others to join and participate. The strength of our society depends on our collective efforts, and the more we grow, the more we can accomplish.

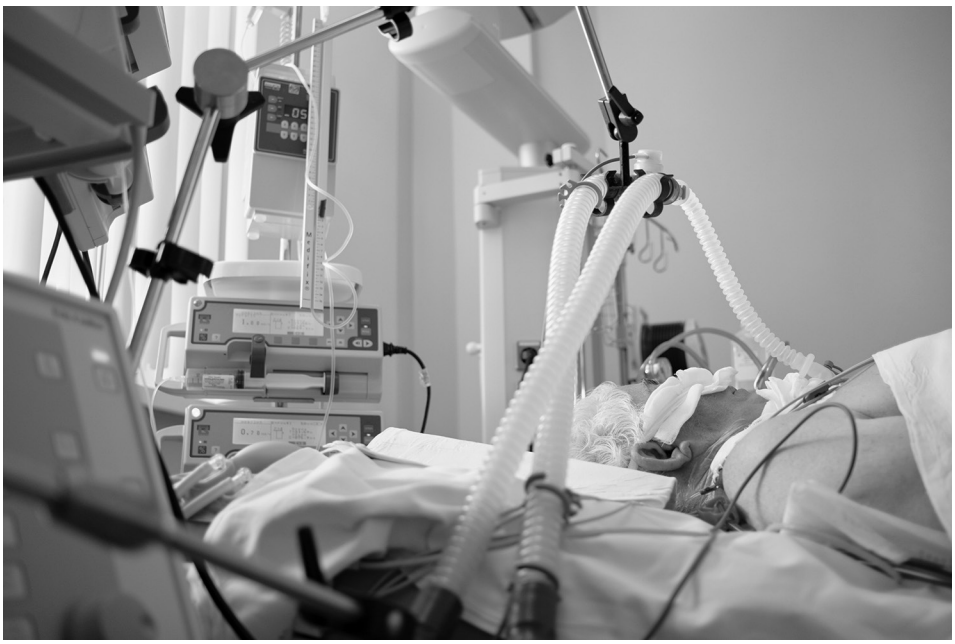
Together, we can continue to protect and advance the practice of anesthesia in Virginia. Thank you for your ongoing dedication to the VSA, and I look forward to all we will achieve together in the coming year.

The Evolution of Ventilator Management

The Role of Anesthesiologists, the Rise of Respiratory Therapists, and the Controversy Over Expanding Their Scope of Practice

By Brooke Trainer, MD
Editor, VSA Newsletter
VSA President-Elect

Dr. Brooke Albright-Trainer



Introduction

The evolution of modern intensive care medicine owes much to the expertise and foresight of anesthesiologists. Long before the widespread establishment of intensive care units (ICUs), anesthesiologists had an intimate understanding of mechanical ventilation and airway management—skills that became crucial in saving lives during public health crises. The polio epidemic of the 1950s was a pivotal moment, highlighting the vital role of anesthesiologists in the development and implementation of mechanical ventilation techniques. Their knowledge of respiratory physiology, ability to manage artificial airways, and commitment to patient survival laid the groundwork for ICUs and the widespread use of ventilators in critical care medicine.

Over time, ventilator management expanded, leading to the emergence of respiratory therapists (RTs) as nonphysician healthcare professionals specializing in respiratory care. Like other nonphysician team members, RTs would augment physician services in an environment where supervision and clinical guidance was readily available. However, in recent years, similar to other nonphysician team members, anesthesiologists are encouraged to beware of questionable scope of practice expansion efforts by RTs. As an example, the RT profession is now seeking to expand their scope of practice to include administering inhaled anesthetics and performing emergent tracheostomies. These efforts raise serious concerns regarding patient safety and the boundaries of medical practice.

Anesthesiologists' Early Understanding of Mechanical Ventilation and Its Application During the 1950s Polio Epidemic

The polio outbreaks of the 1950s posed a significant challenge to healthcare systems worldwide. The most severe cases of polio led to respiratory muscle paralysis, rendering patients unable to breathe independently. Anesthesiologists, with their extensive knowledge of respiratory management, played a crucial role in advancing mechanical ventilation technology.

Before the advent of modern ventilators, the iron lung—a negative-pressure ventilator—was the primary means of respiratory support. However, during a massive 1952 polio outbreak in Copenhagen, the city's hospitals were overwhelmed, and the available iron lung machines were insufficient. Dr. Bjørn Ibsen, a Danish anesthesiologist, proposed an innovative solution: using positive pressure ventilation via a tracheostomy instead of relying solely on the iron lung. This approach provided direct airflow control into the lungs and proved significantly more effective in supporting patients with respiratory failure.

Dr. Ibsen's method marked a turning point in intensive care medicine. With medical students manually ventilating patients using bag-valve masks through a tracheostomy tube, mortality rates dropped from over 80% to around 40%. This dramatic success highlighted the necessity of continuous ventilatory support for critically ill patients, leading to the creation of the first dedicated ICUs. Anesthesiologists, with their expertise in airway management, naturally assumed leadership roles in this new field.

The Emergence and Role of Respiratory Therapists

As mechanical ventilation became widely used outside the operating room, the need for specialized healthcare professionals to manage ventilators and provide respiratory care increased. This led to the development of respiratory therapy as a formal profession.

Respiratory therapy began in the 1940s and 1950s, during the polio epidemic, with "oxygen orderlies" or "inhalation therapists" working under the supervision of anesthesiologists and pulmonologists in ICUs. As mechanical ventilation technology evolved, so did the role of respiratory therapists. The Medical Society of the State of New York formed a Special Joint Committee in Inha-

Continued on page 5

lation Therapy on May 11, 1954. One of its purposes was "...to establish the essentials of acceptable schools of inhalation therapy (not to include administration of anesthetic agents)..."

By the 1960s, RTs had become essential ICU nonphysician team members, assisting with ventilator management, assessing lung function, and optimizing ventilator settings under the direction of intensivists. Their knowledge of respiratory physiology, ventilator weaning, and non-invasive ventilation made them critical in both acute and chronic care settings.

In 2016, the Advanced Practice Respiratory Therapist (APRT) field emerged with the publication of the Standards for Accreditation of Advanced Practice Programs in Respiratory Care by the Commission on Accreditation for Respiratory Care (CoARC). These standards defined APRTs as "credentialed, licensed respiratory care practitioners" with a broader scope of practice, allowing for "higher-level physician collaboration in assessing, diagnosing, managing, and treating patients with cardiopulmonary disease."

A recent push by APRTs to expand their scope to also include administering inhaled anesthetics and performing emergent tracheostomies has raised concerns regarding training adequacy, patient safety, and the appropriate boundaries of medical practice.

Expanding the Scope of Practice of Respiratory Therapists

In addition to the emergence of the APRT model, some RTs are seeking to expand responsibilities, including administering inhaled anesthetics and performing tracheostomies. Their argument is based on expertise in airway management and mechanical ventilation, though these proposals raise serious concerns over patient safety.

Traditionally, administering inhaled anesthetics requires extensive training due to potential complications and has been reserved for anesthesiologists, certified registered nurse anesthetists (CRNAs), and anesthesiologist assistants. The American Society of Anesthesiologists (ASA) does not recognize RTs as members of the Anesthesia Care Team, a necessary requisite to administer inhaled anesthetics, even under the supervision of another physician. ASA does however support RTs using "physician-approved, patient-driven respiratory care protocols that provide the highest quality, safest and most efficacious respiratory care under the direction of knowledgeable physicians."

> *Despite a lack of education, training, and demonstrated need, RTs in Virginia (2024) discreetly attempted to introduce amendments to state regulations to remove exclusionary language to allow them to administer general anesthesia and perform tracheostomies.*

Emergent tracheostomies are high-risk procedures typically performed by physicians in acute settings. While RTs contribute significantly to medical care teams, they lack structured training in administering general anesthesia or performing surgical procedures as outlined in CoARC's Accreditation Standards.

Despite a lack of education, training, and demonstrated need, RTs in Virginia (2024) discreetly attempted to introduce amendments to state regulations to remove exclusionary language to allow them to administer general anesthesia and perform tracheostomies. This was submitted through a fast-track rulemaking process without a clear public announcement, misrepresented as a "merely technical" amendment conforming to "current practice." The regulatory analysis failed to provide evidence supporting this expanded scope.

Fortunately, vigilant stakeholders promptly identified and opposed these changes, preventing their approval due to patient safety concerns. Similar RT expansion efforts in Ohio (2023) and North Carolina (2025) were also identified early and opposed by medical societies. The RT movement appears to be part of a broader effort to expand RTs' roles, similar to past nurse practitioner (NP) and CRNA scope expansions with the exception that APRT "delivers care under the supervision and responsibility of a licensed physician."

A Personal Story: When Professional Boundaries Are Challenged

A particularly troubling example of this issue occurred in a busy ICU where I work as an anesthesiologist and critical care physician. During my ICU rounds, I entered a patient's room to adjust the ventilator settings for a critically ill patient, assessing the next steps in their care. The patient's family was at the bedside, attentively watching my interventions.

At that moment, a respiratory therapist entered the room and openly questioned whether I, the critical care physician managing the patient, had the necessary competency to adjust the ventilator. While this was puzzling to me, it was even more bewildering to the patient's family, who began to wonder whether I was qualified to manage the ventilator for their loved one. The respiratory therapist's actions and assertions, made directly to me in front of the family, clearly undermined my role as the leader of the critical care team.

This example highlights a growing problem: some respiratory therapists have begun asserting control over ventilator management to an extent that challenges medical oversight. While respiratory therapists are highly skilled professionals, their role has traditionally been one of collaboration with physicians, rather than autonomy in critical decision-making.

Conclusion

Anesthesiologists have played a crucial role in the development of modern intensive care, particularly in mechanical ventilation and airway management. Their contributions during the polio epidemic laid the foundation for the establishment of ICUs and the advancement of life-saving respiratory interventions. While respiratory therapists have become essential nonphysician members of critical care teams, recent efforts to expand their scope of practice into areas traditionally reserved for physicians raise significant concerns regarding patient safety and medical

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oversight. The administration of inhaled anesthetics and performance of emergent tracheostomies require rigorous training and expertise that RTs currently lack. As history has shown, the evolution of healthcare professions must be guided by patient safety, adequate training, and well-defined professional roles. Ensuring that scope of practice expansions are evidence-based and transparent is essential to maintaining high standards of care and protecting the integrity of medical practice.

We Want to Hear From You

We'd love to hear from you regarding your thoughts, comments, and experiences with respiratory therapists in your hospital, including responses to the following small poll:

1. Does your hospital or institution restrict critical care physicians from touching ventilators and only allow RTs to do so?
2. Do you think RTs should be able to administer certain medications without the order of a physician?
3. Do you think RTs should be able to administer anesthetics with physician oversight?
4. Do you think RTs should be privileged to perform emergent tracheostomies or cricothyroidotomies independently, without any physician present?

Your insights and experiences are invaluable in shaping the ongoing discussion about professional roles in critical care and anesthesiology.

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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

UPCOMING THEMES: Summer – Critical Care/POCUS
Fall – Health Policy

compared to radiologists (90% vs. 78%, respectively).[3] It also accurately diagnosed melanoma cases compared to dermatologists with ideal treatment options.[4] AI can also revolutionize personalized medicine, enhance population health management, virtual health assistants, patient education, and reduce physician burnout. For the future, there is hope that AI can help predict, prevent, and treat diseases more effectively. This may occur by selecting and matching patients with clinical trials, detecting diseases very early in their development, and anticipating disease-risk years in advance.[5]

However, as AI utilization in healthcare continues to grow rapidly, it is important for it to be used as a complimentary tool to assist clinicians and healthcare organizations in providing patients with safer, equitable, and more personalized care. It's also necessary to make sure that human interaction in medicine is emphasized and continues to be the forefront of clinical practice, so as not to lose the patient-physician trust.

Dr. Francis W. Peabody highlighted the crucial personal relationship between patient and physician in his speech to medical students at Harvard on October 21, 1926: "The significance of the intimate personal relationship between physician and patient cannot be too strongly emphasized…Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine."[6]

Challenges in use of AI in clinical practice

The goal of AI utilization in clinical practice is to improve patient outcomes. However, challenges related to data privacy, security, access, and biases are potential limitations in the application of AI. Effective implementation requires clinical experts to select relevant data and appropriate algorithms to minimize errors. Clinicians can also contribute to bias and discrimination if they are not properly trained in the design and application of AI. For example, if AI is trained on datasets that are not accurately representative of a targeted patient population, then the AI interpretation would be incorrect and thus result in undesired outcomes. However, clinicians' involvement and proper regulation are essential for better outcomes, as AI lacks medical providers' reasoning and years of clinical experienc.

It's also necessary to make sure that human interaction in medicine is emphasized and continues to be the forefront of clinical practice, so as not to lose the patient-physician trust.

AI use also raises ethical and legal concerns, especially with data privacy, security, and informed consent. The Health Insurance Portability and Accountability Act (HIPAA) law of 1996 protects patients' identifiable health information while allowing an exchange of health information that may improve quality of care. This 'Privacy Rule' needs to be followed with AI systems, especially with the increased number of cyberattacks against healthcare organizations. To safeguard patients' protected health information and maintain AI system integrity, it's important to thoroughly investigate cybersecurity failures of healthcare systems so that a robust protection network can be developed. As for ethical concerns of AI, a framework for ethical assessment of digital information is encouraged to prioritize ethical awareness, transparency, and accountability in healthcare systems.[7]

AI technology in healthcare has the potential to improve patient outcomes, reduce physician burnout, lower healthcare cost, and improve global health equity. Future goals include its capability to provide a more individualized, predictive, and precise medical plan for patients. However, challenges related to data privacy, cybersecurity, and informed consent must be managed carefully for AI applications to be effective. More importantly, the patient-physician relationship should be preserved, with AI seen only as a collaborator, rather than a replacement of human intelligence and emotional connection.

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Pending Law Could Allow Anesthesiologist Assistants To Work In Va., Bolster Health Care Workforce

By Charlotte Rene Woods
Virginia Mercury

Ricky Miller would like to come home to Virginia.

He's been in Indiana practicing as a Certified Anesthesiologist Assistant and finished his schooling to do so there because he couldn't in Virginia. This type of medical worker is involved in placing patients under anesthesia for surgeries.

The Virginia Beach native's passion for the work first formed when he was earning his bachelor's degree at Radford University in Southwest Virginia because it fused his interest in physiology and chemistry.

Though he's enjoyed his time in the Midwest, he said he misses his home state with its mountains and beaches. When his grandfather became ill and needed surgery, he longed to be closer to home and more easily able to see family. A bill now under review by Gov. Glenn Youngkin could make it possible for Miller, and other health care professionals like him, to live and work in Virginia.

When hospitals conduct surgery, two key positions other than anesthesiologist doctors can be involved: CAAs — like Miller — or Certified Registered Nurse Anesthetists.

Both workers have medical knowledge and training specific to anesthesiology; VCU Health's program for CRNAs, for instance, touts its decade of ranking high in the U.S. World and Report. While CRNAs need doctoral degrees to practice, CAAs can practice in other states with masters degrees, but they are not able to practice in Virginia due to a lack of licensure.

Senate Bill 882 by Sen. Mamie Locke, D-Hampton, would establish criteria for professionals like Miller to be licensed in Virginia and would direct the Board of Medicine to adopt regulations to govern the practice.

The workforce is in demand and bolstering it was a recommendation from Virginia's Joint Commission on Health Care. Locke's bill cleared the legislature with bipartisan support and now awaits action from Youngkin.

Between the governor's expressed support of bringing jobs into the state and his history of supporting licensure bills, advocates for Locke's bill are hopeful he might sign it.

"I'm just happy and just really grateful that, you know, it seems to be something I can go back to," Miller said of Youngkin's potential to sign the law.

The Medical Society of Virginia threw their support behind the bill and wrote a letter to Youngkin recently to explain how CAAs operate under the supervision of anesthesiologists to monitor patients before, during and after surgery.

"By handling routine but critical tasks, including preoperative evaluations, patient monitoring, and postoperative care, anesthesiologist assistants allow physician anesthesiologists to serve more patients, and dedicate more time to high-risk patients, ensuring expert attention is available where it is most needed," MSV president Joel Bundy wrote in the letter.

Bundy noted that 20 states, Washington D.C. and Guam license anesthesiologist assistants and that the Joint Commission on Healthcare found the supply of anesthesia providers is not keeping pace with demand. Some factors to increasing demand include aging populations that could require more surgeries, increasing numbers of elective outpatient procedures and more non-operating room procedures that still require someone to be placed under anesthesia.

Virginia Society of Anesthesiologists director Dr. Jeffrey Green concurs.

"Anesthesiologists are the only medical physician group that doesn't have multiple choices of advanced practice providers," he said. "CRNAs are the only ones, and so this would essentially be a second group of advanced practice providers for us to have so that we can extend our reach."

For Miller, he said he would come back to Virginia eventually if he would be able to do his job here. While he's enjoyed Indiana, it's "a little cold" for him in the winters and he's appreciated his home state more since leaving it.

"I just think it's a great opportunity, not only for people who want to come home to Virginia," Miller said, "but people who are not even from here to be like 'this is a good place to practice and good place to live.'"

This story was first published in the Virginia Mercury, virginiamercury.com.

CAA Licensure, *from page 1*

Mount Sinai Hospital, in Cleveland, for just over 1 year before starting medical school (and I worked during summer, winter and spring breaks to help pay for medical school). AAs and CRNAs were equals in the anesthesia care team. There was excellent collegiality. The clinical and professional lessons learned from those AAs, CRNA's and Anesthesiologists have undoubtedly contributed to my success as an anesthesiologist.

My family and I moved after residency to Virginia in 1989. I began inquiring about the status of AAs gaining licensure in the state of Virginia. The efforts to establish licensure in Virginia have been going on since the 1980s. VSA has tirelessly continued its efforts over these decades.

20 years ago, I moved from Tidewater to Charlottesville and began practicing at the University of Virginia. Amazingly, there were two CRNAs at UVA with whom I worked with back in Cleveland, in the 80s. When Anesthesiologists and CRNAs would inquire about our past working experience, we would all share stories about how everyone worked so well together.

As passage of this legislation is nearing the end zone, I encourage practices to begin contemplating how CAAs might be integrated into your practice. Additionally, consider whether your practice site could be a potential teaching location for student AAs.

Often, when a student has a favorable learning experience at a facility, that student will want to work there after completing their studies. This scenario is what led me to staying on at Mount Sinai Hospital after college. In addition to the benefit of passing on your clinical and experiential knowledge, establishing a successful student rotation can be a form of recruitment.

If you would like more information about anesthesiologist assistants, please visit the American Academy of Anesthesiologist Assistants website (www.anesthetist.org) or if you are inclined, I welcome your call or email.

Once again, I congratulate the VSA and its membership (past and present) for 35+ years of commitment and persistence that has led to this remarkable accomplishment.

2025 Virginia General Assembly End of Session Update

By Lauren Schmitt
Commonwealth Strategy Group

The 2025 Virginia General Assembly session was a huge success for the Virginia Society of Anesthesiologists. While it may have been a "short" session, it was definitely not a boring one! In just 45 days, we defeated legislation that would have allowed Certified Registered Nurse Anesthetists (CRNAs) to practice independently and passed legislation to finally allow for Certified Anesthesiologist Assistants (CAAs) to practice in Virginia. Both of these were significant victories for anesthesiologists and our patients.

HB 2391, carried by Delegate Mark Sickles, would have removed the current supervision requirement for CRNAs in Virginia. Despite the Joint Commission on Health Care rejecting this concept in December, they still moved forward with trying to advance the proposal. We vehemently opposed this bill and were pleased when it did not even receive a hearing in the House of Delegates.

There were two bills we supported regarding the licensure of CAAs: SB 882 (carried by Sen. Locke) and HB 1647 (carried by Del. Hayes). While HB 1647 did not receive a hearing, the Senate version was successful and passed both chambers with a wide bipartisan majority. The bill is now in the Governor's office awaiting his signature. If he signs the bill, it will become law on July 1. After that, the Board of Medicine will begin the regulatory process for licensure.

In addition to anesthesia bills, there were other high profile bills we worked on. Thankfully, working with our coalition of fellow providers, we were able to defeat SB 904 (Sen. Stanley), legislation that would have repealed the current medical malpractice cap. The current law, which was passed in 2012, has helped make Virginia one of the best states for providers to practice. Repealing this law would have a significant impact on recruiting and retaining providers in Virginia, which would lead to a lack of access for Virginia patients. The bill initially passed the Senate Courts committee on a close vote. It ultimately failed in the Senate Finance committee. This legislation is getting harder and harder every year to defeat, so we have our work cut out for us moving forward.

Another accomplishment was the passage of legislation to protect health care providers from violence and threats of violence in the workplace. HB 2269 (Del. Tran) and SB 1260 (Sen. Aird) will require hospitals to establish a workplace violence incident reporting system to document, track, and analyze any incident of workplace violence reported. Both bills are awaiting the Governor's signature.

The Governor has until March 24 to sign, veto or amend legislation. The General Assembly will return to Richmond on April 2 for "veto session" to accept or reject the Governor's actions. To reject an amendment, they just need a simple majority (51 in the House and 21 in the Senate). To override a veto, they need a 2/3rd majority (67 in the House and 28 in the Senate).

Campaign season is already in high gear, with the primary elections only three months away and the general election in November. All 100 Delegates are up for re-election, and we will elect a new Governor, Lt. Governor and Attorney General. At this point, it looks like former Congresswoman Abigail Spanberger will be the Democratic nominee for Governor. Our current Lt. Governor, Winsome Sears, will likely be the Republican nominee, however two other candidates have emerged. Former Delegate Dave LaRock and former Senator Amanda Chase both recently announced they are seeking the nomination.

For the Lt. Governor race, there are four prominent Democrats all vying for the nomination. This includes Senator Ghazala Hashmi, Senator Aaron Rouse, Prince William County Board of Education Chairman Babur Lateef, and former Mayor of Richmond City, Levar Stoney. On the Republican side, there are three candidates thus far: John Reid (conservative radio host), Pat Herrity (member of the Fairfax County Board of Supervisors) and John Curran (Navy veteran and business consultant).

Our current Attorney General, Jason Miyares, is running for re-election as the Republican nominee. For the Democratic side, former Delegate Jay Jones from Hampton Roads and current Henrico Commonwealth Attorney Shannon Taylor are running to be the nominee.

We will know the official candidates after the primary election on June 17th.

Concerns Regarding Cardiac Implantable Electronic Device Article

From BobbieJean Sweitzer, MD, FACP, SAMBA-F, FASA
Systems Director, Preoperative Medicine
Inova Health
Fairfax VA
Professor, Medical Education
University of Virginia
Charlottesville, VA

Dr. BobbieJean Sweitzer

Dear Dr. Trainer,

I read with interest the article, "ASA's New Cardiac Implantable Electronic Device Practice Management Aid" by Dr. Mark T. Nelson in the Winter 2025 VSA Update.

He and the anesthesiologists from the American Society of Anesthesiologists (ASA) Cardiothoracic committee who developed the ASA practice aid are to be congratulated. Dr. Nelson's VSA Update review is quite comprehensive and well-written.[1]

However, I have a few concerns. Cardiac anesthesiologists are likely much more well versed and knowledgeable about cardiac implantable electronic devices (CIEDs) than the average anesthesiologist. Some of the statements in the VSA Update may be misinterpreted by someone who does not regularly manage patients with these devices.

The statement, "With magnet placement all PMs (pacemakers) revert to asynchronous pacing" is incorrect. In fact, Dr. Nelson goes on to highlight some unique functions of magnets in some Boston Scientific devices where placement of a magnet will not force asynchronous pacing initially, but requires removing and replacing the magnet which is not intuitive to less experienced practitioners. And, some Biotronik pacemakers must be reprogrammed if they are left in an "auto mode" when implanted, because a magnet will not force pacing.

Many practitioners are likely to misinterpret the statement "magnet placement triggers asynchronous pacing in all devices." I am surprised that there is no discussion of management of implantable cardioverter defibrillators (ICDs) in patients who are pacer dependent. Many practitioners are not aware that a magnet placed on an ICD will only inhibit tachytherapies and will NOT result in asynchronous pacing. Magnets can only do one thing.

> *Many practitioners are likely to misinterpret the statement "magnet placement triggers asynchronous pacing in all devices." I am surprised that there is no discussion of management of implantable cardioverter defibrillators (ICDs) in patients who are pacer dependent.*

I am also surprised that the article does not promote obtaining information preoperatively, or as soon as possible, in situations of emergency surgeries to identify the specific model and details of the CIED functionality given the vastly diverse effects of magnets on many pacemakers. For example, while in "Electrocautery Protection Mode" the magnet response of Boston Scientific pacemakers is disabled. And, Abbott and others have pacemakers with "no magnet response" options that are "rarely used." But, rarely is not never.

The Update article mistakenly states that "currents produced by electrosurgery below the umbilicus do not result in CIED oversensing." This is true for transvenous or leadless devices within the heart. There are reports of triggering of tachytherapies from electromagnetic interference (EMI) in subcutaneous devices with currents between the umbilicus and groin.[2] This led the recent 2024 AHA/ACC Guideline for Perioperative Cardiovascular Management for Noncardiac Surgery to recommend reprogramming subcutaneous ICDs or using a magnet to temporarily disable tachytherapies with anticipated EMI above the groin.[3]

I do not disagree with this statement, "The practice aid dispels the myth that CIEDs require formal interrogation prior to discharge from a monitored area." However, I am concerned that the word "interrogation" may be misinterpreted. Any CIED that has been reprogrammed needs to have settings restored to the preoperative parameters before patients are discharged from a monitored setting. Technically this is "reprogramming," not interrogation. But, again, many readers rarely deal with these devices, and medical terminology is notorious for being misinterpreted. I think it would be safer to explicitly remind readers that tachytherapies and synchronous pacing must be restored.

Lastly, I am very concerned that the aid and Update article advise against relying on the ICD to treat ventricular arrhythmias, and that advanced cardiac life support (ACLS) and external shocks should be provided instead. Cardiac anesthesiologists may be very knowledgeable about ACLS, and they may routinely cardiovert or defibrillate patients. The vast majority of noncardiac anesthesiologists rarely, if ever, are in a situation to provide ACLS. Poorly conducted ACLS is common and associated with significant morbidity and mortality. Dr. Nelson published a case report of a patient with an ICD who received an external asynchronous 360 J shock via transcutaneous pads converting the patient's ventricular tachycardia (VT) to ventricular fibrillation.[4] But, before another external shock could be delivered, the patient's ICD delivered a shock resulting in sinus rhythm.

In general, the advantages of removing the magnet outweigh leaving it in place. ICDs are sophisticated devices that terminate tachyarrhythmias with extreme efficacy and safety. Delivering anti-tachycardia pacing before shocks, even with unstable VT, reduces mortality as shown in randomized trials,

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Meet Your Legislator: Delegate Michael Cherry

By Delegate Michael Cherry
District 74

Recently I was asked what it's like trying to digest the large volume of bills we see at the General Assembly each session. With over 2,000 bills each year, it's a great question. The short answer: I rely on my colleagues and subject matter experts for bills dealing with topics which I am not familiar.

Delegates serve on anywhere from two to four committees. I have the pleasure of serving on Education, Privileges & Elections, and Health & Human Services. My service on the Education Committee makes sense as I have a master's in education and previously served as Head of School at a local preK-12 Christian school. My service on the other two committees, particularly the Health Committee, are a bit tougher because I do not have the professional background in these subject matters.

I am a lifelong learner. I love diving in and exploring a new subject matter. Despite not having the professional background that my colleagues in the medical field have, I truly have learned to enjoy my service on the Health Committee.

Take for example the scope of practice laws that have been offered in the last few years around your industry. Certified Registered Nurse Anesthetists have sought changes to the supervision agreement with physicians, including anesthesiologists. Prior to my election to the House of Delegates, this was not an issue that I was familiar with, but my appointment to the Health Committee demanded I quickly get up to speed on this important issue. So, I set out to learn as much as I could.

Without a professional background in the healthcare field, I made appointments with industry experts. I met with various organizations that represented the CRNAs and heard their ideas for why change was necessary. I met with anesthesiologists, physicians, and their representatives to hear their side of the story. As you can imagine, I heard different arguments in support of and opposed to proposed changes.

I also had the opportunity to observe your profession first-hand. When my wife had a medical procedure, I asked about a million questions during the run up to her procedure. Doctors, nurses, and anesthesiologists became a target for my inquiry into the process of anesthesia. I wanted to learn as much as I could about the process outside of the pressures of Capitol Square. I continued to discuss scope of practice conversations with the intent to continue learning.

This is just one small example of how legislators do their homework before voting on bills in Richmond. For some bills, legislators are subject matter experts. Other times, they aren't up to speed on the issue. Either way, they must cast a vote.

I started this article with the fact that some 2,000 bills will be heard in any given year. I am grateful for organizations that help us as legislators understand what we do not know. Their advocacy often makes the difference in us passing good laws and policies or bad ones. It is vital that Virginians, in all professions and from all walks of life, work to stay up to date on matters impacting their career field.

Letter to the Editor, *from page 10*

and may prevent the need for shocks altogether.[5] Internal shocks avoid damage to the device. And, removal of the magnet does not preclude ACLS and external shocks. Magnet removal will always restore all current CIEDs to their permanently programmed functions, and will do so immediately in virtually all situations. If removal does not result in the desired effects then ACLS should be provided.

I applaud Dr. Nelson and colleagues for endorsing that magnet placement on pacemakers are only necessary for "unacceptable bradycardia" (that which is hemodynamically significant), and not just based on arbitrary rates.

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Legal and Ethical Considerations of AI in Anesthesia Practice

By Rachel Carey
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Rachel Carey

Artificial Intelligence (AI) is being hyped as the next thing to revolutionize medicine. Anesthesiologists are beginning to utilize AI to predict postoperative complications, to personalize drug dosing, and to achieve precise vital sign monitoring. However, there are notable issues with AI, and comprehensive legislation and regulation have not kept up with the speed of innovation. Considering the fragmented legal framework regarding the use of AI in healthcare, I offer the following synopsis for anesthesia providers to consider to limit risk when incorporating the use of AI in their clinical practice.

AI Bias

The accuracy of AI can be influenced by several factors: one, the quality and representativeness of the training data, also known as data bias. If the data is incomplete, outdated, or not representative of the patient population for a clinician's practice, AI's predictions and recommendations may be inaccurate. Two, algorithmic bias, where algorithmic design and weighted variable considerations can impact accuracy. Three, historical label bias arises when the outcomes used to train the algorithm are biased due to historical underdiagnosis or other factors. Lastly, feedback loop bias, which occurs when algorithmic recommendations are used to make decisions that reinforce initial biases.

Federal Approach

While the Biden administration adopted orders on the development of AI to guard against bias, the new Trump administration repealed and replaced the orders to emphasize AI innovation over regulation. From a congressional standpoint, Congress is still considering whether to pursue comprehensive AI legislation. However, there are existing statutes and regulations that impact practitioners' use of AI.

AI health management tools and medical devices are regulated by the Food and Drug Administration (FDA). However, practitioners without the resources provided by larger health systems should be more concerned with the Health Insurance Portability and Accountability Act (HIPAA) and regulations under the new Section 1557 of the Affordable Care Act (ACA), both of which are enforced by the Health and Human Services Office of Civil Rights (OCR).

The new Final Rule under ACA Section 1557 prohibits federally funded health programs from discriminating on the basis of race, color, national origin, sex, age or disability.

The Final Rule takes the position that providers receiving Medicare Part B funding is "federal financial assistance" to qualify as a covered entity. The Final Rule also clarified that protections extend to use of AI and established an ongoing duty for providers to identify and mitigate risks. These tools are described as "an automated or non-automated tool, mechanism, method, technology or combination thereof used by a covered entity to support clinical decision-making in its health programs or activities." OCR stressed that in using these tools, each patient's unique facts and circumstances must be prioritized. This rule also created an ongoing duty for provider to get informed consent from patients about the role AI plays in the patients' healthcare.

Virginia Specific Considerations

At the time of writing this article, the Virginia General Assembly passed HB 2094 which prohibits discrimination in AI, and the bill is currently awaiting Governor Youngkin's signature. Government Relations professionals suspect he will veto the bill given his pro-business stance.

Another Virginia specific consideration is the standard of care. In Virginia, the duty of the physician, like other aspects of standard care, is defined as what other "reasonably prudent" providers in Virginia of the same field or specialty would disclose in similar circumstances at the time the case arose. To meet the standard, physicians should consider explaining how AI works to patients, its predictive accuracy, limitations of the tool, any safeguards that have been put in place to ensure reliability of the AI's output, the role played by physician in decision-making, and the role played by AI in decision-making. Because data received during a patient encounter may be in-put into AI tools, physicians should receive a patient's consent prior to use of a tool and disclose to patients how they use and share any patient data obtained during a patient encounter.

The Virginia Board of Medicine provides oversight and guidelines for the ethical and responsible use of AI in clinical practice, but it has not put out any guidance on the use of AI in medical practice. The Board is a part of the Federation of State Medical Boards which has adopted the principles contained in "Navigating the Responsible and Ethical

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PR and Social Media Update: VSA Expands Engagement and Advocacy

By Jason Roop
SpringStory

VSA's social media presence has grown significantly in the last three months—December through February—with increases in reach, engagement, and follower growth across platforms.

Instagram has seen the most momentum, with 178 new followers and a total reach of 78,448, marking a 75% increase in followers compared with the previous period last year. Much of this growth has come from CAA enthusiasm following the licensure effort in Virginia. A collaborative post with the American Academy of Anesthesiologist Assistants, the Medical Society of Virginia, and the Virginia Student Anesthesia Group helped expand that conversation.

Facebook engagement also is up, with the highest-performing posts featuring White Coat Day at the State Capitol, Physician Anesthesiologists Week, and our upcoming Point of Care Ultrasound Training. While X (Twitter) remains a smaller channel for VSA, it continues to be a useful tool for sharing updates.

On LinkedIn, VSA now counts 135 followers seeking content, with engagement at nearly 10%. The most shared and commented-on posts highlighted "Thank a Resident Day," our General Assembly lobby day, our recent board meeting, CAA licensure updates, and VSA member Dr. Mark Simcox's appointment to the Board of Medicine.

Beyond social media, VSA received formal recognition from the governor of Virginia during Physician Anesthesiologists Week. Board member Dr. Brooke Trainer was also featured in a high-visibility newsletter from the Virginia Department of Veterans Services, reaching nearly 400,000 subscribers. The story featured her contributions as a veteran in anesthesiology.

In addition, Virginia Business magazine recognized 38 VSA members in its annual "Top Doctors" list, including 12 in *Pediatric Anesthesiology* and 26 in *Anesthesiology*. This list, published in partnership with Richmond magazine and the Medical Society of Virginia, reinforces the leadership of VSA members in the field.

Work continues to maintain our communication efforts and outreach with the public and our members. VSA recently hosted a portrait session for members at our board meeting, providing fresh, high-quality visuals for upcoming Q&A spotlights on anesthesiology and VSA membership. Media interest continues as well—reporter Charlotte Rene Woods of the Virginia Mercury recently covered VSA's work on CAA licensure (Read the story on page 8).

Through strong advocacy, media coverage and expanding digital presence, VSA continues to amplify its voice in Virginia's health care landscape.

Ethics and AI, *from page 12*

Incorporation of Artificial Intelligence into Clinical Practice" in April 2024.

Mitigating AI Risk under ACA Section 1557

If providers start to incorporate more AI beyond just administrative functions, the biggest adjustment they need to make for compliance is under the new Final Rule for Section 1557 of the ACA. While OCR noted enforcement action for this rule will be considered on a case-by-case basis and consider the size and sophistication of each provider, its overall position is that "[i]f a covered entity does not know whether a developer's patient care decision support tool uses variables or factors that measure race, color, national origin, sex, age, or disability but has reason to believe such variables or factors are being used, or the covered entity otherwise knows or should know that the tool could result in discrimination, the covered entity should consult publicly available sources or request this information from the developer." When determining enforcement, OCR will also assess what manner the tool was used in, whether the provider took active steps to request information from the developer to assess potential for bias, and provider's process for evaluating the tools. While not mandatory, OCR showed strong support for providers adopting the National Institutes of Standards and Technology's Artificial Intelligence Risk Management Framework to use as mitigation plan for AI.

> *At the time of writing this article, the Virginia General Assembly passed HB 2094 which prohibits discrimination in AI, and the bill is currently awaiting Governor Youngkin's signature. Government Relations professionals suspect he will veto the bill given his pro-business stance.*

The above is a brief introduction, not a comprehensive summary, as to the laws and risks associated with the use of AI in clinical decision making. The main takeaway I can provide is if you are incorporating AI into clinical practice, get educated on how the tools work, come up with a documented way to assess the tools' potential bias, and seek competent counsel on applicable regulations you are unsure of and do not know how to implement.

Mindfulness and Anesthesia: A Promising Partnership for Patient Care

By Austin Nguyen
Medical Student
Virginia Commonwealth University School of Medicine
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Austin Nguyen

Gently close your eyes and let go of thoughts about daily life. Visualize yourself on top of a mountain, surrounded by the vast, serene sky. Tune in to the tranquility and affirm, "I am relaxed." These instructions guide my youth group members through meditation, a journey to inner peace and joy.

As a meditation instructor, I've experienced the benefits of cultivating single-mindedness, including improved focus during study sessions, reduced anxiety during exams, and a stronger sense of self. These concepts are also integral to ethical anesthesia care. Ethical practice can be summed up in the ongoing effort to be both a morally good and highly skilled provider. Therefore, anesthesia providers must develop strong mindfulness skills to guide patients through their anesthesia journey, becoming their metaphorical sherpas on the surgical mountain.

In the Short Wave NPR podcast episode "What Happens While You're Under Anesthesia," Dr. Alopi Patel discussed "verbal anesthesia"—a type of emotional and psychological relief she provides to patients.[1] She says, "Okay, while you're sleeping, we're going on vacation. Where do you want to go? Tahiti? Bora Bora?"

Dr. Patel's verbal anesthesia exemplifies how anesthesia providers can reduce preoperative anxiety to improve postoperative outcomes. The integration of mindfulness and mindfulness-based interventions (MBIs) into anesthesiology has emerged as a promising approach to enhance patient outcomes in perioperative care.

Preoperative Anxiety Reduction

Preoperative anxiety is a common phenomenon affecting 60-80% of surgical patients with strong indications that it increases the consumption of propofol, extends extubation time, and prolongs the time to reach a Modified Aldrete Score of 9.2 A randomized controlled clinical study published in December 2023 demonstrated the efficacy of a 20-minute mindfulness meditation intervention in rapidly reducing surgery anxiety in patients undergoing dental implant operations under local anesthesia. The study found that mindfulness meditation had significant positive effects on cardiovascular parameters, physiological findings, and biochemical outcomes.[3]

Specifically, prior to the procedure, the meditation group showed:

- Decreased bispectral index scores
- Reduced heart rate, systolic blood pressure, and diastolic blood pressure
- Lower cortisol levels and State-Trait Anxiety Inventory scores

Beyond anxiety reduction, mindfulness practices have also shown promise in managing perioperative pain and improving postoperative outcomes. A systematic review published in July 2024 found that meditation can provide short-term postoperative pain and anxiety relief for various procedures and surgeries.[4]

The review highlighted that:

- Loving-kindness meditations were effective in reducing postoperative pain and anxiety levels compared to preoperative levels
- Mindfulness-based meditations were particularly effective for alleviating postoperative anxiety

Within this analysis, they noted that previous studies have found that patients who engaged in a mindfulness intervention could potentially alter psychological symptoms and perceived stress levels through the enhancement of mindfulness. These findings suggest that incorporating MBIs into perioperative care could potentially reduce the use of analgesics while improving patient-reported outcomes.[4]

Mindfulness for Healthcare Providers

The benefits of mindfulness in anesthesia are not limited to patients. A study conducted at the Faculty of Medicine, University of Indonesia, examined the effectiveness of an MBI technique in reducing stress levels

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among anesthesiology and intensive therapy residents. The results showed a statistically significant reduction in stress levels after implementing a 4-week MBI program.[6]

In a study during the COVID-19 pandemic, healthcare workers participated in a 30-day trial using the mobile mindful meditation (Synctuition) app engaging in 20-30 minute daily meditation sessions.

Despite experiencing high levels of stress, all groups showed a statistically significant stress reduction after using the Synctuition mindful meditation app based on pre- and post-intervention measurements via the Cohen's Perceived Stress Scale, which measures the "degree to which situations in someone's life were deemed stressful."[7]

This finding highlights the potential for mindfulness practices to support the well-being of anesthesia providers, potentially leading to improved patient care and reduced burnout rates among healthcare professionals. Improving provider mental strength and morale will only benefit patient care long term.

Implementing Mindfulness in Anesthesia Practice

While the evidence supporting the use of mindfulness in anesthesia is growing, implementing these practices in clinical settings requires careful consideration. Patient perception of mindfulness practices is still unclear. Some patients may be more receptive while others may not be as open. Providers should utilize their own judgement when determining whether a moment of mindfulness would be appropriate. Other challenges in fully integrating mindfulness practices into anesthesia care include:

1. Standardization of interventions: The heterogeneity in meditation practices, patient and physician cultures, duration of treatments, and surgical interventions assessed makes it difficult to generalize conclusions about particular populations or specialties.[4]
2. Timing of interventions: Research suggests that the efficacy of mindfulness interventions may depend on specific time frames, with some studies indicating that interventions are most effective right before surgery.[4] These time frames may not be achievable in certain situations, including periods when there are not enough providers to spend an accumulated amount of time throughout the day incorporating mindfulness practices into the anesthetic plan.
3. Long-term efficacy: More research is needed to assess the long-term benefits of mindfulness interventions in surgical settings.[5] It is unclear how pain scores may be impacted if patients continue to practice mindfulness days to weeks after their procedure. Additional studies may provide more evidence for mindfulness in Anesthesia practice.[5]

As research in this field continues to evolve, anesthesia providers should consider incorporating evidence-based mindfulness practices into their care protocols. By doing so, they may enhance patient satisfaction, improve surgical outcomes, and contribute to a more compassionate and effective healthcare system.

From reducing preoperative anxiety to managing postoperative pain and supporting provider well-being, mindfulness-based interventions offer a holistic approach to perioperative care.

As research in this field continues to evolve, anesthesia providers should consider incorporating evidence-based mindfulness practices into their care protocols. By doing so, they may enhance patient satisfaction, improve surgical outcomes, and contribute to a more compassionate and effective healthcare system.

Though not explicit, ethical practice necessitates ethical providers. Practicing mindfulness individually and with patients can strengthen our resolve to be morally good and proficient providers. As we continue to explore this intersection of ancient wisdom and modern medicine, the potential for improving patient care and provider well-being is truly exciting.

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White Coats On Call 2025

By Joshua Sison, OMS-III
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Del. Joe McNamara with Joshua Sison

On a cold day in Richmond, anesthesiologists from all over the commonwealth gathered to discuss opposing HB2391 concerning continuing physician oversight over CRNAs and to support bill SB882 regarding the expansion of certified anesthesiology assistants into Virginia.

This was my second year participating at the state level, and I was looking forward to providing more perspective to our delegates as a student and as a former anesthesia technician.

After an early morning trek from Roanoke, I arrived in Richmond with enough time to settle down with a coffee and get briefed by our VSA lobbyist, Lauren Schmitt. Immediately I noticed how much fuller the room was as compared to last year.

There were a lot of familiar faces such as Dr. Jeffrey Green, Dr. Casey Dowling, Dr. Craig Stopa, Dr. Joseph Walch, and Dr. Marie Sankaran-Raval. My friends Karen Frieswyck LUCOM OMS-III, Joe Ponce LUCOM OMS-II, Michele Adema LUCOM OMS-II and Luke Johnson VCU MS-II also took time from classes and rotations to attend.

This session marked a significant increase in medical student participation, as last year my colleague Grace Carroll VCOM OMS-III and I were the only students present.

Before I could be introduced to those present, Ms. Schmitt briefed us on our plan and who we were meeting. This year I was the only representative from the Roanoke region, so I was set to meet with my delegates on my own. As this was going to be my third time participating in a lobby day, I was ready to take charge in speaking with the delegates about the bills.

As a medical student aspiring to be an anesthesiologist, and as someone who has worked with both physicians and CRNAs, I recognize the important role that both clinicians provide for patients undergoing procedures.

My unique experience working as anesthesia technician allowed me to learn from both anesthesiologists and CRNAs, creating an environment that fostered my passion for anesthesiology.

At Carilion Roanoke Memorial, I saw the great dynamic that anesthesiologists and CRNAs had as they worked together as a team to safely protect the patient when they are at their most vulnerable. Discussing with my delegates, I took my experiences and described that each member of the team has a role in patient care and that having a physician working with CRNAs in delivering anesthesia only strengthens the care that is provided for patients.

> *"I stressed the important point that AAs do not replace CRNAs and only supplement the number of providers available throughout the state."*

I also discussed that even at a level 1 trauma center, anesthesia care was limited in the number of anesthesiologists and CRNAs that were available to provide that care. With both delegates, I elaborated on anesthesiologist assistants (AAs) who were seeking to gain practice rights in Virginia.

We discussed how Roanoke Memorial is the main level 1 trauma center that covers and receives high acuity cases from rural towns from southwest Virginia, West Virginia, North Carolina, Kentucky, and Tennessee. I stressed the important point that AAs do not replace CRNAs and only supplement the number of providers available throughout the state.

Additionally, I discussed their educational background and how AAs will practice under the current model of physician-supervised anesthesia, which is similar to 20 other states and territories. I brought up how AAs already practice close to home with our proximity to D.C., Kentucky, and South Carolina, and how this bill could expand care for our patients in southwest Virginia.

After my last meeting with Delegate McNamara, I reflected again about how grateful I was to be able to represent patients and physicians from southwest Virginia. It was satisfying to see more students take up the cause of advocacy, demonstrating the important role we play as future anesthesiologists taking care of our patients in and out of the operating room.

If you are a medical student interested in lobbying or even just knowing more about the issues that involve anesthesia, please reach out to me, the Virginia Society of Anesthesiologists, or the Virginia Student Anesthesiology Group (@asa_VSAG on Instagram) for more information on getting involved. Look forward to seeing you all for ASA's national lobby day.

ASA March Board of Directors Recap

By Jeffrey Green, MD, MSHA, FASA
VSA/ASA Director
Academic Chair and Program Director
Mary Washington Healthcare
Fredericksburg, VA

Dr. Jeffrey A. Green
VSA ASA PAC
Director

The American Society of Anesthesiologists (ASA) Board of Directors met March 1-2, 2025 in Rosemont, Illinois for the first of three scheduled board meetings this year.

On Friday, there were closed Section meetings for Finance, Administrative Affairs, Professional Affairs, and Scientific Affairs as well as a meeting of the resident component governing council, the ASAPAC executive board, and Administrative Council. Starting on Saturday, the caucuses, including our own Mid-Atlantic caucus, met before the first formal session of the board. This was followed by the first session of the official meeting, during which the ASA President and CEO each gave updates to the board on their progress for this year.

President Don Arnold, MD spoke about the ASA Strategic Plan and progress made on each of the pillars of the plan. ASA CEO Brian Reilly then updated the board on his vision for increasing ASA's "relevance and revenue," progress on key performance indicators, and ASA staffing updates. Then the Chair of the Anesthesia Quality Institute (AQI) Board of Directors, Randy Clark, MD spent the remainder of the morning session talking about the AQI and possible directions for its future. AQI leaders entertained an extensive question and answer session from Board members before breaking for lunch.

After lunch, the Board members presented testimony to the four review committees on the various reports submitted to each section. Items of interest receiving significant testimony included proposals for creating Board-designated funds for spending on the Safe VA Care initiative and the Center for Anesthesia and Perioperative Economics, proposed draft revisions to the statement on the anesthesia care team, revisions to other ASA statements such as the statement on the ASA Physical Status Classification, and funding options for the AQI. The afternoon concluded with a reception in honor of President Arnold.

On Sunday, the Board again formally met to approve all the review committee reports after integrating suggested modifications from the review committees and any respective budgetary adjustments. Next the Board heard from Faye Evans, MD, Director of Programs for the World Federation of Societies of Anesthesiology. This was followed by a lively discussion on ASA strategy in the changing political landscape of the Trump administration and a legislative and regulatory update from ASA's Manny Bonilla and Matt Popovich.

ASA Board of Directors meetings are open to all members. Members are welcome to provide testimony and listen to Board deliberations. You are encouraged to attend if you ever want to get a close-up view of how the ASA governance functions and how each interested state delegation and other stakeholders provide input into ASA policy, finance decisions, and strategic direction.

Next up for the Virginia delegation is the ASA Legislative Conference in Washington, DC on May 5-7, where we will take to the Hill to meet with our congressional leaders to lobby for items of interest to the anesthesiology community.

It is encouraging to see the high number of residents and medical students who are usually able to attend this meeting—it is often described as "inspirational" and "career-defining" by those trainees who attend. We hope you will join us when registration opens soon.

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 available to you at any time 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

Encourage Your Practice Administrators to Join VSA

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

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

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

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

- On this page, click on the category you're interested in – in this case, its: Anesthesia Practice Administrators and Executives – Educational Member
- Click on the + sign next to the title
- The box that opens, will contain full details and the membership rate(s)

Value What's Valuable

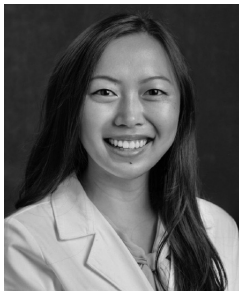
Perspectives from Different Stages in the Medical Journey

By Sarah Cederholm, MD, Michelle Adema, BS and Alexis Anello, MS
Liberty University College of Osteopathic Medicine
Lynchburg, VA

Left to Right: Joseph Ponce, Anthony Haddad, Alexis Anello, Dr. Jeffery Green, Senator Mark Peake, Emily Schroer, Dr. Sarah Cederholm, Michelle Adema, Karen Frieswyk, and Kenny Craig

Dr. Sarah Cederholm

Dr. Sarah Cederholm



Michelle Adema, BS

Alexis Anello, MS

It was the end of a vascular case, an above knee amputation in a diabetic woman on dialysis who had multiple comorbidities, and I stepped into the OR to check on her. The CRNA commented "The case is over, I'm waking her up," and noted she was a little lethargic at getting back to breathing but was otherwise fine.

I said "Ok, let's see if she can fly," and switched her to manual ventilation with the CRNA assisting with breaths as needed. Within about one minute, I flipped her back onto the vent and said, "This woman is about to code. We need the crash cart. We need to get ready to code her." The CRNA looked at me in total surprise. I pointed to the vital sign monitor and said, "Draw up your epi, get calcium, get ready. Start pushing pressors, this patient is tanking." The surgical team sent a runner to get the code cart, and a backboard was brought into the room.

Within another minute, despite avoiding hypoxia and hypercarbia, and despite giving pressors to stabilize her, she went into Vfib, and I called the code. The team was ready, the drugs were in line, the chest compressions were effective and immediate. The woman's life was saved.

That right there is the value of physician involvement, oversight, and on-site presence in operating rooms, and in every single location where any sort of anesthetic is delivered. We offer foresight, we offer knowledge, we offer leadership; physicians enable success. We reduce morbidity. We reduce mortality.

For every minute a patient is coded and hypoxic, morbidity and mortality increase. Hospital lengths of stay increase. Take the physician out of the scenario above, and you are left with a surprise code, unprepared, and minutes behind the eightball. Likely, the patient would have died. If you want to talk medical costs, the cost of patient deaths in an OR is very high. The cost of long-term care for a hypoxic brain injury is equally as costly.

It is an undeniable fact that physician anesthesiologists are necessary for the delivery of safe and cost-effective anesthetic care. The team model, which certainly increases access to care and delivery of care to a higher number of patients, is only successful because physicians lead the teams. The physician takes on the responsibility for multiple patients and are the back up for all critical events for the nurse anesthetists in the rooms and off-site procedure suites.

We also very importantly plan the anesthetic care. We think creatively and expansively about each case and what is needed to safely, effectively, efficiently, and wisely administer anesthesia. Every anesthetic case presents risk to the patient. We advise permanent physician oversight to handle every risk that materializes, no matter how "apparently simple" the case may be.

Physicians protect patient lives. Physicians reduce hospital lengths of stay through their morbidity reduction. Physicians are the experts on best anesthetic practices and safest delivery, have the most experience of all the providers, and carry the actual responsibility for the patient.

To remove physicians from the delivery of care, is shortsighted and results in long term increased hospital costs due to poorly delivered care and poor outcomes. This is a fact which is revealed in places in which nurse anesthetists have been given permission to practice without a physician involved. A broader adaptation of that already performed experiment is not advisable and will increase government and health care costs. Value what is valuable. Liken this to flying an airplane with no pilot. Who wants to get on the airplane?

We have established the common mentality that physicians are valuable and bring valuable insight to the practice of medicine

Continued on page 19

and delivery of anesthesia. What do physicians think of the bills up for vote this year that affect the administration of anesthesia to our patients, our families, and our communities?

Virginia House Bill 1647 provides approval for Certified Anesthesia Assistant (AA) licensure in the state of Virginia. We fully support this bill.

An AA is directly comparable to a certified Physician's Assistant (PA). They are the counterpart of a PA in the operating rooms and anesthesia suites. They have rigorous requirements to enter AA school, and they have an equivalent education for the administration of anesthesia as their certified registered nurse anesthestist (CRNA) colleagues.

They are governed by the board of physicians and remain under physician oversight just like a CRNA. They perform the same scope of practice and are able to sit the same cases as a CRNA, including cardiac cases. I personally have worked with several cardiac AAs in Charleston, South Carolina, and I would immediately approve their licensure in Virginia in a heartbeat.

My experience working with them proved they are skilled, professional, competent anesthesia providers. They were a daily delight to work with and absolutely increased our staffing capacity in a safe and competent manner. Licensing Anesthesia Assistants is licensing providers equivalent in skill and scope of practice as a nurse anesthetist. They increase our workforce. They add value to our practice. There is not one logical reason to keep this ready and waiting workforce at bay.

Virginia House Bill 2391 proposes that CRNAs be granted legal authority to practice medicine, specifically anesthesia, independently. As revealed in the opening story, physicians do not approve of this idea.

We fundamentally and wholeheartedly disagree with any nurse that claims to be able to practice medicine equally to a physician. Physicians are the final remaining patient advocates. We are the providers with the most training, most knowledge, highest standards for board requirements, and greatest level of concern for patient safety.

Nurse anesthetists are governed by the board of nursing and are excellent team players but are not competent to practice without governance.

Again, who flies a plane without a pilot? Cost savings come through ardently providing the best care at the lowest cost. Lesser care at lower cost ultimately is a recipe for higher costs because the side effects are morbidity, increased hospital lengths of stay, and mortality. It has been proven. We strongly advise against passing this bill.

Michelle Adema

On January 14th, 2025, medical students, residents, and physicians gathered at Virginia's Assembly Building to participate in White Coats on Call. Our mission was to inform our government on critical issues, particularly patient safety and healthcare accessibility. As you read this, you might be wondering what a medical student knows about anesthesia.

While I may have a long journey ahead before practicing as an anesthesiologist, the current state of the medical field can profoundly impact our future. We have a duty to educate society on the importance of shaping our healthcare system.

During White Coats on Call, we divided into teams to meet with our respective representatives. Students from Liberty University College of Osteopathic Medicine (LUCOM) along with Dr. Cederholm and Dr. Green met with Delegate Zehr, Delegate Walker, and Senator Peake. We shared our experiences as medical students and expressed our dedication to becoming doctors.

Consider this: 4+4+4+ 2. Four years for an undergraduate degree, four years of medical school, four years of residency and an additional two if we want to specialize. That's fourteen years that we take very seriously. We make these sacrifices, including our personal lives, to ensure we are competent and effective members of the patient care team.

We aim to continue our teamwork to work with CRNAs, physicians, nurses, and technicians. Additionally, we advocate for the inclusion of Certified Anesthesiologist Assistants (CAA) to expand our accessibility.

Overall, we had a fantastic day meeting everyone and forming relationships both in the medical field and in government. At all levels of our medical career, we will always fight for patient accessibility and safety. Together, we are shaping the future of healthcare, ensuring that every patient receives the care they deserve.

Alexis Anello

Participating in the White Coats on Call lobby day in Richmond, VA, was a transformative experience that reshaped my perspective on advocacy as a future physician. Before attending, I was unaware of the extent to which physicians could actively meet with our delegates and senators in person, advocating for bills that directly affect their patients and profession.

Like many others, I assumed advocacy was limited to writing letters or signing petitions. However, this day opened my eyes to a new dimension of being a physician - one that goes beyond the clinical setting.

As Michelle explained, our fourteen years of education and training--from undergraduate studies to medical school and residency--are often focused on becoming competent, practicing physicians. The lobby day emphasized that as physicians, we have the unique opportunity to shape legislation and advocate for our patients in ways that significantly impact the healthcare system. This realization has inspired me to commit to participating in lobby days annually throughout my career, both as a student and soon as a practicing physician. It has shown me how we can champion patient safety, accessibility, and the advancement of medicine on a broader scale.

Additionally, the knowledge and inspiration I gained from this experience have sparked a desire to promote and participate in lobby days across other specialties. Whether it's addressing bills relevant to family medicine, pediatrics, psychiatry, or other fields, I now recognize the value of advocacy in advancing each discipline's unique goals and improving patient care.

By encouraging participation in these events within various clubs at LUCOM, I hope to empower my peers to use their voices and make meaningful contributions to the future of healthcare policy.

These experiences have not only solidified my passion for advocacy but also reminded me of the importance of valuing what's truly valuable in the role of a physician. It encompasses more than treating patients--it includes taking proactive steps to ensure their needs are met at every level, from bedside care to the policies that govern their access to healthcare.

From Clinical Experience to Policy Application: A Policy Elective Experience

By Yena Son, MD, MPP
VSA Update Associate Editor
VCU Health Systems
Richmond, VA

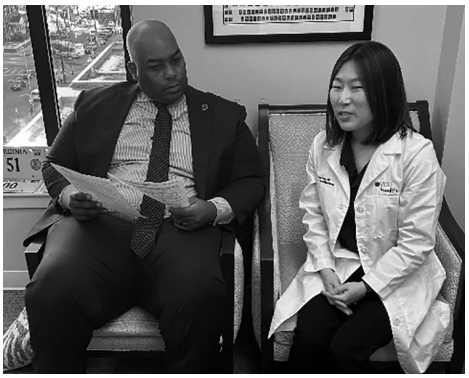
The 2025 Virginia General Assembly session ran from January 8th – February 22nd. Physician organizations, including the Virginia Society of Anesthesiologists (VSA) and the Medical Society of Virginia (MSV), lobbied on a range of critical bills and action items. Most notable among these were proposed changes to Certified Anesthesiology Assistant (CAA) licensure in Virginia, CRNA supervision requirements, and the medical malpractice cap.

My journey into advocacy and policy started during residency at the 2024 American Society of Anesthesiologists (ASA) Legislative Conference. That event opened my eyes to the immense impact that residents and anesthesiologists, at any stage in their careers, can have on policymaking.

The ASA also offers a Policy Research Rotation in Washington, DC, a four-week immersive experience designed for residents to witness firsthand the political, legislative, and regulatory factors that influence patient care. Inspired by this, I teamed up with Dr. Sankaran-Raval, a former president of VSA, to create my own two-week policy rotation. Since I live and work in Richmond, I saw this as an incredible opportunity to dive deep into the legislative process happening right here in Virginia.

Every day during my rotation brought something new, thanks to the dynamic pace of the legislative session. I spent most days attending Senate and House subcommittee and committee meetings (such as Health committees, Health Professions, Health and Education), soaking up the energy of debates and discussions shaping the future of healthcare. Before this elective, I had no idea just how accessible the legislative process is to the public. Not only can you attend meetings and voice your opinion in person, but you can also testify virtually via Zoom (with prior registration) or leave comments online about House bills.

The sessions are even livestreamed and archived on the General Assembly website, and the Virginia Senate has its own YouTube channel. I was amazed to see so many community members and stakeholders present, passionately speaking up in support of or against key bills.



Sen. Bagby and Yena Son

> *I'm excited to carry the lessons I learned during my rotation forward as I continue my training and beyond—and I encourage you to get involved, too! The future of healthcare is being shaped right now, and we all have a role to play.*

In addition to attending these meetings, I participated in VSA's White Coats on Call Lobby Day and MSV's Lobby Day, where we had the chance to meet directly with legislators.

These events bring together physicians, residents, medical students, and, for MSV, physician assistants and PA students, to advocate for important issues. During these Lobby Days, we fought for the highest standards of patient care and shared our expertise with legislators on issues such as protecting healthcare providers from violence (House Bill 2269 and Senate Bill 1260), increasing access to care in a safe manner, and expanding treatment for substance abuse and mental health.

I was fortunate to meet with several key legislators, including Senator Bagby, Delegate Ward, Delegate Orrock, and Delegate Wyatt, along with their dedicated legislative staff. The opportunity to speak directly with policymakers—answering questions, sharing insights, and advocating for change—was an incredibly rewarding experience.

One of the most significant bills VSA was tracking this year aimed at removing CRNA supervision requirements. This bill, which is introduced each session but has yet to pass, didn't make it out of the House of Representatives this time. While it was defeated this year, it's likely we'll see it introduced again in the future.

Another major issue on the radar was CAA licensure in Virginia. The House bill didn't make it out of committee, but the Senate bill passed and is now under consideration in the House subcommittees. If passed, this would be a huge win for increasing access to care for Virginia patients while keeping the effective, safe, and collaborative care-team model intact.

Although my policy rotation has wrapped up, the opportunities for involvement are far from over. VSA is constantly engaged in legislative efforts, advocating for policy changes and working with legislators and stakeholders to shape the future of healthcare. MSV offers year-round opportunities to connect with legislators through White Coats on Call 365, along with their annual Lobby Days. There are also other ways to stay active in advocacy, such as ASA's Resident Advocacy Champion Program, which I participated in and received a certificate.

While the General Assembly session may only last part of the year, policymaking is a constant, ongoing process. I'm excited to carry the lessons I learned during my rotation forward as I continue my training and beyond—and I encourage you to get involved, too! The future of healthcare is being shaped right now, and we all have a role to play.

Photos from VSA Lobby Day at the General Assembly and VSA's Annual Membership Meeting

Dr. Marie Sankaran-Raval, Del Rodney Willett and Dr. Deborah Barron

Dr. Deborah Barron, Dr. Marie Sankaran-Raval, Sen. Schuyler VanValkenburg and Dr. Jeff Green

Dr. Marie Sankaran-Raval, Dr. Deborah Barron, Sen. Creigh Deeds, Dr. Lyn Wells, Dr. Casey Dowling and Dr. Yena Son

Katy Bortz (CSG intern); VSA Lobbyist Lauren Schmitt; Dr. Alice Coombs; Akash Sinha, current president of the VAAA; Astrid Meenan, CAA student at Case Western Reserve University; Felipe Joglar-Viera, CAA student at Case Western Reserve University; Sarah Graham Taylor, lobbyist for VAAA

Dr. Jeff Green, middle, receives the VSA Career Award from Past Presidents Dr. Marie Sankaran-Raval and Dr. Craig Stopa

ASA President Elect Dr. Patrick Giam receives an award from VSA Past President Dr. Craig Stopa

ASA LEGCON 2025

May 5, 2025 - May 7, 2025
Hyatt Regency Washington on Capitol Hill, Washington, DC

Drive change on Capitol Hill: Your voice is needed. Join ASA advocates and change makers in Washington, D.C. to explore emerging issues, educate decision makers, and help shape the future of the specialty.

SAVE THE DATES

ASA ANESTHESIOLOGY 2025

October 10 - 14, 2025
Henry B. Gonzalez Convention Center
San Antonio, TX |

VSA Luncheon
Saturday, October 11, 2025

From the Virginia Workers' Compensation Commission Latest Quarterly Newsletter

Pursuant to Virginia statute requiring a fee schedule for medical services provided to eligible injured workers, the Medical Fee Services (MFS) Department will establish and maintain medical fee schedule quality standards for the Virginia Workers' Compensation Commission.

The department will provide direction, training and information to the public on the medical fee schedule and related requirements. By facilitating understanding of the medical fee schedule, the department's aim is to ensure that medical fee schedules are properly executed, monitored, and maintained.

The Medical Fee Services Department will respond to health care providers, employers, insurance companies, and third party administrators' medical fee schedule inquiries.

The Medical Fee Services Department will be responsible for:

- Administration of the Medical Fee Schedule
- Responding to Medical Fee Schedule Inquiries
- Education and training for the public

Ethics in Medical Practice

Dr. Jaikumar Rangappa

Medical ethics is an applied branch of all medicine
A system of principles in practice with a moral sin
Based on set of values in case of a difficult decision
In medical practice or research to the mind foreign.

Values are justice, autonomy and beneficence
And respect for any form of non-malfeasance
These tenets help patients and doctors
Families, colleagues and care providers.

To work towards same common goal
With no suspicion or calling any foul
A few break ethics rules with no control
While majority practice with an honest soul.

Beneficence - responsibility to act in patient's best interest
Includes all available types of prevention & any treatment.

Non beneficence (malfeasance) dictates to do no harm
Due to neglect or discrimination in any shape or form
When issues become complex may need guidance
From colleagues, experts and lawyers in confidence.

Autonomy gives patient right to accept, refuse treatment
Unless they are medically or mentally deficient
As all forms of procedures need an Informed Consent
With mutual communication & complete agreement.

Justice to treat patients fairly is a nuanced principle
May not be an Equal care but surely care equitable
Sharing medical complexities is definitely feasible
In large communities it makes it legally justifiable
Sadly, in emergency, pandemic health care is horrible.

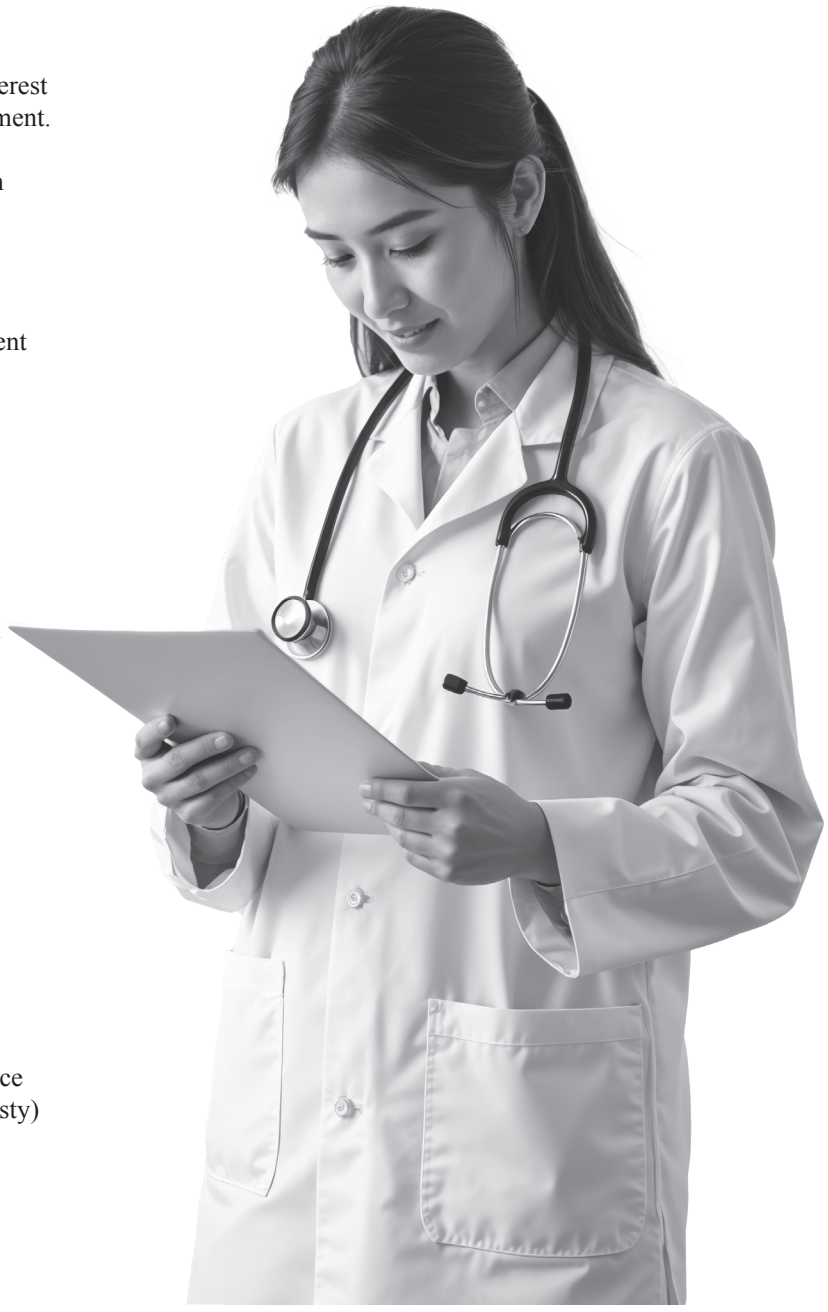
In society a good caring health care provider
Lives by personal example, is not a hoarder
Of the ever expanding health care pie
With all stress and strain will not cheat & lie.

With any patient disagreements of any type
Care demands patient interest first with no hype
Ethical guidelines help to be the good moral type
With a conscience clear the doctor won't gripe.

Facing an ethical dilemma in practice is common
Errors do happen of omission and commission -
(Happened with my practice apologized to patient twice
Forgave me for my honesty Didn't complain for travesty)
Cover up of negligence and mistakes ruins practice
Remember old Hippocrates with an ethical choice.

Clear ethical guidelines is very sound, critical
Challenging, as current laws become political
Caring for patient as one's family is good
To keep attorneys away from neighborhood.
If only one to one doctor-patient relationship is a trend
With no politicians, lawyers, insurance trying to bend
American health care, it will be a divine godsend
Hippocrates will be reborn and good health will transcend.

Medical ethics promotes 'Trust' for best interest
Among all doctors, nurses assistants & patient
The Greek's Oath guides us all 'Do no harm' to recipient
Leading to 'Healthy Longevity' in future to be nonviolent!



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