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Unless otherwise noted, all articles are the opinions of the contributors, and the FSA does not agree, disagree or endorse any services or products.



Sonya Pease, M.D., FSA President

Advancing the Practice of Anesthesiology

At this year's annual ASA conference in San Diego, two new practice guidelines and two new practice advisories were presented to the House of Delegates for consideration; Practice Guidelines for Central Venous Access, Practice Guidelines for Preoperative Fasting, Practice Advisory for the Perioperative Management

“Although guidelines and statements are not intended to dictate how we practice medicine, they certainly do provide powerful expert opinions that warrant our full attention ...”

of Patients with Cardiac Implantable Electronic Devices and Practice Advisory for Prevention of Peripheral Neuropathies. All four of these documents were discussed within the reference committees and caucuses and presented to the House of Delegates for approval. Ultimately, all four were adopted by the House of Delegates, with some amendments.

Regarding the central venous line guideline document, the routine use of ultrasound guidance for elective placement of intravascular lines was hotly debated. Anesthesiologists who have placed central lines for many years without the use of ultrasound believe strongly the use of this newer modality has no business being

mandated by our society. In addition, the expense of an ultrasound machine in many smaller community hospitals is not a financial option. But the fact is ultrasound does reduce the possibility of complications in patients with higher risks, and I do see a day when ultrasound guidance for elective line placements will be an accepted practice.

ASA Standards, Guidelines and Statements start with a task force of physician experts who have been asked, usually by the ASA president, to assist in the development of specific clinical decision-making tools that are intended to provide guidance and to improve the quality of patient care throughout our specialty.

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Advancing the Practice of Anesthesiology, from page 1

More than 50 Standards, Guidelines and Statements created by our society can be found on the ASA's website in the members' area under the "Clinical Information" tab. These documents, including the new additions outlined above, form part of the clinical foundation of each of our practices. Although guidelines and statements are not intended to dictate how we practice medicine, they certainly do provide powerful expert opinions that warrant our full attention, because going against these generally accepted principles may not bode well when there is an adverse outcome or complication.

The House of Delegates always offers an exciting exchange of ideas. I believe each one of us, no matter our background and no matter our current anesthesia practice, is represented within this governing body of our society, and I would highly recommend every anesthesiologist to take the time to review the work that comes out of this governing body. 

Sincerely,
Sonya Pease, M.D.
President
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Tallahassee Report



Republicans Win Veto-Proof Majorities in House, Senate

By Jon Johnson, FSA Legislative Consultant

With Election Day behind us, it is time to reflect on the election's outcomes and how the FSA PAC faired with its political donations. Since the primary, the FSA PAC donated to 11 different candidates as well as to the Rick Scott gubernatorial campaign. This year we are happy to report that we had a 100 percent success rate. Every candidate we donated to since the primary election won their respective elections.

As I am sure you noticed, Florida, like much of the South and the country as a whole, trended in favor of Republicans and conservatives. The election was largely nationalized; Obama, Pelosi and Reid were all fixtures in local candidates' communications, and consequentially several down-ticket Democrat candidates lost on account of things happening above them and out of their control. What's worse for Democrats is what people called an intensity or an enthusiasm gap. The results, as listed below, were staggering.

Congressionally, Republicans picked up four seats and held off legitimate challenges in two seats they previously occupied.

The prior partisan makeup of Florida's delegation was 15 Republicans and 10 Democrats. The Republican pickups were Boyd CD 2 (North Fla.), Grayson

CD 8 (Central Fla.), Klein CD 22 (Broward, Palm Beach) and Kosmas CD 24 (East Central Fla.). Daniel Webster beat incumbent Alan Grayson, Congresswoman Suzanne Kosmas lost to Republican challenger Sandy Adams, Ron Klein lost to Allen West and long-time Democrat incumbent Allen Boyd lost to Panama City's Steve Southerland. There were two competitive Republican-held seats, CD 12 in Polk (Open Putnam) and CD 25 in South Florida (Open M. Diaz-Balart). In Polk County, the Republican, former State Rep. Dennis Ross, held strong. And in South Florida, Republican David Rivera beat Joe Garcia to retain the Republican seat.

The Republicans enjoyed a huge sweep in the Florida cabinet seats.

In races for attorney general, chief financial officer and agriculture commissioner, all went Republican. And although the governor's race was considered a toss-up prior to election night, the unprecedented early and absentee Republican voters gave Rick Scott the edge to take over the governor's mansion.

Florida has a 40-member Senate, and the previous partisan split was 26 Republicans and 14 Democrats. Senators are elected to staggered four-year terms. Odd-numbered seats are on the ballot one year, and even-numbered ones are on



the ballot the next. This year it was even-numbered seats, except for a few that were prematurely vacated. Of the 22 Senate seats slated to be on the 2010 general election ballot, seven of them were decided prior to the general election without opposition. All of the competitive Senate seats were won by Republicans. **The new margins in the Florida Senate are a veto-proof partisan split of 28 Republicans and 12 Democrats.**

The House of Representatives has 120 members, and each is elected every two years. The previous partisan split was 76 Republicans and 44 Democrats. The Democrats took a devastating hit in the Florida House, losing five incumbents. And every competitive and toss-up seat was also held by Republicans. **The new margins in the Florida House are a veto-proof partisan split of 81 Republicans and 39 Democrats.** [FSA](#)



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Clinical Corner

Sedation in Digestive Endoscopy: 2010 Update

By Eric A. Harris M.D., M.B.A., and David A. Lubarsky M.D., M.B.A.

During the final months of 2009, the major societies representing anesthesia providers and gastroenterologists issued position statements concerning the safe use of non-anesthesiologist administered propofol (NAAP.) Not surprisingly the arguments for and against NAAP generally fell on either side of predictable fault lines. While the ASA/AANA guidelines were more general, pertaining

of propofol stating that when the drug is used for sedation or anesthesia, it “should be administered only by persons trained in the administration of general anesthesia and not involved in the conduct of the surgical/ diagnostic procedure. Patients should be continuously monitored, and facilities for maintenance of a patent airway, artificial ventilation, oxygen enrichment and circulatory

- Monitoring of the patient should include oxygen saturation, heart rate, and blood pressure at regular and frequent intervals. Ventilation should also be monitored, preferably with the use of capnography. The practitioner performing the monitoring must be present throughout the entire case and must not have additional responsibilities.
- Sedation is a continuum which may require rescue from an unintended depth of sedation. If this occurs, the procedure should be halted until the patient is returned to the desired level of sedation.

“With respect to efficacy and economics, the four domestic GI societies continue to strongly support the use of propofol.”

to sedation given for any type of procedure, the GI societies focused solely upon the use of propofol during gastrointestinal endoscopy. As expected, the ASA emphasized that optimal care involves an anesthesiologist directing the care of every patient receiving anesthesia. However, acknowledging the economic and personnel limitations of this proposal, the society outlined a set of recommendations to improve the safety of propofol administered by non-anesthesia providers. This statement, released on Oct. 21, 2009 (and jointly supported by the AANA), is an update of the society’s statement from five years earlier.

At the foundation of the ASA/ AANA statement is the warning included in the package insert

resuscitation must be immediately available.”¹ (A warning with practically identical wording is included in the packaging of fospropofol.) The ASA/AANA incorporated the language of the package insert into the following set of recommendations²:

- The physician directing the sedation protocol should have a thorough understanding of the pharmacology of the drug(s) used. In addition, the physician must be proficient in the practical skills of airway management and advanced life support skills appropriate for the patient population.
- The practitioner administering the drug(s) should also be skilled in airway management.

Within two months, the GI community released its position statement on this topic. It was endorsed by the four major GI societies (American Association for the Study of Liver Diseases, American College of Gastroenterology, American Gastroenterological Association and American Society for Gastrointestinal Endoscopy) and not surprisingly takes a less rigid stance than the ASA/ AANA recommendations. Citing numerous prospective studies and case reports (the largest of which surveys more than 460,000 cases of upper and/or lower endoscopies³), their report rests upon the fact that there have been only three reported deaths during endoscopic procedures performed

with non-anesthesiologist-directed sedation. All three deaths occurred during upper GI endoscopies, and all patients had significant comorbidities (patients were ASA III or above). [A study published subsequently increased the sample size to 646,080 patients and reported only four deaths⁴.] This complication rate is equivalent to what has been reported for endoscopists administering only benzodiazepines and/or narcotics for sedation⁵ and is comparable to mortality rates seen with general anesthesia^{6,7} or MAC.⁸ Smaller case series suggest that nurse-administered propofol may also be safe for patients receiving ERCP or exams under sedation (EUS)⁹⁻¹² or deep small bowel enteroscopy.¹³ The authors of the consensus statement therefore concluded that NAAP is safe for patients receiving upper and/or lower endoscopies, and may even be suitable for patients undergoing more invasive endoscopic procedures. A survey of the GI literature finds that while increasing BMI is occasionally cited as a risk factor for non-anesthesiologist sedation, a history of obstructive sleep apnea (OSA) reported by the patient is not.¹⁴ Furthermore, advanced age also is not identified as a risk factor; elderly patients (70 or above) show no increased incidence of complications when receiving NAAP for sedation, although they do require a lower dose.¹⁵

The international medical community has for the most part overwhelmingly supported the use of propofol by non-anesthesia trained personnel. During a meeting in Athens (Sept. 18-19, 2009), 32 individuals from 12 countries (representing the fields of gastroenterology, anesthesiology and medical jurisprudence) assembled to issue position

statements regarding various elements of sedation for GI endoscopy.¹⁶ One hundred percent of the respondents believed that patients rated ASA I-III could be safely sedated by a trained endoscopist/nurse team in the absence of an anesthesia provider. The committee noted that this is in accordance with the published national guidelines in Austria, Germany, Spain, the United Kingdom and the United States. Furthermore, they were queried whether gastroenterologists and nurses with appropriate training for propofol sedation during endoscopic procedures (but no specific anesthesiology training) could administer the drug safely and effectively; 97 percent (31 of 32) voted affirmatively, with one abstention. This statement is supported by the published national guidelines in Austria, Germany and the United States. (It is not sanctioned in the United Kingdom and is not mentioned in the Spanish guidelines.)

With respect to efficacy and economics, the four domestic GI societies continue to strongly support the use of propofol. When compared to benzodiazepines and narcotics, propofol is associated with reduced time to achieve adequate sedation,^{5,17} shorter recovery times^{18,19} and improved patient satisfaction.^{20,21} Propofol combined with a narcotic may be even more efficacious.²² These factors, in addition to the absence of a dedicated anesthesia provider, result in significant cost savings.¹⁸ The conclusion of the panel was that “the use of anesthesiologist-administered sedation for healthy, low-risk patients undergoing routine GI endoscopy results in higher costs with no proven benefit with respect to patient safety or procedural efficacy.”²³

One area where the two specialties agree is the need for proper training of practitioners who oversee propofol administration. Indeed, the gastroenterologists’ position statement is very specific in its training recommendations, advocating a four-part regimen:

- Didactic training about the pharmacology of sedative agents and the physiologic spectrum of sedation.
- Airway workshop training focusing upon airway assessment, the ability to restore airway patency, and proper bag-mask ventilation technique.
- Simulation training using high-fidelity manikins.
- Preceptorship under the direction of an anesthesiologist or skilled endoscopist.

However, a survey of the literature reveals no published studies regarding the prevalence of standardized airway training for endoscopists.²⁴ In the 60-page text of the *Gastroenterology Core Curriculum*, a document published by the four major GI societies outlining “best practices in gastroenterology training,” the full discussion of sedation training consists of all of two sentences.²⁵ A formal method of testing as well as a requirement for continuing education and recertification are also suggested, although here, too, there are no specific guidelines given.²⁶ Thus, it appears that while the GI societies are advocating a rigorous training and recertification regimen, there may be little structured opportunity for their members to pursue these recommendations.

Perhaps the most glaring difference between the statements issued by

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the two specialties is the presence of a practitioner whose sole job is to monitor the patient. While this is a clear mandate in the ASA/AANA consensus statement, it is not referenced in the GI report. The latter addresses the need for proper monitoring but eschews the responsibility (presumably for economic reasons) of assigning a dedicated person to fulfill this function.

The position of the GI societies was significantly weakened on Aug. 11, 2010, by the publication of the Food and Drug Administration Docket #FDA-2005-P-0059. This statement was released in response to a 2005 petition submitted on behalf of the American College of Gastroenterology, requesting that the FDA rescind its recommendations that propofol should only be administered by clinicians skilled

in general anesthesia, and that it should be given by a practitioner whose sole duty is to administer the drug and monitor the patient. The conclusions of the FDA were as follows:

- **The warning is warranted and appropriate in light of the risks associated with the use of propofol as a sedation agent for endoscopic procedures.**

The FDA disagreed with the ACG's supposition that propofol poses no greater risk than other commonly used sedative agents. The narrow therapeutic range of propofol, combined with its serious cardiorespiratory side effects, makes it a drug that demands unique consideration. In addition, the FDA noted that practitioners who are reluctant to deal with the effects of oversedation may inadvertently

undersedate patients, resulting in discomfort, anxiety and possible GI consequences (e.g., colon rupture due to patient movement). The FDA concluded by noting that its decision is consistent with the policies of JHACO, the American Association for Accreditation of Ambulatory Surgery Facilities, the Accreditation Association for Ambulatory Health Care and the ASA. While the FDA agreed that propofol, when properly dosed, is ideal for short GI procedures, given its rapid onset and elimination, it noted that the issue at hand was the safety of propofol, not the efficacy.

- **The studies submitted fail to show that the warning is unwarranted.** After reviewing the 31 studies submitted by

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the ACG in favor of repeal, the FDA was not convinced by the evidence provided. The administration paid little heed to individual case reports or opinion pieces, and further cited a lack of data from prospective, randomized, adequately powered, well-controlled clinical trials. In fact, the conclusions that the FDA did find credible all strengthened the case that inadequately supervised propofol administration is dangerous.

- **Increased procedural costs do not support removal of the warning.** The FDA reasserted its position that patient safety trumps economic savings.
- **The warning does not unduly restrict the practice of gastroenterologists.** The purpose of the FDA's release is to offer guidance; it is not meant to restrict privileges of any medical provider or specialty.

A new development in the field involves the use of a computer to assist with the administration of propofol.² These drug-delivery systems fall into three categories:

- **Patient-Controlled Sedation (PCS):** Much like with PCA machines, these require a conscious patient to activate the device, which gives a predetermined amount of drug after an adjustable lockout period has elapsed. The theory behind their success is that patients who have progressed to a level of unconsciousness will be unable to re-dose themselves.²⁻³⁰
- **Target-Controlled Infusions (TCI):** These devices provide infusions based on

pharmacokinetic models of the specific drug, using a computer-controlled pump; the target concentration is automatically achieved and maintained over time by varying the infusion rate according to a three-compartment pharmacokinetic model.³¹ While they have enjoyed clinical success, the unpredictable and non-linear relationship between age and appropriate target drug concentration makes them somewhat unreliable.³²⁻³⁴

- **Computer-Assisted Personalized Sedation (CAPS):** The most sophisticated of the three systems, it acts as both a drug-delivery and patient-monitoring system by continuously monitoring six parameters (oxygen saturation, respiratory rate, heart rate, non-invasive blood pressure, end-tidal carbon dioxide and patients' responsiveness to verbal and tactile stimuli³⁵). The platform continuously checks for early signs of cardiorespiratory depression and adjusts the infusion accordingly (although the automatic dosing safeguards can be manually overridden by the clinician³⁶). The system is also designed to respond to early signs of over-sedation, as indicated by apnea or hypoxemia, by stopping or reducing delivery of propofol to maintain the targeted degree of sedation, increasing oxygen delivery to the patient and verbally prompting patients to take a deep breath. One multi-center study of 1,000 subjects concluded that CAPS was instrumental in achieving the desired level of minimal to moderate sedation while helping to prevent patients from progressing into deep sedation

or general anesthesia.³⁷ Despite this reported clinical success, the FDA remained unconvinced of the safety of the Sedasys® device (Johnson & Johnson's proprietary CAPS system) and issued a "not approvable" letter on Apr. 20, 2010.³⁸ An appeal is expected from the parent company.

The future course of this controversy will likely remain contentious because shrinking compensation and an increased patient load will force each side repeatedly to stake a wider claim. As the population ages and the availability of medical care expands, gastroenterologists will find themselves faced with older and sicker patients. A standardized schedule of sedation training needs to be incorporated into gastroenterology fellowships,³⁹ and a recertification plan will need to be implemented. The introduction of fospropofol will likely complicate the debate because many non-anesthesiologists erroneously view it as a drug that embodies all of the benefits of propofol without the inherent risks.⁴⁰ New techniques for lower GI endoscopy, including capsular high-resolution CT colonoscopy and the use of water as opposed to air insufflations,⁴¹ have been shown to be less distressing to patients and may therefore obviate the need for deep sedation. Although the complication rate for NAAP is low, the few deaths that do occur may ultimately thrust this issue into the medico-legal arena.⁴²

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FSA 2011 Annual Meeting

June 10-12, 2011

The Breakers Resort & Spa • Palm Beach, Florida

Reserve your hotel room now at The Breakers by calling 888/273-2537. The 2011 base room rate for FSA attendees is \$215/night plus taxes and fees for single/double occupancy.* The base rate applies to standard superior rooms. Rooms in other categories may be available at higher rates. Refer to "Florida Society of Anesthesiologists" room block.

For more information, visit www.fsahq.org.

*The standard superior room type is NOT suitable for families—due to fire code restrictions, The Breakers is obligated to refer families larger than two adults to a larger room. Cribs and rollaway beds typically will not fit in standard superior rooms.



For Your Practice



Data Exchange in the Information Age: Creation of the Anesthesia Quality Institute

By Richard P. Dutton, M.D., M.B.A.
Executive Director, Anesthesia Quality Institute

The Anesthesia Quality Institute (AQI) is a nonprofit 501(c)(3) corporation formed with seed money from the American Society of Anesthesiologists to serve as a clearinghouse of information for the specialty. The purpose is to leverage the tools and connectivity of the Information Age to improve the safety and efficiency of anesthesia practice. Unlike the Anesthesia Patient Safety Foundation (APSF),

the Foundation for Anesthesia Education and Research (FAER) or the data projects of the subspecialty societies, the AQI is tasked with collection and dissemination of data across the breadth of anesthesia practice in the United States, including groups from the largest universities to the smallest private practices. This will be accomplished by creation and administration of the National Anesthesia Clinical Outcomes Registry (NACOR).

Unlike the National Surgical Quality Improvement Project (NSQIP) of the American College of Surgeons, the NACOR will be broadly inclusive in pursuit of anesthesia data. The NSQIP conducts focused reviews and abstraction of randomly selected cases from participating institutions, at considerable cost in time and manpower. This has made it impractical for all but large centers to support. While the data gathered is useful, it does not represent surgical practice at the ground level. The NACOR, in contrast, will be based on the continuous, passive capture of digitized information from anesthesia billing systems, quality management programs, hospital information technology platforms and Anesthesia Information Management Systems (AIMS). Working through vendors of these products, the NACOR will build a database that begins with simple practice and case demographic information and then works iteratively “upward” toward more sophisticated clinical outcome and risk adjustment information. In this way it is intended to parallel—and to some degree influence—the “digitization” of medicine.

At the level of the individual practitioner, the AQI will solve a number of pressing problems. It will provide a common data collection and reporting format that will meet the needs of MOCA recertification;

“The AQI is tasked with collection and dissemination of data across the breadth of anesthesia practice in the United States ...”



the Surgical Care Improvement Project; hospital quality management efforts (including survey by The Joint Commission); and participation in federal data collections and subspecialty registry projects organized by the Society for Cardiovascular Anesthesia, the Society for Pediatric Anesthesia, the Society for Obstetric Anesthesia and Perinatology, SAMBA and others. The data itself will provide important benchmarking for both quality management and business applications, and participation in the AQI will open an educational channel that will be used to foster adoption of best practices across the specialty. For vendors of anesthesia information technology, the AQI will help to standardize formats and definitions and will encourage the dissemination of electronic platforms for collecting and reporting data.

At the national level, the AQI will provide demographic and “denominator” data to inform the ASA leadership’s efforts and provide context for the more focused efforts of the APSF, FAER and the Closed Claims project. Data in hand, it will be possible to influence important discussions in the Center for Medicare and Medicaid Services on the most appropriate performance standards for perioperative care. In an era of steadily increasing enthusiasm (and federal pressure) for comparative effectiveness research and adoption of electronic health care records, the AQI and the NACOR will provide credibility to the ASA in its efforts to guide the debate toward sensible standards with the greatest chance of providing benefit to our patients. Linkage with the Surgical Quality Alliance, a similar project just launched by a consortium of surgical societies, and the data efforts of the Association

of Operating Room Nurses will paint a picture of the perioperative experience that includes both detailed process data and long-term functional outcomes.

As a research tool, the NACOR will offer academic anesthesiologists a new and different resource for understanding clinical practice.

“Although still in infancy, the AQI is growing rapidly.”

In much the way that the National Trauma Data Bank and the Society for Thoracic Surgeons’ database have fostered an increased understanding of outcomes in the surgical specialties, the NACOR will provide a global look at anesthesia over time. Indeed, it is a strategy of the AQI to seek financial support through grants and contracts from federal agencies and private foundations anxious to build information technology infrastructure nationwide. This will lead to a series of hypothesis-driven studies leveraging the data capture mechanics of the NACOR to produce increased understanding of controversial areas of anesthesia practice.

Examples include the comparative effectiveness of pain procedures, the benefit of monitoring standards in outpatient anesthesia and the appropriate threshold for blood

transfusion during trauma and emergency surgeries. As a resource for contributing anesthesiologists and their practices, the NACOR will become the largest and most important “data mine” in our specialty, with the potential to contribute in part or whole to dozens of research projects in the next decade.

Although still in infancy, the AQI is growing rapidly. The technology for collecting and warehousing data is in place, alpha test sites are being recruited, data bridges are under construction from half a dozen IT vendors and the first case-specific data began accumulating in January 2010. The first reports of NACOR data appeared in July, and the first AQI Research Fellowship will be offered in January 2011.

Change comes quickly in the Information Age, and knowledge is power. This is the vision of the AQI: Information. Knowledge. Change. The power to improve the care of our patients.

More information about the AQI and the NACOR, including a contact address, is available through the AQI’s website, www.aqihq.org/Introduction.aspx. 

Visit the FSA Career Center

[HTTP://CAREERS.FSAHQ.ORG](http://careers.fsaHQ.org)

Position Seekers: Search hundreds of national positions for FREE. We offer anonymous CV posting, coaching services and custom position alerts.

Recruiters & Employers: Browse resumes for FREE, create a company profile and have your position broadcasted to seekers FREE.



NATIONAL POSITIONS FOR ANESTHESIOLOGISTS, RESIDENTS & MORE

Society News

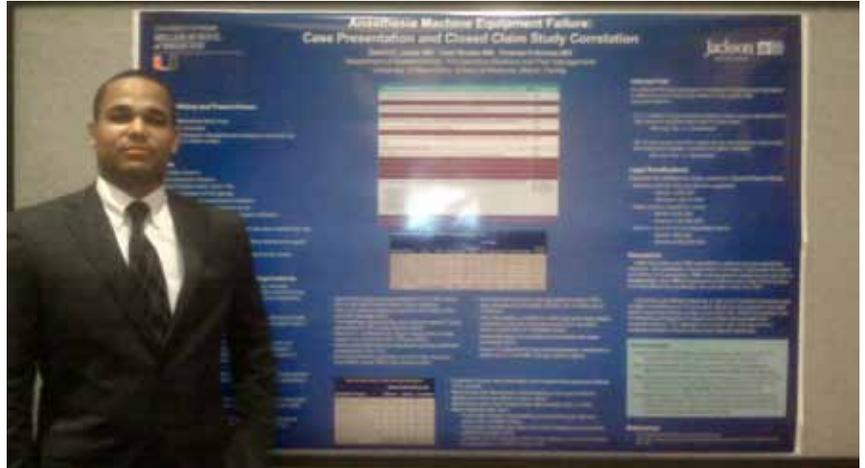
2010 FSA Annual Meeting Offers Something New— Poster Sessions

By Thomas Fuhrman, M.D.

Department of Anesthesiology, University of Miami Miller School of Medicine

There was something new for those fortunate to be able to attend this year's FSA annual meeting: poster sessions. FSA members submitted 20 posters that presented research and medically challenging cases. The posters, which were presented in three separate sessions on Friday and Saturday, were displayed along the wall in the exhibit hall. The authors were present for their sessions to smile bravely (as one of the residents described it) and to discuss their posters with the attendees. CME credit was offered for these sessions.

This was the first year for this type of session, and it was very successful. Next year the FSA will again sponsor poster sessions at the annual meeting. Plans for next year's sessions are not finalized, but a poster-discussion session is under review. It is anticipated that the submitters of the top three or four posters will be



Above: Dr. David Jones, anesthesia resident at the University of Miami, presents a poster that describes an equipment failure and subsequent follow-up showing resident education lacking in that area.

invited to orally describe their work and to take questions from the attendees in a special one-hour session. The Poster Committee is hoping to be able to offer prizes for the top posters at next year's meeting.

Look for the poster submission invitation in an upcoming FSA newsletter. [FSA](#)

Below: Drs. Krishnaprasad Deepika and Dhamodaran Palaniappan from the University of Miami's Department of Anesthesiology with their poster that describes a difficult case made easier with TEG monitoring



Above: Dr. David Varlotta combines the printed poster with his iPad as he presents a case of an embolism caught in real time with TEE.



Society News

New Ways to Educate the Public

By Al Rothstein, FSA Media Consultant

In the FSA's efforts to educate the public about patient safety and the role of anesthesiologists, we have two new opportunities—and we need your participation!

FSA on Facebook

We have created a new page on Facebook called “Your Safety During Surgery” specifically to inform patients and their families about topics such as

- surgery;
- questions to ask before surgery;
- separating good pain clinics from the bad ones; and
- how to measure their vital health.

In fact, visitors to the site can even take a vital health survey and get results that suggest how to improve their health. It is part of the ASA's Know Your Vital Health Campaign.

We have also posted videos and links to educate patients as well as information about malignant hyperthermia.

You can help us educate the public by joining Facebook and linking to our page. It is easy to register at www.facebook.com. Once you are a Facebook member, simply search for “Your

Safety During Surgery,” and you will be taken to the page. You can also find our Facebook page by clicking on the Facebook logo on the FSA's website, www.fsahq.org. You must still register on Facebook first.

Once you are on our Facebook page, you can then click the “like” button, which will link your page to ours. It will also allow you to get our updates on patient safety. These updates are ideal for your family members and friends, so please encourage them to join Facebook and link to our page. Those of you who are already Facebook members can send a note to your Facebook friends suggesting they “like” the page.

FSA Blog

We also have a new blog hosted by Donald Ayer, the father of Julie Rebenzer, who died after breast augmentation surgery in a Sarasota doctor's office because of an unqualified anesthesia provider. Mr. Ayer has been on a mission to improve office surgery around the country ever since. His personal story is at www.fsahq.org/blog.

You can participate by using the blog to post your thoughts on office surgery safety. We welcome you to use the blog to help us improve office surgery in Florida.

These are just two of the ways we are reaching out to the public. Your involvement is a critical part of that! **ASA**



ASA Directors' Report



ASA HoD Takes Action on Practice Issues, Administrative Issues

By David Varlotta, D.O., Director, and Jeff Jacobs, M.D., Alternate Director

The Florida Society of Anesthesiologists sent 21 delegates and alternate delegates to the American Society of Anesthesiologists' annual meeting in San Diego, Oct. 15-20, 2010. The delegation participated in two FSA Caucus meetings, two Southern Caucus meetings, two ASA House

"We express our sincere thanks for the time and effort they devoted to these important professional activities."

of Delegates meetings and various reference committee meetings, as well as served as ASA committee members. We express our sincere thanks for the time and effort they devoted to these important professional activities.

The ASA HoD presented, debated and ruled on important issues under consideration. Some will affect the practice of anesthesia while others will affect the way the society is managed and the direction it will take in the future.

Anesthesia Practice Issues

The HoD **approved** the following:

- Update of Practice Guidelines for *Preoperative Fasting and the*

Use of Pharmacologic Agents to Reduce the Risk of Pulmonary Aspiration: Application to Healthy Patients Undergoing Elective Procedures

- Update of Practice Advisory for the *Perioperative Management of Patients With Cardiac*

Implantable Electronic Devices: Pacemakers and Implantable Cardioverter-Defibrillators

- Update of Practice Advisory for the *Prevention of Perioperative Peripheral Neuropathies*
- Update of the Standards for *Basic Anesthetic Monitoring*
- Advisory on *Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners*
- Adoption of the CDC's *Syringe Single Use* recommendation. This advises needles and syringes are single use devices and should not be refilled. Complete information can be found on the CDC's website at www.cdc.gov/injectionsafety/.

- Adoption of the ASA-ACOG's joint statement on *Optimal Goals for Anesthesia Care in Obstetrics*, which has been updated to reflect the fact that ACOG has revised its committee opinion on "vaginal birth after previous cesarean delivery." While this statement still recommends such trials of labor be undertaken in "facilities with staff immediately available to provide emergency care," ACOG now notes that trial of labor after cesarean section (TOLAC) may be undertaken in facilities without such staffing after discussion of the risks and benefits with individual patients.

These documents will be posted on the ASA's website in the coming weeks.

The HoD **disapproved** the following:

- Practice Guidelines for *Central Venous Access*. The ASA in the coming year will evaluate a wide range of members' bias toward the use of ultrasound for CVP placement before issuing revised guidelines.

The ASA HoD initiated projects that would affect anesthesia practice in the future. Two are detailed below.

AIMS

Creation of an Electronic Medical Records with “meaningful use” is a goal of the United States government. An ASA committee will study impediments to AIMS implementation, essential AIMS functionality and how AIMS use can be defined as “meaningful.” The committee will develop a timeline and guidelines aimed at making easier and more rapid implementation of AIMS possible.

ASA Quality ‘Seal of Approval’

A demonstration project will be initiated to determine the potential for, and the feasibility of, creating a program allowing ASA members, groups or hospital departments (or their respective hospitals) to demonstrate a level of quality practice and safety that exceeds minimum standards and contains elements of excellence the ASA wishes to exemplify.

ASA Administrative Issues

Land Use

The ASA owns approximately seven acres of land at its Park Ridge headquarters. The current building is too small to adequately serve the society and its members, and the adjacent land has been deemed not suitable for a new headquarters building. The ASA’s Administrative Council and Section on Fiscal Affairs will be looking for new land in the Chicago area while plans are drawn up for a new headquarters. The estimated cost of this project is approximately \$20 million. The HoD agrees this expenditure is in the best interests of the society and its members.

Advocacy

Considerable discussion took place at the caucus and HoD levels concerning the ASA’s Washington office. Many delegates expressed concern the D.C. office is understaffed and underfunded to deal with implications of the new National Health Care Law and resulting regulations. The D.C. office is adding four new employees and will continue to evaluate staffing concerns in an effort to assure resources are properly appropriated to meet the demand for ASA advocacy.

The ASA-PAC raised a record amount of money this year and election cycle. Florida won the Alabama Cup (a trophy) for most money raised by a state and for the greatest number of individuals contributing. We thank all those who have contributed and those who encouraged others to contribute. Of special note is the effort Michael Lewis, M.D., dedicated to this effort.

Leadership Update

At the conclusion of the meeting, Mark Warner, M.D., of Mayo Clinic Rochester assumed the role of ASA president, and Florida’s own Jerry Cohen, M.D., ascended to the office of ASA president-elect. Michael Lewis, M.D., was elected vice chair of the Southern Caucus and began his term on the ASA-PAC board of directors. Hector Vila, Jr., M.D., stepped down from his position on the ASA-PAC board of directors as well as from his leadership position in the Southern Caucus. We sincerely thank him for all of his efforts.

The terms for those elected to ASA office as members of Florida’s

delegation began at the conclusion of the meeting. We would like to thank those individuals whose terms have expired and who will no longer be serving. Your time and effort were invaluable. We encourage you to remain involved. The ASA committee application process begins soon. If you are interested in serving on an ASA committee, you will have to self-nominate using the ASA’s website. When you self-nominate, please let Drs. David Varlotta, Jeff Jacobs and Sonya Pease know. We are required to send a recommendation on your behalf. 



Applicants Approved

ACTIVE

Igor Ianov, M.D.
Atlantic Beach

Kathryn H. Bietenholz, M.D.
Jacksonville

Baiju P. Sheth, M.D.
Tampa

Ronak A. Patel, M.D.
Jacksonville

Ronda J. Garcia, M.D.
Jacksonville

Evan Bloom, M.D.
Maitland

Michael G. Katos, M.D.
Gainesville



Calendar

Thursday, December 9, 2010
7 p.m. Eastern

FSA Board Meeting
Telephonic meeting

March 2011

FSA Board Meeting

Date and time TBD
Held in conjunction with the FSA legislative visits at the state Capitol Tallahassee, Fla.

May 2-4, 2011

ASA Legislative Conference
Washington, D.C.

Thursday, June 9, 2011
5 p.m. Eastern (tentative)

FSA Board meeting
The Breakers Resort & Spa
Palm Beach, Fla.

June 10-12, 2011

FSA Annual Meeting
The Breakers Resort & Spa
Palm Beach, Fla.

*To reserve your room for the FSA 2011 Annual Meeting, call the hotel at 888/278-2537 and mention the FSA to receive the group rate of \$215 (plus tax, single or double occupancy up to two adults) per night.

July 28-31, 2011

FMA Annual Meeting
Disney's Contemporary Resort
Orlando, Fla.

October 15-19, 2011

ASA Annual Meeting
Chicago, Ill.

June 8-10, 2012

2012 FSA Annual Meeting
The Breakers Resort & Spa
Palm Beach, Fla.

Florida CME Events

The American Society of Anesthesiologists sponsors CME courses throughout Florida. For a complete listing of ASA educational opportunities, visit <http://events.asahq.org>.

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District Director 1 North
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District Director 1 North
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District Director 2 Central
Clarkson Driggers, M.D.

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District Director 5 South
David Birnbach, M.D.

District Director 5 South
Steve Gayer, M.D.

District Director 5 South
Melvin Gitlin, M.D.

ASA Delegates

ASA Director, Florida
David Varlotta, D.O.

ASA Alternate Director, Florida
Jeff Jacobs, M.D.

ASA Delegate 1 North
Richard Henry, M.D.

ASA Delegate 2 Central
Rebecca Welch, M.D.

ASA Delegate 3 West
Kurt Markgraf, M.D.

ASA Delegate 4 East
Sonya Pease, M.D.

ASA Delegate 5 South
Michael Lewis, M.D.

ASA Delegate 6 At Large
Eugene Fu, M.D.

ASA Delegate 7 At Large
David Lubarsky, M.D.

ASA Delegate 8 At Large
Jeffrey Jacobs, M.D.

ASA Delegate 9 At Large
Jay Epstein, M.D.

ASA Delegate 10 At Large
Charles Chase, D.O.

ASA Delegate 11 At Large
Hector Vila, Jr., M.D.

ASA Delegate 12 At Large
Rafael Miguel, M.D.

ASA Delegate 13 At Large
Gary Richman, M.D.

ASA Delegate 14 At Large
J. Knox Kerr, M.D.

ASA Delegate 15 At Large
David Whalley, M.D.

ASA Delegate 16 At Large
Jonathan Slonin, M.D.

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