LSA Welcomes our First Medical Student Committee

Allan Parr, L4, LSU-Shreveport

LSA is excited to announce the beginning of its first medical student committee and medical student ambassador program.

The vision for LSA student committee is to build a network of Louisiana medical students to represent LSA as student members and boost LSA student involvement. All Louisiana medical students across LSU-New Orleans, LSU-Shreveport, Tulane, and UQ-Ochsner are encouraged to join LSA.

Our goal is to create a multi-institutional platform for Louisiana medical students interested in pursuing careers in anesthesiology. I believe this will be a great opportunity to share the ideas of like-minded individuals across the state of Louisiana and build strong connections among our future anesthesiologists. In addition, LSA offers its student members valuable networking opportunities to connect with LSA members and local leaders in anesthesiology.

We have begun recruiting 1-2 medical students per school to serve as LSA ambassadors for their school. Student ambassadors will represent LSA at all AIG meetings, serve as liaisons for their school’s LSA members, participate in state-wide ambassador meetings, and attend the LSA annual conference.

For the future, the LSA student committee plans to offer unique opportunities, learning experiences, and awards for applicable LSA student members. This will include leadership opportunities, shadowing opportunities, writing/research, volunteer work, social events, meetings, etc.

Save the Date for the 2020 LSA Annual Meeting. Louisiana Anesthesiology 2020
April 17-18
New Orleans, LA
organization. Finally, the catch is this forgiveness program ONLY applies to your William D. Ford Federal Direct Loan Program. Indirect loans or Federal Family Education Loans (FFELs) are not included, however if you consolidate your loans under a Direct Consolidation Loan then they may qualify. There are a lot of stipulations, so some homework is needed to help there. Needless to say, even a $80,000 exemption is worthwhile.

**3-Moonlighting.**

I'm sure that's what everyone was wanting to hear about. As a medical resident you are “legally allowed to provide medical care as a licensed physician and receive direct financial compensation in return for services,”1 however, not all medical residency programs are created equal. In almost all circumstances you must have prior authorization approved by a supervisor to moonlight, and that’s only after 2 years of residency training. In addition, the Accreditation Committee for Graduate Medical Education (ACGME) caps the number of “combined educational and work hours for residents”2 at 80 hours per week. Basically put, not all residency programs allow it, it must not interfere with your normal duties, and you can’t exceed 80 hours per week. Another hot topic that you may need to do your homework on if you’re considering.

Finances are often awkward to talk about and consider, however you too can manage the pitfalls and heavy expenses associated with medical training by researching a little bit on your own and by continuing to read this Newsletter.

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**HOW DID LOUISIANA DO ON ASAPAC DAY OF CONTRIBUTING (DOC)?**

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<th>The rankings for Louisiana in the three categories are as follows:</th>
<th># of Donors - #2</th>
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<td>Louisiana had 46 donors and raised a total of $7,087.47 for the June 20, 2019 ASAPAC Day of Contributing (DoC)</td>
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Residency application season is upon us. If you are a 4th year medical student, it is fair to say you are stressed out, just like I am. The anxiety starts before even starting the ERAS application. How do you even pick the programs you want to apply to? How will you afford to apply to the programs you end up deciding on? And what are the chances of you matching into these programs to begin with? These questions are valid and scary. Then there is the whole complicated process of choosing which of your attendings you will ask to write your letters of recommendations, preparing for interviews, and strategically ranking programs.

Navigating this complicated process can be made easier by using the following three resources:

1-Talk to a recent graduate friend.
Even if that friend is not applying to the same residency you are applying to, their advice can be valuable. They have been through the process last year and it ought to be fresh in their mind. Hopefully they can share valuable reflections. Finding someone who matched into anesthesiology will be even better.

2-Setup a meeting with your home institution’s residency director.
Not only is their input useful to assess your competitiveness in general, but they can also provide helpful tips about away rotations, asking for letters of recommendations, and pitfalls to avoid during the application process and on the interview trail. Residency directors are experts in terms of what programs want to see in your application. They also want their home institution’s applicants to be successful in the match whether at their institution or elsewhere.

3-Talk to your school’s Anesthesia Interest Group (AIG).
The AIG team members (President, VP, etc.) might be very helpful in various ways. They can get you in touch with recent graduates and connect you to many leaders from your home institution’s anesthesia department. Your AIG might also help get you involved in research and share some of their personal experiences while rotating through anesthesia at your home institution or elsewhere. Reaching out to AIG becomes even more important for students in their 3rd year, as the insight of upper classmen can be very helpful.

Applying to residency is a stressful process that very few people can relate to, but you don’t have to do it alone. Remember to lean on those who have gone through the process before you and those who are going through it with you. And don’t forget there is light at the end of the tunnel. Others have made it, so it’s doable right?
Some would argue that public engagement for physicians is not a priority, or even a little taboo. For physicians, public engagement encompasses all the ways in which they communicate with people outside of the traditional medical sphere. With today's society moving toward audio/video platforms as their preferred means of staying connected, it is no wonder that doctors have utilized various forms of media (i.e. blogs, podcasts, Twitter, Instagram) to interact with their community at large.

Meet Peter Kim, MD and David Draghinas, MD, both anesthesiologists, who also happen to be a successful financial blogger for “Passive Income, MD” and a podcast host of “Doctors Unbound,” respectively. I spoke to both recently by phone for this article. Take a look at how each has come to master the art of media by first stepping outside of his comfort zone.

Dr. Kim was a full-time husband, father, dog-dad, and physician, and he found himself searching for a financially rewarding endeavor that would be an improvement to his work life balance and not also require his physical presence.

He started experimenting with ways to earn income passively – investing in stocks, real estate, and a variety of other businesses that make up his “investment collection.” To Dr. Kim, maintaining a diverse financial portfolio is as exciting as it is strategic. The more entrepreneurial he became, the more his peers took note and encouraged him to “share the wealth.” “Passive Income, MD” was born as he began documenting his personal cash flow campaign.

Dr. Kim had never seen himself as a strong writer, which is essentially what delayed his media debut. However, he realized that “people connect more with the message and not necessarily the articulation.” Like many of his colleagues concerned with job security, physician burnout, and an ever-present student debt, Dr. Kim believed that if he could procure income passively while continuing to practice, he could counter some of these stressors. Thus, what started as a few savvy side-hustles riddled with a few missteps, eventually led to financial freedom.

Through his blog, Dr. Kim hoped to help other doctors achieve financial independence so that they can continue to work in medicine without burnout. Whether that be fewer shifts or more time spent with individual patients or teaching. Dr. Kim’s theory was that if passive income could alleviate some of the stressors tied to the profession, doctors would lead more sustainable practices and would continue to work out of passion, rather than obligation.

Dr. Draghinas, or Dr. Dave, also a full-time family man, began to notice the physician image in the media more commonly portrayed in a negative light.

He often wondered, if doctors are such experts in their field, and pursuing additional roles, then why is their prestige in the workplace going down? As many are now CEOs, politicians, authors, life-coaches, tech-gurus, etc, Dr. Dave decided to shed light on all these fascinating individuals by creating an interview-based podcast, “Doctors Unbound.” He believed that by sharing these unique stories, he could create both a resource and a community that fostered a mutual learning environment for some of the soft skills (i.e. writing, public speaking, etc.) that were never taught in medical school.

Similar to the delay Dr. Kim experienced in launching his blog due to self-criticisms as a writer, Dr. Dave contemplated his podcast idea for years, because he too, doubted his public speaking skills. Dr. Dave points out that many doctors sabotage their own creative pursuits outside of medicine because of the fear of being perceived as less-refined or
As fourth year started, I embarked on my surgery elective. I was in the OR. I thought I knew then that I wanted to be a surgeon. I even enjoyed the smell of the bovie. I loved every minute to the operating theater. I was intrigued by every aspect of place in the hospital. I knew that I had found myself drawn to surgery. However, it wasn't until the surgery rotation that I found my specialty had nuances that made the specialty interesting to me. But, it wasn't until the surgery rotation that I found my specialty had nuances that made the specialty interesting to every single one of my the core rotations. I felt that each specialty had nuances that made the specialty interesting to me. But, it wasn't until the surgery rotation that I found my place in the hospital. I knew that I had found myself drawn to the operating theater. I was intrigued by every aspect of it. I loved the ceremonious acts of scrubbing in, the first cut, I even enjoyed the smell of the bovie. I loved every minute I was in the OR. I thought I knew then that I wanted to be a surgeon.

As fourth year started, I embarked on my surgery elective. That's when I noticed things started to change. Every time I stated I was on the surgery pathway I was met with interesting “are you sure?” looks. However, I was never one to shy away from hard work, long hours, and intense pressure. It’s where I thrived and did some of my best work. I continued to press on. My day to day routine was: wake up at 4:00AM, be at the hospital by 4:30AM, pre-round on my patients, participate in resident rounds and then head to the OR. Of course the day did not end there. After the surgeries I would go to the clinic, and then attend afternoon rounds. I found myself leaving the hospital “late” every day, but still earlier than that of surgery residents. I was exhausted, physically and mentally. I found myself having limited time to take care of myself and maintain meaningful relationships. I would stop at the drive-thru and eat on the way home, read up on my patients and surgeries for the next day, and then go to bed. Every day was the same. I felt as if I was stuck in the movie Groundhog Day.

My friends, family, and I started to question if this was really the right career for me. I was older than my fellow students and considered a non-traditional female medical student. As my parents would put it, I'm no “spring chicken.” I started to ask myself what were the things I really wanted to accomplish in my professional and personal life. I know that I wanted the option of having a family, I wanted to be available for major events in my siblings' lives, and I wanted to fulfill my duties to my aging parents. I started to question, could I really do this with a surgery residency? Could I do it with any residency? How could I be a good doctor, sister and daughter?

I watched as my colleagues settled into a chosen specialty and began the residency application process, but for me it felt like I was back to the drawing board. I knew I loved the OR, working with my hands, and I thought I worked well under pressure. What did I want to do for the rest of my life? It was then that my friend suggested anesthesiology. My only exposure to this specialty so far had been through surgery. Who were those guys on the other side of the ether screen? I knew that if I wanted to learn more, I had to be proactive. I started to reach out to the staff anesthesiologists to see if they could point me in the right direction. To my very pleasant surprise, I was met with a warm and welcoming reception. Everyone I encountered was so excited when I expressed interest in anesthesia, which was quite different from previous experiences.

On my first day, I was directed from one operating theater to another. I participated in minor surgeries and major transplants. I saw pediatric and geriatrics patients, patients that were frail to the morbidly obese, the stable to acutely unstable and all things in between. I noticed the breadth and depth of knowledge that was demanded from the residents and attendings. There was also a huge sense of camaraderie within the specialty. As I finished my week on anesthesia, I felt excitement. It checked all my required boxes: I was in the OR, I was working with my hands, there was the inherent pressure, and most importantly, I was happy. I can see myself being able to obtain all aspects of my personal goals. Although my path to anesthesia started with surgery and took me to a “mid school crisis”, I’m glad it happened. It allowed me to find something that I was just as passionate about but that did not require me to compromise my personal goals; with anesthesia I can be a great doctor, sister, and daughter.

When asked, “if you could give one piece of advice to your medical student self, what would you say?”

**Take control of your finances early, it will ultimately shape your ideal life and career.**

*Dr. Peter Kim, Obstetric Anesthesiologist at Cedars-Sinai in Los Angeles*

Focus on your medical training and becoming the best doctor you can. Once you do that, start trying things out, soft skills that you can stack on top of your medical expertise. You then will be a medically trained expert with unique skills who can provide something special to your community.

*Dr. Dave Draghinas, Anesthesiologist at a private practice in Dallas*

**Why I Ultimately Chose Anesthesia over Surgery**

*Ly Zhang, MS4, UQ-Ochsner Clinical School*

I was one of those students that found myself enjoying every single one of my the core rotations. I felt that each specialty had nuances that made the specialty interesting to me. But, it wasn't until the surgery rotation that I found my place in the hospital. I knew that I had found myself drawn to the operating theater. I was intrigued by every aspect of it. I loved the ceremonious acts of scrubbing in, the first cut, I even enjoyed the smell of the bovie. I loved every minute I was in the OR. I thought I knew then that I wanted to be a surgeon.

As fourth year started, I embarked on my surgery elective. That's when I noticed things started to change. Every time I stated I was on the surgery pathway I was met with interesting “are you sure?” looks. However, I was never one to shy away from hard work, long hours, and intense pressure. It’s where I thrived and did some of my best work. I continued to press on. My day to day routine was: wake up at 4:00AM, be at the hospital by 4:30AM, pre-round on my patients, participate in resident rounds and then head to the OR. Of course the day did not end there. After the surgeries I would go to the clinic,
It was a flexible and self-directed rotation, so I chose the surgeries I wanted to see. I really enjoyed cardiothoracic anesthesiology, and spent a week in the cardiac OR. I will never forget the first time I saw someone’s lungs breathing and the heart beating in an open chest. I’ve never felt so close to both life and death. I was captivated. Everyone in the room had a critical role; one false move could be detrimental. Diligent communication between the nurses, surgeons, anesthesiologists, and perfusionists was vital. I loved feeling a part of a bigger team, each piece an integral component of the whole. The heightened energy in the room was enthralling and kept me coming back.

The next week I wanted to appreciate a mix of anesthetic procedures, so I spent a few days going to neurosurgery cases and then to maxillofacial surgeries. The physicians and anesthesia residents also gave me recommendations to cases they thought would be especially interesting. Each day I learned something completely different from the last day. I really appreciated that the residents and doctors made every effort to involve me and ensure I was in the front line of each procedure. At the end of every day, I felt a sense of accomplishment and professional growth.

Similar to the lecture series given at Ochsner, UMC weekly lectures enhanced my learning and overall experience of the rotation. Every Thursday, the residents and medical students presented short topics in anesthesia and a visiting professor or program director discussed salient issues in medicine. This allowed me to meet diverse people in anesthesia and to expand my academic network.

Overall, I gained an invaluable experience from the several weeks I spent with the various anesthesia teams. I feel especially grateful to have split this time at two excellent institutions which diversified the learning experience daily. Without a doubt, I would recommend spending time with the department of interest at your home institution, but also seeking out away opportunities if possible.
Anesthesiology in Medical School:

An Argument in Favor of More Experience from the Inexperienced

James O'Malley, MS3, UQ-Ochsner Clinical School

What anesthesiologists do on a day to day basis may not be familiar to many medical students. When asked what an anesthesiologist does, a medical student might give a fine textbook answer about the perioperative management of patients. But to really know about the perioperative management of patients, one must gain hands-on experience in the field of anesthesiology.

For many programs including the University of Queensland – Ochsner Clinical School, this is a 4th year medical school endeavor that is allotted minimal time. By this point in time during 4th year, many medical students have already decided on their path without having had any real experience in the field of anesthesiology. Typical rotations for the 3rd year of medical school include internal medicine, surgery, pediatrics, OB/GYN, and psychiatry. One could easily argue that an anesthesiology rotation belongs among these.

Lack of exposure to anesthesiology prior to the 4th year of medical school is detrimental to the field. One could speculate that without this exposure, many who would have gone into the field do not. This reduces the volume of applicants and therefore it reduces selectivity.

Waiting until 4th year to do an anesthesia rotation is also detrimental to the individual student because it could help quite a bit to start networking and looking for research opportunities as a 3rd year.

Doing a rotation in one's field of interest makes networking and finding research opportunities far easier.

In closing, anesthesiology is an amazing field that deserves a rotation during the 3rd year of medical school. The benefits of a move like this could reverberate throughout the medical field for years to come as fewer quality anesthesiology applicants would be lost on a yearly basis. Furthermore, medical students interested in anesthesiology would benefit in networking and research opportunities that could lead to residency spots.
Ultra-Cool Ultrasounds

University of Queensland-Ochsner Cohort students were treated to a special workshop on April 25th, 2019: ‘Ultrasound Use and Operation’ led by Dr. Yashar Eshraghi. Dr. Eshraghi is the Medical Director of Pain Research in the Division of Pain Management at the Ochsner Medical Center. As an aside, this event was my first time ever attending an Anesthesiology Interest Group meeting and acted as the catalyst for my interest in Anesthesiology!

The workshop began with an informative PowerPoint peppered with funny anecdotes from Dr. Eshraghi. He taught us how he uses ultrasound in his day-to-day work and about techniques in angling the probe to get the best view on the ultrasound screen.

As a third-year medical student, with very little exposure to Anesthesiology, I was unaware that ultrasound was used so heavily in this specialty.

Dr. Eshraghi pointed out what we were looking at on the ultrasound screen, such as the differences between what subcutaneous fat looks like in comparison to muscle, and how to differentiate an artery from a vein.

After this presentation, students got some hands-on practice time with the ultrasound machines in the simulation lab. We used each other as vascular models, which left us with very sticky forearms from the ultrasound gel! We also practiced placing IVs into mannikin arms using the ultrasound machine for guidance towards the veins.

All in all, the afternoon was a ton of fun and very informative. Dr. Eshraghi gave great instruction about ultrasound and made at least one third-year student in the workshop want to join the LSA and become an anesthesiologist.
2019 ELECTIONS MEMO – LOUISIANA
Haynie and Associates, a Louisiana lobbying and government relations firm
http://www.haynieandassociates.com/

2019 IS AN ELECTION YEAR:
All 105 House and 39 Senate seats are up for election.
Louisiana holds statewide elections every four years. This year all 105 House and 39 Senate seats, the Governor, Lt. Governor, Attorney General, State Treasurer, Secretary of State, Insurance Commissioner and Commissioner of Agriculture are all up for election. This is a big year!
Legislators were term limited to 12 years back in 1995. So term limits initial impact was 12 years ago and we are again seeing a very large group of members hitting their 12-year term limit and retiring this cycle.
Governor John Bel Edwards’ (D) re-election is being challenged by two Republican candidates – Congressman Ralph Abraham (R) and Businessman Eddie Rispone (R)

IMPORTANT DATES:
August 6-8 Candidate Qualifying – all legislative and statewide positions
October 12 Primary Election (Louisiana has ‘open’ or ‘jungle’ primaries - where the top two candidates with the most votes move to the runoff – even if in the same party)
November 16 Runoff Elections
January 13, 2020 Swearing in and new process of an independent/secret ballot election of NEW Speaker of the House and President of the Senate followed by committee chairs and committee assignments announcements during early February
March 9 - June 1, 2020 Regular non-fiscal session

LARGE TURNOVER AND SHIFTING POLITICS:
16 of the 39 Senators are term limited, resulting in open seat races and a huge loss of instructional knowledge in the Senate. Many House members are looking to “move up”
31 of the 105 House members are term limited, and another 20 House members have been elected in special elections since the 2015 election cycle
Most anticipate a more independent and conservative legislature for 2020-2024
New leadership across the board from President of the Senate and Speaker of the House to most committee Chairmen
Governor’s Race will be a main focus in the media, but the House and Senate races will set the tone for legislative agendas 2020-2024

Political Advocacy from a Medical Student’s Point of View
Alan Boiangu, MS3, UQ-Ochsner Clinical School

I began my 3rd year of medical school knowing only two things. I wanted to be an anesthesiologist and I wanted this to be the year that I broke into the field as more than just a student fresh off his pre-clinicals. Early in the year, I knew that I had to reach out to the faculty here at Ochsner and let them know about my interest in the field. It started with a meeting here and there, maybe a research project, but nothing that truly made me feel like I was making great strides toward my goal of matching into anesthesiology. That was the case until I met one of the attending anesthesiologists here at Ochsner, Dr. Joseph Koveleskie. He introduced me to some of the political aspects of a career in anesthesiology and encouraged me to attend the ASA Legislative Conference in Washington D.C. Until then, I had only heard about the annual October ASA conference, happening in Orlando in 2019, which I knew I'd like to attend to learn more about the field and to network. I decided to take the opportunity to go to learn about politics and healthcare.

Arriving in D.C., I didn't know what to expect. All I really knew was that this conference was politically themed and it was open to attendings, residents, and even medical students. Needless to say, I learned a lot about both the profession and its obstacles in the near future. Being a lowly medical student, thinking about Medicare reimbursements and the issue of scope of practice in the nursing field seemed so far removed from where I was in my career. However, I learned that these issues involve all of us, from those just starting out, to those established in the field. The student loan issue really spoke to me. I know first-hand what it is like to just borrow and borrow with seemingly no end in sight. At this point, I have become so desensitized to that ever-increasing number, that I just keep telling myself that “my career is priceless.” It is very disconcerting, and a little legislative relief would definitely be welcome!

I feel like the ASA Legislative Conference gave me a voice. I was able to go up on Capitol Hill and allow my concerns to be presented to people that have the power to affect change.

I have to say, political advocacy is something I’ve never personally done, so I can’t say my first rodeo was particularly impressive. However, I felt a bit of an adrenaline rush advocating for a profession I’m not even a part of. It felt like an opportunity to say, “I care about more than just my success, I care about everyone’s success in this great field.” I believe doing this will make me a better doctor and a better advocate for doctors and patients everywhere and I cannot wait for next year.
Females are well on their way to closing the gender gap in medicine, currently comprising 35% of U.S. physicians, and 25% of anesthesiologists. However, the gap is still present in medical leadership, with females comprising only 16% of all medical deans and department chairs in the U.S.

Dr. Julie Broussard not only works as a full-time anesthesiologist, but she is also the Chief Anesthesiologist for Parish Anesthesia of Lafayette, the Lafayette General Health System Anesthesiology Director, the LSA Acadiana Division Board Member, and the Louisiana Alternate Director for the ASA.

She held an assistant medical director position right out of residency, and then was appointed as medical director soon after moving to her hometown of Lafayette. She believes her leadership potential, willingness to help with a new vision and direction of the hospital, and experiences of leadership from the past are what have given her the upper hand in her career. She has kindly offered to share her journey, how she traversed these obstacles, and advice for aspiring leaders in anesthesiology.

The Gap
Dr. Broussard denies ever being discriminated against by peers for being a female physician. In fact, she recalls always being “respected and even applauded by (her) partners for being able to take on extra tasks in (her) career while busy raising children.” She finds that it is the lay people, surprisingly often other women, who have a hard time recognizing women as physicians. Dr. Broussard states that almost daily, she has patients that refer to her as “Miss Broussard” or automatically assume she is a nurse. This confusion of title does not let these errors in credentials bother her, but does reinforce to her patients her role in their care. On the flip side, Broussard talks about the advantages of being a woman in anesthesia. Because she is the only female member of her group, she is requested frequently on cases for both women and children. She states that often women want other another woman in charge of their care in an attempt to retain some modesty while asleep in the operating room. Along that same line, she is often requested to provide care for her colleagues and their loved ones. She attributes this, in part, to her “mother bear” nature of being protective and attentive to their needs of comfort.

Pro tips
I asked Dr. Broussard for any advice she had for rising female leaders in medicine. The following is an excerpt from her response: “First of all, promote other females; manage your female colleagues up when opportunities arise. In my experiences, ladies have a natural ability to multi task better than anyone else; women are usually great at team building and communicating. My motto has always been to answer requests with ‘I’d be happy to help’ even when there is no apparent benefit to me. I’ve come to realize that policies, rules and protocols are created by the people who agree to sit at the table. I’d much rather ‘be in the room that it happens’ [sic] to take a quote from Hamilton, (referring to the song “The Room Where It Happens” from the 2015 Broadway musical Hamilton), than to just sit back and hope that someone else understands my group and profession’s interests and will speak up for us. Most people shy away from making decisions for others because of the fear of failure or unpopularity. All people really want is a leader who will make a decision based on thoughtful consideration and have the flexibility to change when things aren’t going as well as planned. Be that kind of leader.”

Hindsight is 20/20
Dr. Broussard gives some words of advice to her medical student self:
1. Give up the idea of perfection and instead strive for the idea of being exhaustively experienced.
2. Run towards, not away from, challenging cases and difficult situations.
3. Learn to be comfortable with being uncomfortable.
4. Realize that “this is how we have always done it” is never the correct answer.
5. Leadership is not about the leader, it’s about the movement of the group. Stand up for what you believe in even if it makes you the lone nut; if you are passionate about something, be inviting and leave room for your first follower.

LSA Goals & How You Can Help Accomplish Them
1. Increase Membership
   - There are still physician anesthesiologists who are not members of ASA or LSA. Urge your colleagues to join.
   - JOIN or RENEW
   - LSAAPAC.ORG

2. Contribute to LSAPAC
   - On average 15% of LSA members contributed to the LSAPAC. We would like to reach at least 30%.
   - LSAPAC.ORG

3. Contribute to ASAPAC
   - Despite tremendous effort, less than 46% of LSA members contributed to the ASAPAC. We want to increase to 60%.
   - ASAHQ.ORG

4. Increase Participation
   - Join a committee, become an LSA Ambassador, write for the newsletter, attend the LSA Annual Meeting.
   - GET INVOLVED

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Commencement Address at the Emory Anesthesiologist Assistant program

Kraig S. de Lanzac, M.D., FASA
ASA Assistant Secretary, LSA Immediate Past-President

Over the weekend of August 9 – 11, 2019, I had the honor and privilege to deliver the commencement address at the 49th graduation ceremony from the Emory School of Medicine Master of Medical Science Program in Anesthesiology. This program is better known as the Emory Anesthesiologist Assistant program. Graduates from the 27 month program are eligible to sit for the Certifying Exam for Anesthesiologist Assistants and then become anesthetists practicing under the medical direction of an anesthesiologist. Currently AAs are able to practice in 17 jurisdictions, but Louisiana is the only state where they are specifically not allowed to practice by law.

My weekend in Atlanta started off with a tour of the very impressive Emory AA program facility. This facility houses the faculty and staff of the program as well as a state-of-the-art conference room, simulation center, and plenty of room for students to learn and study when not on clinical rotations. Students of the Emory program spend a minimum of 2500 hours on clinical rotations during their training and education with more than 50 different clinical sites.

I had the privilege of addressing all of the underclassmen on Friday afternoon and they were captivated as I described how the Louisiana statute, which excludes them, came to be in 2004. The subject matter was important enough to them that they stayed despite the fact that it was late on a Friday afternoon. A few of the AA students and AA faculty were especially interested as they have ties in Louisiana, but as a result of current law, are prohibited from coming home and practicing in Louisiana. On Friday night I was able to have some relaxed time at dinner with many of the AA faculty members including some that I have known for years and one, Richard Brouillard, ScD, MMSc, who I worked with on an accreditation review of the Case Western Reserve Master of Science in Anesthesia Program almost two decades ago.

On Saturday morning, a beautiful and meaningful graduation ceremony took place. It was very special to see these young students who have worked so hard, and paid a lot of tuition, walk across the stage into the next phase of their lives. After awards were given out, I addressed the graduates, faculty and their family and friends on the importance of always being human in their interactions with their patients, no matter how busy, tired or frustrated they are. Specifically, I focused on the use of the word “human” as an adjective defined as, “representative of or susceptible to the sympathies and frailties of human nature.” I walked the audience through the patient journey before, during and after anesthesia and described the tremendous impact they can make on the patient’s experience and well-being with just a little effort. I explained that these are lessons that all of us, including this author continue to learn.

Overall, it was a very rejuvenating experience watching these young professionals transition from student to graduate. It was an honor to be even a small part of the celebration and a weekend I will not soon forget. I thank the entire staff and faculty of the Emory program for allowing me this special opportunity.
This "takeover edition" newsletter was conceived while chatting with Sarah Vitug, a 4th year UQ-Ochsner* medical student interested in anesthesiology. Sarah comes from San Diego, CA where she studied pre-med and journalism. It was a natural fit for her to use her journalism experience for LSA. Sarah and her team have done a nice job of writing articles from the medical student's perspective. That perspective may not seem so accessible to those of us who are years out from training, but take a moment to think back when you were in their shoes.

Their words convey the joyful novelty of discovering what that person did behind the drape in the OR, the excitement and uncertainty of applying to residency, and the anxiety over their future ability to get a job and repay loans. Most of us can relate to that. Join me in saluting their effort on this newsletter, but more generally join me in welcoming these and all the other anesthesia students and residents in Louisiana entering our specialty. These are our future colleagues, possibly some are our future bosses, and almost certainly many of these will be the physicians who will take care of us and our families as we age and need surgery. They are indeed soon enough "taking over."

The good news is that we have lots of young, eager, intelligent faces still wanting to practice anesthesiology. Now the not so good news. We currently face and will likely continue to face major political challenges in the healthcare system.

For example, the current most concerning issue is the out-of-network billing problem that the states and now the federal government are trying to "treat or cure" with major legislation. Be afraid. Even if this doesn't seem like a big deal to you now in your practice, I tell you I am worried, ASA is worried, you should be worried. This is a major issue and worthy of your attention. The problem for us right now is that two out of the three proposed bills currently at the federal level are major windfalls for the insurance industry at guess who's expense? Yes, ours. It is a tough issue to understand and to explain even to fellow physicians. A surgeon that I know sees no problem. He thinks yes, to be fair, patients should be informed before all care is rendered, whether or not every single clinician that patient may come in contact with is in that patient’s particular network. Sounds simple enough. But he conveniently ignores that likely the current system at hospitals was designed to make sure that only the surgeon and the procedure (think "facility fee") were pre-authorized and approved for payment by that particular patient's Titanium Tier 3 Mega Insurance Company PPO Plus policy. It is not a trivial matter to make sure that every anesthesiologist, radiologist, pathologist, hospitalist, ER doc and others are also in that particular plan's network. Insurance plans with multiple tiers and flavors and complex fine print have proliferated at the same time that insurers have chosen to narrow provider networks to improve profitability. It will take considerable costly resources and perhaps cause delays to care if everything must be pre-approved and the burden is placed on the clinicians. By the way, I have a basic question. Why is it primarily our responsibility to know if a patient's insurance
covers our services?? Isn’t it the patient’s insurance?? Regardless of the answer to that question, the reality is that this IS what is being expected of us. The insurance industry has done a nice job of pushing the responsibility for this issue (their complex contracts, their “surprise insurance gaps”) onto our shoulders. We are patient advocates, so we do want to help and we will help, but we cannot bear this burden alone.

**CAN we explain this complex issue to legislators, to the public, and to our physician colleagues?? CAN we make a difference in the legislative outcome? I believe absolutely YES! ASA and LSA are hard at work doing just that.**

But without dozens or better hundreds of additional contacts from LSA members to our legislators in Louisiana, these legislators will falsely believe that there is not much of a problem. They will literally say, “we haven’t heard much from the doctors on this issue, so we believe it is in the best interests of patients to pass this legislation.” We MUST explain the major negative unintended consequences of an arbitrary quick fix that limits our ability to collect full payment for our services. If you think you don’t understand the OON billing issue, then please check your email’s trash for the last several months. In it are numerous emails from LSA and ASA on the topic. Please read them. Please follow the links and contact your legislators immediately to tell them your thoughts on OON billing.

I wish there weren’t such serious advocacy issues that need to be confronted. But the truth is there are a lot of serious issues, new ones crop up and the issues seem to get more complicated each year. The needs of advocacy in our specialty have changed over time just like our patients and our training has changed. In 1982 when I started medical school, anesthesia residency was two years long, a 34 year old ASA 1 patient spent a week in the hospital getting worked up for and recovering from a 45 minute elective open inguinal hernia surgery, and although I didn’t even know what the word ‘advocacy’ meant with regards to the ASA, I am certain that if I broached the topic my attendings would have said, “son, all you need to worry about is learning ‘Baby Miller,’ you can participate in that political stuff later when you are an attending if you don’t think you can cut it in the operating room.” Now of course everything has changed. Residency is three years long with many residents also doing a fellowship to remain competitive. Your first case of the day is more likely to be a 75 year old morbidly obese, hypertensive, diabetic patient with CAD and “just a touch of pulmonary hypertension” seen on a two year old echo and the surgeon wants to do the same hernia surgery but with robotic laparoscopy, arms tucked, table turned 180 degrees and it is booked for 2.5 hours. To top it off, the hospital administrator will complain if they are not discharged home before 1pm. Today students and residents are already knowledgeable and proactively interested in the serious politics of healthcare.

The following LSA Members are speaking at the ASA Annual Meeting. Click the link on each speaker to see when and where they are speaking during the meeting.

**12:00 PM - 12:10 PM**
**MC1070 / Monitor 06 - A Peculiar Case Of Subcutaneous Bleeding In A Pregnant Patient After Epidural Placement**
Muhammad Anwar, MBBS
Tulane University School of Medicine

**1:50 PM - 2:00 PM**
**MC2452 / Monitor 03 - Anatomically Unique Pheochromocytoma Resection**
Christopher Busack, MD
Tulane University School Of Medicine

**2:40 PM - 2:50 PM**
**MC1254 / Monitor 04 - Anesthetic Care For Coexisting Myasthenia Gravis And Limb Girdle Muscular Dystrophy**
Laura Edwards, MD
Tulane University School Of Medicine

**9:00 AM - 12:00 PM**
**Just a simple CABG? A Case of Heparin Resistance**
Kelly G. Ural, MD
Ochsner Medical Center
are the new realities of anesthesiology. Wishful thinking won’t change residency requirements back to two years, it won’t make that sick as heck patient go away, nor will it make the advocacy issues like out-of-network billing suddenly disappear. The only answer to all of these issues is for us to “improve our game.” The students and residents are on board. They get it. Do you? Please join with me, join with the proactive members of ASA/LSA, the residents and the medical students like the ones that have prepared this newsletter and commit to “upping your advocacy game.”

*The University of Queensland School of Medicine in Brisbane Australia has partnered with the Ochsner Health System to provide the two years of clinical work for a large cohort of their medical students. These are over 90% American and Canadian students who would otherwise qualify for a U.S. medical school spot but seek an international experience with their two years of classroom work in Australia. ‘UQ Ochsner’ has now graduated 8 classes of students with very good success in matching to U.S. residency spots in virtually ever specialty.*

LSA Goals & How You Can Help Accomplish Them

1. Increase Membership
   There are still physician anesthesiologists who are not members of ASA or LSA. Urge your colleagues to join.
   JOIN or RENEW

2. Contribute to LSAPAC
   On average 15% of LSA members contributed to the LSAPAC. We would like to reach at least 30%
   LSAPAC.ORG

3. Contribute to ASAPAC
   Despite tremendous effort, less than 46% of LSA members contributed to the ASAPAC. We want to increase to 60%
   ASAHQ.ORG

4. Increase Participation
   Join a committee, become a LSA Ambassador, write for the newsletter, attend the LSA Annual Meeting.
   GET INVOLVED

APRIL 17-18
LOUISIANA ANESTHESIOLOGY 2020
LSA Annual Meeting