TSA NEWSLETTER

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Save the Date!
TSA Annual Meeting 2023
September 7-10, 2023

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TSA LIST OF EDITORS

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2023 ANNUAL MEETING

September 7-10, 2023

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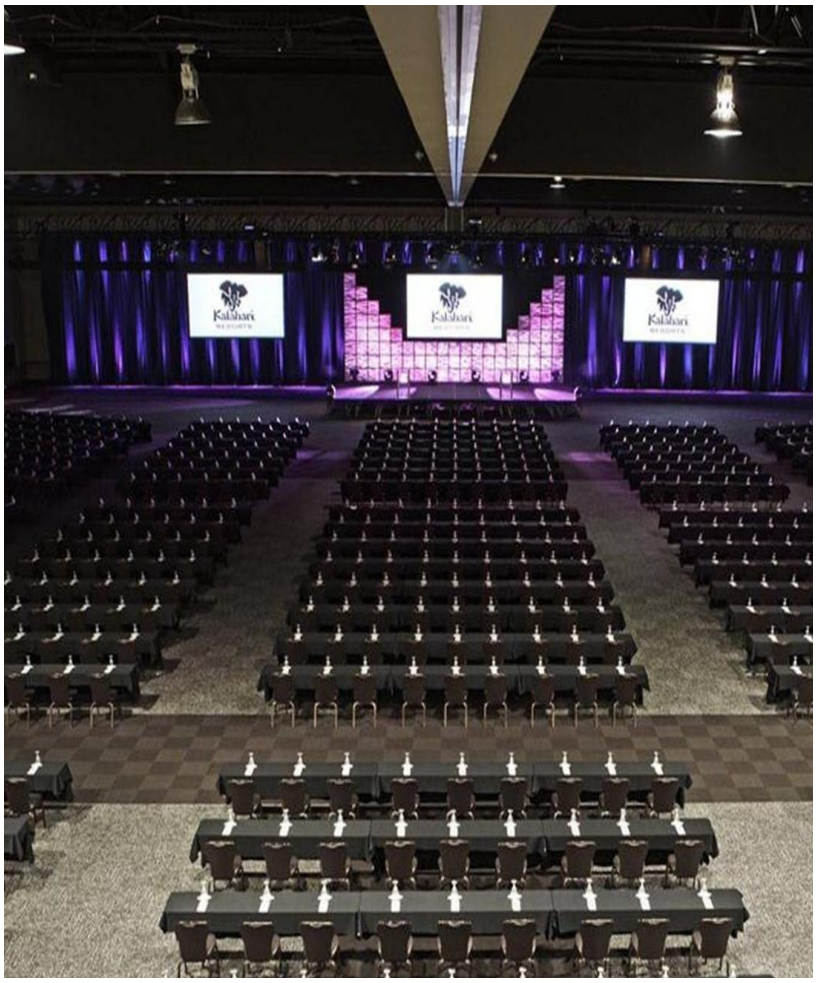
TSA 2023 TRANSITION TO PRACTICE PROGRAM

COMING SOON

The 30th Annual TSA Golf Tournament begins with a shotgun start at 7:30 a.m.
Contact the TSA Office at info@tsa.org



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Message from your TSA President

Happy New Year! Hopefully you had a blessed and enjoyable Christmas and Hannukah. What a busy 4 months since our annual meeting! The Texas Society of Anesthesiologists (TSA) has undertaken a myriad of efforts since we were all together in Round Rock this summer. Hopefully this missive will provide you with insight as to the focus of your leadership team, board and committees while we are all working hard in our various practices across Texas.

Appropriate payment for our services remains front and center for TSA. We were recently made aware of dramatic changes in FAIRHealth datapoint values and modifications to the actual variables themselves beyond what is listed in statute. Consequently, in November, your leadership team met with the executive leadership of FAIRHealth in order to make them aware of concerns that have been raised by our members. You can be confident that we made a clearly stated and strong case to make sure that the data that FAIRHealth provides is accurate and useful; some of our suggestions were implemented and others were not. We are working to resolve these differences by partnering with members from across the state as appropriate in order to rectify this issue. We hope to have an update for you by the end of the winter.

Election day has come and gone, but the active engagement of our governmental affairs team remains intrepid and bipartisan. Nearly all candidates (89 out of 90) supported by TSA were successful in winning their elections all across the state! We recognize that the TSA will inevitably support a candidate that may be despised by some members and lauded by others; thank you for recognizing that the TSA does and must contribute to any policy-maker that supports safe care for our patients and the sustainability of our practices regardless of their party. Our outstanding governmental affairs director, Mrs. Elizabeth Farley has demonstrated an efficacious and enthusiastic work ethic on behalf of the TSA and we are grateful for her leadership of our efforts. Additionally, we have a new member in the TSA office, Ms. Jasmine Owen. Hopefully you will have the chance to meet Jasmine at the TSA Anesthesiologists Days at the Capitol in Austin this March. Welcome Jasmine!

The Practice Management Committee has activated and announced a dedicated TSA email to support any member who needs technical/logistical support in navigating the independent dispute resolution process. This email is IDR@tsa.org. Thank you to the Practice Management Committee for leading this effort. Additionally, the TSA has been following the evolving No Surprises Act (NSA) landscape closely and is coordinating our efforts with the American Society of Anesthesiologists as well. The TSA also thanks the Texas Medical Association for truly leading the charge on behalf of the house of medicine in filing an additional lawsuit following the maliciously and persistently anti-physician implementation of the NSA thus far.

The TSA has formally submitted the new advocacy rotation which was approved by the House of Delegates in September to the American Board of Anesthesiology (ABA) for formal approval during their winter meeting. Our team put forth a solid effort to submit a comprehensive academic curriculum and are hopeful that the ABA will approve this rotation when they meet. If approved, we will have the opportunity to enroll 2 residents in Spring 2023 so be on the lookout if you are interested!

The TSA Scholarly Target Anesthesiology Research for Texas (START) will likely send its first grant application announcement to the membership in the winter of 2023. We are very excited about starting this first of its kind funding opportunity ($25,000 per award) to support discovery and investigative excellence here in Texas. It is our hope that awardees eventually go on to compete effectively for funding from the NIH or other governmental and non-governmental organizations. Go Texas!

You may recall that I volunteered to visit any group that would like an update on *their* TSA. Since our annual meeting, I have given this ~1-hour presentation for Baylor College of Medicine, Houston Methodist Hospital, and the University of Texas San Antonio. This offer remains open for the rest of my term (until September 2023); if you would like for me to visit your group or department, please email our excellent executive director, Mrs. Chris Bacak at chris@tsa.org. Thank you, Chris, for running our society with care and dedication!

There is more taking place in the TSA which supersedes what we are able to include in this brief article. I am happy to commit to providing an update about *your* TSA in every published newsletter for this next year. It is my great honor and genuine pleasure to serve as your TSA President; please do not hesitate to reach out to me if there is anything that I can do to be supportive to you.

Deadline Extended for TSA Logo Submission

The deadline to submit your TSA logo suggestions has been extended to May 1, 2023!

If you missed our first message, the 2022 TSA House of Delegates approved a resolution to create a new logo for the TSA. The approved resolution stated that the TSA President would establish a committee of his choice to determine the symbols that reflect the society, the committee will obtain logo ideas and bring the top two or three designs to the 2023 House of Delegates for final selection by a vote of the House members.

Dr. Williams appointed Dr. Scott Meril to chair the ad-hoc committee.

If you would like to submit a logo suggestion and design, please do so no later than May 1, 2023. This is a great opportunity for you to contribute to the proud legacy and history of the TSA.

If you are interested in submitting, please send your ideas and artwork to chris@tsa.org

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On the Shoulders of Giants: Legends of Texas Anesthesiology
Charles H. Gillespie, M.D.
Scott & White Memorial Hospital

Dr. Charles Gillespie was born in 1914 and raised in the small central Texas town of Bartlett, just northeast of Austin. He grew up on a rural farm during the depression era and milked cows most mornings before going to school. In spite of pressure from his family to become a preacher, he sought out a medical career and enrolled at the University of Texas Medical Branch in Galveston, graduating in 1940. He was an internal medicine resident at Scott and White Hospital when the bombing of Pearl Harbor occurred and, soon afterwards, enlisted in the Army. According to reports, within 5 minutes of reporting for duty at Fort Sam Houston in San Antonio, he was told "they didn't any more internists, they needed anesthesiologists." He explained to them that he had little knowledge of the specialty. He said they told him, "We'll teach you." Thus, he became the first trainee in the Brooke Army Medical Center anesthesiology training program. At that time, World War II was in full swing and he served in the United States Army Medical Corps with the rank of Captain. He was part of one of the first teams to develop the Mobile Army Surgical Hospital (M.A.S.H.) units and, in 1944, served in a rapid response neurosurgical team supporting the D-Day invasion at Normandy and at M.A.S.H. units throughout the European theater. In an interview for an article in *Texas Medicine*, Dr. Gillespie recalled his memories of the battles raging outside the medical tents where they were operating. He said, "We got reports on the progress of the battle and, of course, we could hear the firing. But we were so cotton-picking busy, we didn't worry too much about what was going on out there. The hospitals were fairly well protected, but one day a bullet came through the tent and landed on the sterile tray we had for the instruments."

Having completed an internship at Scott & White Hospital in Temple in 1939 and, after serving as an anesthesiologist in the army, he sought out further training in anesthesiology. Under the tutelage of Ralph Tovell, M.D. he completed an anesthesiology residency at the Hartford Hospital in Connecticut, and afterward a fellowship at Yale University. Once his training was complete, he returned to central Texas in 1947 to join the senior staff at Scott & White Hospital. As he was arriving, Dr. Claudia Potter was nearing retirement, and Dr. Gillespie soon assumed the role of Chief of Anesthesiology.

Dr. Gillespie was passionate about education and, in the late 1940's, he established the anesthesiology residency training program at Scott & White Hospital, the first in Texas. This was the same year that his good friend (and UTMB class of 1940 classmate) Dr. M.T. "Pepper" Jenkins was establishing the anesthesiology residency

program at UT Southwestern. In contrast to the accepted hierarchy of that time, Dr. Gillespie was instrumental in establishing the department of anesthesiology as a separate department instead of a division of the department of surgery. He served as the Chair of Anesthesiology at Scott & White Hospital for 26 years of his nearly 40 year career.

He also had a strong interest in expanding the scope of anesthesiology into pain management. He said, "The development of pain clinics is an important aspect of the practice of anesthesiology. It is pretty well an extension of the fact that the anesthesiologist is trained in the principles of blocking nerves that are hurting." Dr. Gillespie established the very first pain clinic at the hospital and was a recognized early pioneer in this developing subspecialty of anesthesiology.

Beyond the hospital walls, Dr. Gillespie also assumed leadership roles in organized medicine. This culminated when he served as the President of the Texas Society of Anesthesiologists from 1963 to 1964. In addition, he and his wife Estelle led goodwill delegations of physicians to the Soviet Union and China. These exchanges of scientific ideas were some of the first collaborations of their kind.

Dr. Gillespie retired in 1981 from Scott & White Hospital, having spent 35 years of his 38 year career there. His passion for education led him and his family to establish and endow the Gillespie Family Lectureship in Anesthesiology and Pain Control. Their generosity has allowed many distinguished guest speakers to visit the residency program to teach young physicians in training. His name remains well known in the hospital where he served and led for so many years.

Dr. Gillespie passed away in 2008 on October 4th, following a storied career in medicine. He was preceded in death by his wife Estelle in 2001. He is survived by his five children, Anne, Jean, Claire, Alan, and Ray. We recognize all of his contributions to our specialty and appreciate his leadership during the infancy of anesthesiology as a medical specialty. ♦

Reference:
L Besaw. TMA 50-Year Club Members Helped Make It. *Tex Med*. 1995 Nov;91(11):34-5, 37.
"S&W's Second Anesthesiologist Retires After 38-Year Career" Temple Daily Telegram. Jan 8, 1981.

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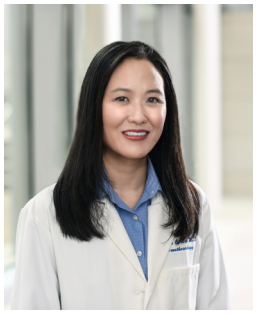
Anesthesiology: Sober Dissertation

The origin has to be classic, in the deepest etymology: the knowledge (truth) about the absence of being (absence of feeling). A true philosophical debate that could easily endorse positions between believers and agnostics, rationalism and hedonism, as well as views on the eschatological meaning of science, conscience, relativism, and dogmatism. One way or the other, modern attention is completely focused (literally firing all neurons, BIS wise 98) on the green pastures of molecular biology, functional MRIs, difficult airways, practice management, and quality issues, going through the latest House bills, Medicare reforms, and poetry on Letheon.

My roots, as classical as they can be, almost sound like a modern version of Mamma Mia, or the Soprano's, but definitely not Jersey Shore: a connection of wild-turning trigger points yet as traditional as Chinese medicine, a swirl of dotted black and white, as old as a Ying and Yang, modern-like entropy, TOF-watch, or a Vigileo. It is becoming hard to find yourself in the pursuit of FASA, an MBA, accredited fellowships, master's degrees, and doctorates, all to the fine tune between Hippocratic oath and Uber rides during interview season, or the latest PGA. Karma and meditation, curing the loneliness of generational changes, lost between any personal spaces or the new office space, filled with glorious memories and triumphant new expectations, those of the ramparts often looked down from by seasoned sea wolves, accustomed to storms and famine. *Cogito, ergo*... therefore I am, yet I am and I, therefore, know: such a question is probably more nebulous than the propofol in an IV tubing or the CSF in a glass syringe, swirling in my thoughts. A smile (can't be escaped nitrous) shines, maybe jokes (unlikely) or my funny accent to the latest patient, who keeps guessing the wrong nationality.

To be or not to be, for now, sir/ma'am, it does not matter, the only quite certain probability is the loss of consciousness (desired), with semi-absolute and semi-quantic certain amnesia, a durable warranty to any future litigation. Well assuming, diligent vigilance will also preserve organ functions and avoid several ischemic complications.

In the end, it may seem an interesting profession, remarkable to few and unknown to the majority—other than margarita dispensers (Texas), bourbon (Midwest), and Napa Valley wine (guess where?). Well, it is what is ladies and gentlemen, but whatever we are, whatever we think to know, it is compelling that with honest joy, anesthesiologists we became, but most certainly first were born. ♦



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A Global Health Experience in the Age of COVID-19

Many of us may not have realized that, as the world shut down in March of 2020 and international borders closed due to concerns of the spread of the COVID-19 virus, many countries were left without the medical resources for which they were once accustomed. Medical missions, volunteer organizations, and relief efforts were forced to discontinue aid to these developing countries and many people were left without medical care in many areas of the world. As global supply issues changed, many international communities faced a scarcity of medical supplies. In some instances, access to medical equipment was already challenging, only to be worsened by decreased production, limited travel, and the closing of shipping ports.

As academic physicians, we recently traveled to Africa as invited speakers and guests of a hospital that serves a rural population. As with most third world countries, conserving limited resources was a standard practice and crucial to providing patient care. When we disclosed that we use disposable laryngoscopes and LMAs, there were audible gasps in the audience. Working in an environment where everything (i.e., oral airways, stylets, endotracheal tubes) is sterilized and reused, they were incredulous that supplies and equipment were so easily discarded. Even bag valve masks were sterilized and reused, often resulting in difficult mask ventilation due to the sterilizing chemicals saturating the equipment. Ventilators were already a luxury pre-pandemic and the shortage was only made worse with the pandemic. The hospital had one video laryngoscope for difficult intubations, however, the resolution of the screen was so poor that it offered only a mild benefit.

Despite all these hardships, it was amazing to see the resilience exhibited by the medical professionals. During the pandemic, this hospital did not have an anesthesiologist for almost two years, as the previously affiliated U.S. medical organization withdrew the two anesthesiologists before borders closed. A U.S. residency program stopped sending their global health elective resident during this time as well. Some physician volunteers (i.e., pediatricians, internal medicine physicians) remained and, without the benefit of visiting anesthesiologists, they became primary consultants for airway interventions for the last two years. These non-anesthesiologists also became the primary teachers of airway management skills for their trainees during the pandemic.

Unlike the U.S., the physician workforce in some parts of Africa is comprised of many physicians who may have only completed an intern year. Not all physicians enter residencies after their intern year. Many decide to work as independent physicians for a few years before returning to their residency education. Some may end

up in rural areas where they become a doc-of-all-trades, performing different types of care ranging from being a critical care doctor, surgeon, and anesthesiologist. Of all the interns we met during our visit, none had ever had simulation airway training…practicing for the first time in vivo. Access to airway education is extremely limited and many enter the workforce without any formal training in airway management.

Throughout our stay, it was apparent that our colleagues were eager to learn so they could provide excellent care. Unfortunately, education is sometimes limited, and at times nonexistent, without the help of volunteers and global health initiatives. As U.S. physicians, we were always aware that we had many luxuries regarding supplies and equipment; however, we realized on this trip that we also take the access to education for granted. In the U.S., it is an expectation that airway management skills are taught by trained professionals. We came to realize that, in many rural parts of Africa, airway management skills are often learned by reading outdated textbooks and being taught by practitioners who have no formal training themselves, perhaps propagating poor or inappropriate ideas on to new learners. Although we have seen and heard many global health organizations asking for donations for supplies, equipment, and doctors to care for patients, we have not seen as much attention being called for physicians to educate. In some ways, education is equally as important for patient care. For example, if endotracheal tubes are donated, it still requires someone with intubation skills to use that endotracheal tube. We may not all have the means to donate physical supplies and equipment but, as anesthesiologists, we are all trained and possess the knowledge and skills to teach others, which are equally as valuable. As physician-educators, we hope that the airway education we provided will not only make an impact in the learners' education but also translate into improving patient care for the future. Even something as simple as showing how to properly position and pre-oxygenate the patient may make a significant difference in patient care. It may have even more of an impact in a third-world country where video laryngoscopes are not available and patient positioning could be the deciding factor between a successful and unsuccessful intubation.

Overall, this trip was enlightening, as reading about the limited resources in developing countries is not equivalent to witnessing it first-hand. As anesthesiologists, we have much to offer in terms of our versatility and wide range of skills. As international borders have begun to reopen, we encourage others to participate in global health and education at least once in your career. We believe that you will find it to be a very rewarding experience. ♦

Announcement

TSA President-Elect Dr. Baskar Padakandla will soon begin the process of making committee appointments for 2023-2024. If you are interested in serving on a committee, or would like to continue serving on a committee, please notify Chris Bacak at chris@tsa.org by May 12th. Let Chris know which committee/s you are interested in serving on. If you are requesting appointment to a new committee, also include one or two sentences explaining why you are interested in the particular committee. You may view a list of TSA committees in the members only section of our website by clicking here. The TSA greatly appreciates your willingness to serve the patients and physician anesthesiologists of Texas!

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Who Doesn't Love Babies? Declining Interest in Pediatric Anesthesia

The results of the 2022 National Resident Matching Program (NRMP) match for Pediatric Anesthesiology Fellowship positions did not yield the result that our program anticipated. To our dismay, we were unable to fill any of our three fellowship positions despite being a well-regarded tertiary care center with a Level I trauma center, robust Neonatal and Pediatric Intensive Care Units, located within the largest medical center in the world. Our close-knit group of pediatric anesthesiologists have concerns and are unsure how to remedy this problem in the future. At this point we have more questions than answers. What has led to this? Why is the field we love declining in popularity? Is there a lower level of comfort managing small babies among current residents? Did the Covid-19 pandemic lead to a lack of adequate exposure to pediatric anesthesia during residency training? Or is the field of pediatric anesthesiology simply losing its charm?

The Covid-19 pandemic may have played a role in current anesthesiology residents' decreased interest in applying to a pediatric fellowship. Benefits of forgoing fellowship include better immediate

compensation and less overall financial burden. The overall burnout rate for healthcare workers increased during the pandemic. It is possible that residents felt that forgoing fellowship would allow earlier access to a better work life balance to ease the burden for those who felt the effects of burnout. In 2021, a survey of 75 pediatric anesthesia fellows was conducted to discern the impact of the COVID-19 pandemic on their education and wellness. The results showed a significant negative impact on this group regarding clinical work, finances, certifying examinations, mental health/well-being, and their overall educational experience during the fellowship year. This limited experience was due to decreased number of clinical days secondary to quarantine or lockdown. They also reported salary reductions in their future jobs. Lastly, some feel that sub-specialty training actually restricts their job prospects, limiting their employment opportunities to children's hospitals. This is especially concerning for residents who desire a mixed practice.

A recent article discusses the discordance between pediatric anesthesia fellowship positions and the number of applicants. Reflecting an increasing national need for pediatric anesthesiologists, there has been an increase in pediatric anesthesiology fellowship positions from 100 to 226 over the last thirty years. However, this is the fifth year in a row that the percentage of unfilled NRMP position has increased. In 2021 there were 167 applicants for 226 total positions across 60 programs. Of these, 165 applicants matched, leaving 61 positions open across 27% of the programs. In 2022, the number of applicants declined to 142 for 215 positions across 58 programs. The reduction in available positions was a result of some programs decreasing the number of positions they offered. Two programs withdrew from the NRMP match altogether in 2022. The 2022 match resulted in 137 matched applicants, leaving an all-time high of 78 unfilled positions across 39 programs. This translates to 67.2% of all programs having at least one unfilled fellowship position. While some programs were able to find applicants outside of the match, the disparity between the number of applicants and the number of available positions is trending in a very concerning direction.[1]

While the primary reason for fellowship programs is training of future qualified pediatric anesthesiologists, fellows also play an important role in the workforce of a hospital. With fewer fellows, the workload must ultimately be picked up by other anesthetists – whether faculty anesthesiologists, residents, or midlevel providers. Depending on the structure of the hospital, this could lead to staffing issues and even safety concerns. Furthermore, we are concerned some program directors may feel undue pressure to fill their fellowship positions, so they may choose less qualified candidates to lower the risk of not matching their positions.

Whatever the reason, there is a notable decrease in fellowship trained pediatric anesthesiologists. The benefits of subspecialty training are increased comfort, skill, and experience in managing the most complex pediatric surgical cases, especially in the neonate and infant populations. Some argue that further training in pediatrics is not necessary, as evidenced by the long history of non-fellowship trained anesthesiologists providing care for children in private practice. Is this safe? The answer depends on the patient's age and co-morbidities, the experience of the anesthesiologist, and the available perioperative support. It can certainly be argued that complex cases should be performed in specialized children's hospitals with faculty who have undergone sub-specialty training. In addition, it may be difficult for anesthesiologists to maintain pediatric-specific knowledge about airway management, optimal

ventilation parameters, appropriate drug dosages, and fluid management if the volume of pediatric patients they encounter is too small or inconsistent.

Approximately 6 million children, including 1.5 million infants, undergo surgery every year in the United States. This number of infants and small children is only going to increase with continued scientific advancements resulting in better outcomes for previously terminal conditions. One can safely assume that the need for pediatric trained anesthesiologists will only increase with time. So how do we fill the void of declining applicants in the coming years? Pediatric anesthesia faculty can make concerted efforts to mentor medical students and residents, highlighting the benefits of pediatric anesthesiology fellowship training. We can engage them in educational sessions, present interesting cases, and involve them in research opportunities. Perhaps the recent announcement by the Society for Pediatric Anesthesia that resident and medical student membership fees will be waived and that medical students can attend the annual meetings for free will encourage more trainee participation in society meetings and functions. Trainees should be reminded that a shortage of pediatric anesthesiologists creates increased demand and job security.

As pediatric anesthesiologists we feel privileged to take care of the most vulnerable members of society and we hope to recruit more compassionate and capable physicians into our specialty in the future. This most recent downturn is something that we all should watch closely to see if the trend continues. ♦

References:

1. Cladis FP, Lockman JL, Lupa MC, Chatterjee D, Lim D, Hernandez M, Yanofsky S, Waldrop WB. Pediatric Anesthesiology Fellowship Positions: Is There a Mismatch? Anesth Analg. 2019 Dec;129(6):1784-1786.

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Obstetrical Anesthesia Highlighted at TSA 2022

The 2022 TSA Annual Meeting included both economic and scientific news for obstetrical anesthesiologists.

For starters, the House of Delegates received a briefing on the "No Surprises Act." A victory for patient rights when it was passed by Congress last December, the Act has been twisted by commercial insurance companies in its implementation. The final regulations have allowed payors to create erroneously deflated qualifying payment amounts as the basis for arbitration, leaving physicians without adequate payment and patients without in-network access to quality care. A battle we thought was won is still raging, with the next major skirmish to take place in the Court of Appeals, right here in Texas, in response to a lawsuit brought by the Texas Medical Association and vigorously supported by the TSA and ASA.

The scientific program made it clear that anesthesia safety is a reality, and major negative outcomes are rare enough to be negligible. Paradoxically, this has not improved outcomes; gains in safety are instead 'reinvested' in sicker patients and more complex cases. As Dr. Richard Dutton underscored in his lecture "Anesthesiology and Patient Safety: Shifting from Mortality to Health", we anesthesiologists are victims of our own success. We have enabled our surgical (and procedural) colleagues to push the limits of clinical safety on a daily basis. It could be called the "JFK Syndrome", alluding to the famous speech by our past president launching the Apollo Program: "We don't do these things because they are easy, but because they are hard." This describes our work every day as anesthesiologists.

The session on obstetrical anesthesia and the Betty P. Stephenson Lectureship by Dr. Joy Hawkins of the University of Colorado (and formerly of the Baylor College of Medicine and the inaugural class of the Texas A&M College of Medicine) made similar points for that subspecialty: general anesthesia for cesarean section is safer than ever, but high-risk patients are ever more common, while disparities in access and resources for pregnant patients contribute to adverse outcomes and will require deliberate efforts to resolve.

General anesthesia is not ideal in labor and delivery; we wish for patients to enjoy the delivery of a healthy baby in the safest, most comfortable, and natural conditions. Yet, this is not the case all the time, especially in units caring for the most complex patients. The anesthesia team is often estranged from the planning and communication process for complex patients and may be 'invited to the party' too late to provide constructive input. Patient education, expectations, and concerns are often primed by other staff members that are not anesthesia trained, especially when considering the safety and quality of care during and after general anesthesia. Dr. Girish Joshi addressed this in his lecture on "Print to Practice: Recent Publications that May Influence the Future of Anesthesia Care". We should not let anyone demonize general anesthesia. While continuing to stress the importance of neuraxial anesthesia, we should be equally positive regarding the benefits of general anesthesia. Good anesthesia is good anesthesia, by whatever route.

Healthcare in the United States is complicated by geography, social and ethnic diversity, a wealth gap, and the intricacies of insurance coverage. All of these factors contribute to adverse outcomes in obstetrical care, often with striking amplification: 50% of maternal mortality is in African American patients, who collectively have higher rates of contributing comorbidities. Dr. Hawkins presented more than a few studies that link the latest reports of maternal mortality to poor health conditions in predominantly African American communities. We, as anesthesiologists, are challenged to intervene in the earlier stages of medical optimization but must be aware of population risks. We must recognize that risks associated with race and ethnicity may be due to both the inherent risk for disease and to social disparities caused by poverty, food insecurity, and lack of access to preventative care. Conditions such as pre-eclampsia are created by both genetic circumstances, such as risk for obesity and hypertension, and socioeconomic conditions such as lack of early prenatal care, inability to fill expensive prescriptions, and even limited access to fresh fruit and vegetables. A society that cannot work with their own members to respect individual identities, while still recognizing the risk associated with certain human customs, is not a healthy society in a broader sense and meaning. ♦

Larry R. Hutson, Jr., M.D.
Site Chief of Anesthesiology
Baylor Scott & White Memorial Hospital
Temple, TX

New Monoclonal Antibody Biologic Medications and Perioperative Implications

It feels like they're everywhere – popup ads and TV commercials with snappy jingles for the newest medication, complete with smiling patients, catchy tradenames, and announcers going over side effects at a blistering speed. A relatively new prescription medication risankizumab (Skyrizi) has been advertised heavily ever since its approval in January 2022 by the U.S. Food and Drug Administration for the treatment of adults with active psoriatic arthritis.[1]

Previously approved for moderate-to-severe plaque psoriasis in April 2019, this new indication broadened the market for risankizumab, and marked the third anti-interleukin 23 (IL23) inhibitor to become commercially available for psoriatic arthritis. Both of the other IL23 inhibitor medications – ustekinumab (Stelara) and guelkumab (Tremfya) - have similarly been the subject of intensive advertising campaigns.[2] All of these drugs are monoclonal antibody drugs (also commonly referred to as "biologics") that target specific antigens and are named using the conventional "MAB" (acronym for monoclonal antibody) suffix.

Risankizumab binds to a subunit of the IL23 cytokine, which is known to be essential in regulating the inflammation that results from infections or chronic autoimmune conditions through the effects of IL23 on interleukin 17 and TNF-alpha. Together, these cytokines work to keep immune cells in an inflammatory state.[3] By blocking IL23, risankizumab and other similar IL23 inhibitors reduce inflammation, which in turn reduces psoriatic plaques and arthritis symptoms, with the ultimate goal being remission of the disease entirely. Furthermore, it has a convenient dosing schedule, as patients undergo induction via an initial injection followed by a second subcutaneous injection one month later, then every 12 weeks after that for maintenance.[4]

One of the downsides of the immunosuppression induced by these medications is susceptibility to infection. Upper respiratory and tineal infections are the most common and, in trials of patients on risankizumab specifically, they experienced a higher rate of infection (22.1%) than patients given a placebo (14.7%).[3] It is this characteristic that causes the most consternation about patients on this medication and surgical procedures.

There are currently no comprehensive published guidelines for perioperative management of these IL23 inhibitors, as they are too new. However, there is consensus opinion that risankizumab, just like the other IL23 antibodies, can be continued through low risk surgical procedures that do not result in a break in sterile technique during which the respiratory, gastrointestinal, and genitourinary tracts are not entered.[1,6] Examples of this would include dermatologic procedures, ophthalmologic surgeries, or a biopsy of the breast to name a few.[6]

While orthopedic surgeries and joint replacements are also considered low risk for infection, the American College of Rheumatology (ACR) and the American Association of Hip and Knee Surgeons (AAHKS) published a new set of guidelines in 2022 for the perioperative management of biologics, which included the addition of the newest ones now on the market. They recommended, in general, to hold biologic immunosuppressants in

patients with all forms of inflammatory arthritis for their next dosing cycle, and to proceed to schedule surgery after the dose is due. For risankizumab, that would mean scheduling surgery at 12-13 weeks after their last dose.[7,8]

It becomes trickier when discussing moderate and high-risk surgeries. Surgeries considered moderate risk include those of the genitourinary tract where contamination is not present, sterile abdominal or thoracic surgeries, and head and neck surgeries, while high-risk surgery can be defined to include procedures where the infection risk is greater, such as where there are breaks in sterile technique, spillage from the GI tract, pre-exiting active infection, or devitalized tissue. This would also include emergency surgeries or more complicated surgical procedures from the moderate risk group.[6,9] There are some recommendations for a patient to hold their next dose of a biologic and be scheduled after that, just as with the joint replacement recommendations. Many guidelines recommend holding biologics for the longer of either three to five half-lives of the medication or the dosing interval. For, with its 29 day half-life, the longer of the two would still be the 12 week dosing interval.[10]

Other agencies, such as the British Association of Dermatologists (BAD), note that there are few studies of the efficacy of stopping IL23 inhibitor therapy for surgery, nor studies of the effect that continuing IL23 antibody treatment has on post-operative infections and wound healing. Many of the opinions about perioperative management of these biologics are extrapolated from studying similar drugs in patients with inflammatory bowel disease or rheumatoid arthritis.[9]

Stopping risankizumab, and other biologics, carries a significant risk of a flare-up in the patient's psoriasis or psoriatic arthritis. These flare-ups may be managed with short term steroid use, which may also have implications in related to post-operative wound healing. A study of rheumatoid arthritis patients noted that those who stopped their biologic for a procedure were three times more likely to have an acute flare-up of their disease within the next 12 months, but also noted that half of patients had no significant issues related to their rheumatoid arthritis while off their medication.[10]

In the intraoperative setting, there are no known interactions between any of the IL23 cytokine antibodies and any medications commonly used in the practice of anesthesiology.[7]

On the post-operative side, patients should be monitored more closely for signs of infection, and the medication should not be restarted until adequate wound healing is demonstrated and all sutures and / or staples have been removed.[11]

Ultimately, the surgeon or proceduralist is going to have to take a proactive approach for elective moderate and high-risk surgeries, calculating the tolerance of increased infection risk. They will then have to coordinate with the prescribing physician and the patient on potentially holding the next dose, on the proper timing of the procedure related to the previous dose, and on timing to resume the medication if it was held.[11] This may result in lengthy wait times for elective surgeries in this cohort of patients.

It should be noted that while risankizumab is currently approved for psoriatic plaque and psoriatic arthritis, there are several phase 3 studies underway of it in the treatment of ulcerative colitis and Crohn's disease.[12] Given the usage of other biologic therapies in inflammatory bowel disease, it is not a stretch to think that there could be an expansion of the indications for risankizumab and other similar biologics, resulting in more patients for which timing of the discontinuation of these medications becomes a consideration in the planning of surgeries and procedures. ♦

REFERENCES

1) Evans J. FDA Approves Risankizumab (Skyrizi) for Psoriatic Arthritis. Jan 21, 2022. Available at: https://www.medscape.com/viewarticle/967072

2) Naik PP. Adverse effects of anti-interleukin-23 agents employed in patients with psoriasis: a systematic review. Dermatology. 2022 Jun 13;1-11. Doi: 10.1159/000524199. Online ahead of print.

3) Skyrizi Injection (Risankizumab-rzaa). Updated 1/2022. Available at https://www.drugs.com/pro/skyrizi-injection.html

4) Papp KA, Blauvelt, A, Bukhalo M, et al. Risankizumab versus ustekinumab for moderate-to-severe plaque psoriasis. N Engl J Med. 2017 Apr 20;376(16):1551-1560.

5) Rezaieyazdi Z, Sahebari M, Khodashahi M. Preoperative evaluation and management of patients receiving biologic therapies. Arch Bone Jt Surg. 2019 May;7(3):220-228.

6) Mentor A, Strober BE, Kaplan DH, et al. From the American Academy of Dermatology: Joint AAD-NPF guidelines of care for the management and treatment of psoriasis with biologics. J Am Acad Dermatol. 2019;80:1029-72

7) American College of Rheumatology. (2022, February 28). Updated Guideline Introduces New Recommendations for Use of Medications Around Total Hip and Knee Replacement [Press Release]. https://www.rheumatology.org/About-Us/Newsroom/Press-Releases/ID/1210

8) 2022 American College of Rheumatology/American Association of Hip and Knee Surgeons Guideline for the Perioperative Management of Antirheumatic Medication in Patients with Rheumatic Diseases Undergoing Elective Total Hip or Total Knee Arthroplasty https://www.rheumatology.org/Portals/0/Files/Perioperative-Management-Guideline-Summary.pdf

9) Choi YM, Debbaneh M, Weinberg JM, et al. From the Medical Board of the National Psoriasis Foundation: perioperative management of systemic immunomodulatory agents in patients with psoriasis and psoriatic arthritis. J Am Acad Dermatol. 2016;75(4):798-805.e797.

10) Watson S, Zelman D. (2021, December 15.) Stopping Biologics for RA. WebMD. https://www.webmd.com/rheumatoid-arthritis/features/misinformation-stopping-ra-biologic-therapy.

11) The Handbook of Perioperative Medicines. [Internet]. [United Kingdom]: United Kingdom Clinical Pharmacy Association; c2022. Cytokine Modulators (Immunosuppressants). Available from https://www.ukcpa-periophandbook.co.uk/medicine-monographs/cytokine-modulators-immunosuppressants.

12) Ferrante M, Panaccione R, Baert F, et al. Risankizumab as maintenance therapy for moderately to severely active Crohn's disease: results from the multicentre, randomized, double-blind, placebo-controlled, withdrawal phase 3 FORTIFY maintenance trial. Lancet. 2022 May 28;399(10340):2031-2046. Doi: 10.1016/S0140-6736(22)00466-6. Online ahead of print.

SUMMARY OF ACTIONS
TSA HOUSE OF DELEGATES
September 8-9, 2022

1.) Recognized and applauded special guests from the American Society of Anesthesiologists, Texas ASA officers, new members of the TSA and TSA Past Presidents.
2.) Accepted and approved the Minutes of the TSA House of Delegates Meeting of September 12, 2021, as written.
3.) Accepted Resolution 4-Honoring the Past While Looking to the Future and Resolution 5-Hortense Ann Becker as new items of business.
4.) Recognized Christina Bacak for her service and dedication to the TSA. Chris celebrated her 20th anniversary with the TSA in 2021.
5.) Recognized Baylor College of Medicine, Baylor Scott & White-Temple, McGovern Medical School at UT-Houston, Texas Tech Health Science Center-Lubbock, UT Health Science Center-San Antonio, UT Medical Branch-Galveston, and UT Southwestern Medical Center for maintaining 100% resident membership in the TSA.
6.) Recognized TSA members who have been accepted into the 2022-2023 TMA Leadership College and past participants of the program.
7.) Recognized Niklas L. Glenesk, MD as the 2022 William H. King Advocacy Award recipient.
8.) Presented the Ray Callas Outstanding Key Contact Award to John S. Scott, Jr., DO, FASA.
9.) Presented the TSAPAC Texas Trophy Award to Chris T. Miller, MD TSA Director for District 2 for having the highest percent of members contributing to the TSAPAC in 2022.
10.) Accepted all items published on the consent calendar for information only.
11.) Expressed appreciation to the members of the Reference Committees, the TSA President, Speaker, Vice-Speaker, Chris Bacak and Jennifer Bacak.
12.) Approved an independent dispute resolution subcommittee of the practice management committee to serve as a resource for physician anesthesiologists in Texas who are undergoing the IDR.
13.) Approved a policy research rotation with our legislative team in Austin, Texas during the months of the legislative session, with a stipend of $5,500 per resident selected.
14.) Approved recommend that TSA create an owned and operated medical journal, entitled “Texas Journal of Anesthesiology”, or TJA and that additional details be deliberated by the TSA Editorial Board.
15.) Approved the establishment of the TSA Scholarship Targeted Anesthesiology Research for Texas (START) Grant. Additional details should be deliberated by the Education Sub-Committee on Research.
16.) Approved the 2023 projected budget.
17.) Established Juneteenth as a paid holiday for the TSA office staff.
18.) Recognized and applauded Carin A. Hagberg, M.D. as the recipient of the 2023 Distinguished Service Award.
19.) Recognized and applauded Rebecca “Becky” Hein as the 2022 Cindy Zerwas Special Friend Award recipient.
20.) Recognized and applauded Katharine E. Heffner, MD as the 2022 Dr. James Adkins and Linda Adkins Resident Award recipient.
21.) Approved the addition of Section 9.2092.4 to the TSA Bylaws.
22.) Approved the creation of Section 9.221 of the TSA Bylaws.
23.) Approved the modification to Section 9.20611 of the TSA Bylaws.
24.) Approved revisions to the Preamble of the TSA Bylaws.
25.) Allocated $15,000 in the TSA 2023 budget to create a digital media campaign, with the ability for the TSA Board of Directors to approve additional funding if needed.

26.) Approved an Ad-hoc Committee on Website Redesign to conduct a facelift of the website and modernize the advocacy portion in preparation for the 88th Legislative Session. Quotes to determine the cost of the redesign are to be collected by the committee.

27.) Approved recommend that the TSA policy statement on the administration of an anesthetic by a non-physician provider be readopted if the proposed recommendation by the Ad-Hoc Committee on Core Values is not approved.

28.) Approved a "5-Year Review Policy", written by the Board of Directors, that includes the designation of a member of the Executive Committee to monitor adherence to the policy.

29.) Approved a retreat for the purposes of directing the future goals of the Society for the next five years.

30.) Elected the following:

President-Elect	Udaya B. Padakandla
Secretary	Amr E. Abouleish
Treasurer	Elizabeth Rebello
Assistant Treasurer	C. Nicholas Lee
ASA Delegates:	
Place 7	C. Nicholas Lee
Place 8	Jeremie J. Perry
Place 10	David C. Mackey
Place 11	S. Lynn Knox
Place 17	Girish P. Joshi
Place 23	Sherif Z. Zaafran
Place 24	Tim M. Bittenbinder
Place 26	Udaya B. Padakandla
Place 27	Thomas J. Oliverson
Place 28	George W. Williams
ASA Alternate Delegates:	
Place 1	Jose M. Soliz
Place 2	Jeffrey S. Richards
Place 3	Bracken S. Kolle
Place 4	Zachary S. Jones
Place 5	Stacey L. Allen
Place 6	Russell K. McAllister
Place 7	Christopher R. Cook
Place 8	Kristina L. Goff
Place 9	Vijaya Gottumukkala
Place 10	Xuan Tran Langridge
Place 11	Scott S. Meril
Place 12	Richard P. Dutton
Place 13	Andrew L. Zak
Place 14	Radha Arunkumar
Place 15	Joe F. Bryan, II
Place 16	Benjamin D. Harvey
Place 17	Michelle Z. Koehler
Place 18	Jeffrey W. Steiner
Place 19	Brandy M. Bergeron
Place 20	Vishal Raizada
Place 21	Austin D. Street

Place 22	Stacy L. Norrell
Place 23	Ramy Mankarious
Place 24	Brian D. Dewan
Place 25	Christopher T. Miller
Place 26	January Tsai
Place 27	Anna M. Allred
Place 28	Kristyn B. Ingram
Place 29	Mark A. Margolis
Place 30	Edward J. Prejean, III

31.) Approved the TSA BOD resolution: Looking forward the TSA will endorse a maintenance of certification entity that provides value to its diplomates in cataloging and relaying information about members' completed CME.

32.) Approved the TSA BOD resolution: Looking forward the TSA should endorse a maintenance of certification entity that provides value to its diplomates in advocating for the superior qualities of its diplomates compared to those who do not maintain certification including comparison to non-physician providers.

33.) Approved submission by the TSA BOD, of resolution in item 31 and 32, to the ASA BOD.

34.) Approved replacement of the TSA Bylaws Preamble to read: The mission of the Texas Society of Anesthesiologists is to advance, promote, and preserve the highest quality, evidence-based, physician anesthesiologist-led care for all patients. We strive to achieve our mission through our core values of compassion, professionalism, advocacy, inclusion, and well-being.

35.) Adopted the Texas Society of Anesthesiologists Policy Statement on Core Values.

36.) Approved that the TSA will advocate for Hospital-based physicians (Emergency medicine, Radiology, Pathology, Surgery, Hospital Medicine, Anesthesiology) to be able to bill and be paid directly for Uncompensated Medical Trauma Care (UMTC) by the Texas health and human services when trauma patients come for emergency perioperative care and for Fair UMTC Payment.

37.) Approved an ad-hoc committee for Independent and Small Group Anesthesiologists.

38.) Approved establishing a committee of the president's choice to determine symbols that reflect the society, obtain logo ideas and bring the top two to three designs to the 2023 House of Delegates for final selection by vote.

39.) Approved that the TSA honor Hortense Ann Becker's memory and legacy with a suitable plaque in the office of the TSA reflecting TSA's respect for Ann.

ACTIONS OF THE BOARD

SUMMARY OF ACTIONS
TSA BOARD OF DIRECTORS
September 11, 2022

1.) Recognized Mr. Gerardo Trejo, Texas Society of Anesthesia Technologists and Technicians (TSATT) President.
2.) Approved the minutes of the April 20, 2022, TSA Board of Directors Meeting as written.
3.) Approved motion to provide annual funding of $1,000 to all active residency programs in Texas to attend the ASA ADVANCE. The next review will occur in 2024.
4.) Approved annual funding of $1,000 per resident delegate from Texas to the ASA Resident Component House of Delegates.
5.) Announced that a membership-wide email message will be sent out calling for self-nominations, or those of a colleague, for the office of TSA Vice-Speaker of the House of Delegates.
6.) Took a moment of silence in memory of the victims of 911.
7.) Approved motion to update the Texas Pint to the Cathy L. Scholl, M.D. Texas Pint in member of Dr. Catherine L. Scholl.
8.) Announced that members who are interested in serving on Texas Medical Association (TMA) committees, councils, or boards should contact the committee chairs of the TSA Committee of TSA Members Serving the TMA for guidance.
9.) Noted that Dr. Jeremie J. Perry will explore the value of sending a TSA member to the ASA Executive Physician Leadership Program and report back to the Board at its 2023 winter meeting.
10.) Approved additional funding of $5,000 for a digital media campaign.
11.) Appointed an Ad-Hoc Committee on Website Re-Design to include a member from the Administrative Affairs, Communications, Governmental Affairs, History, and Membership Committees, a member from the Resident Component, and a member from the Editorial Board. The Communications Committee designee will serve as the chair of the ad-hoc committee.
12.) Charged the Ad-Hoc Committee on Website Re-Design first with providing a meaningful website facelift prior to the legislative session then following the facelift to obtain quotes to determine the cost and possibility of website re-design.
13.) Requested that Dr. Jeremie Perry work with a member of the Executive Committee to create a policy for reviewing/sunsetting TSA position statements/policies every five years.
14.) Dr. Williams plans to engage members who are part of small groups and will provide an update regarding the Ad-Hoc Committee for Independent & Small Groups at the 2023 winter board meeting.
15.) Approved creation of the email address IDRhelp@TSA.org
16.) Allocated $500.00 for a 3D metal plaque in memory of Hortense Ann Becker.
17.) Informed members that the 2023 cost of living salary adjustment for the TSA staff will be approximately 9%; the funds were included in the 2023 budget approved by the 2022 House of Delegates.
18.) Announced that Director of Governmental Affairs, Elizabeth Farley will be coordinating the efforts for the TSA policy research rotation.
19.) Informed the members that the Editorial Board has begun working on the creation of TSA's "Texas Journal of Anesthesiology" (TJA).
20.) Tasked the Bylaws Committee with changing the oversight of the website from the Editorial Board to the Communications Committee.
21.) Noted the Education Sub-Committee on Research is developing a full profile on how the Scholarship Targeted Anesthesiology Research for Texas grant will be administered.
22.) Designated the Art Committee with the responsibility of obtaining logo ideas and bringing the top three designs to the 2023 House of Delegates for final selection.

23.) Appointed the following members to the TSA House of Delegates:
   - Kristyn B. Ingram as a Delegate to District 1 in Place 2;
   - Esteban Arredondo as an Alternate Delegate to District 4 in Place 14; and
   - Lisa A. Caplan as a Delegate to District 7 in Place 7.

24.) Expressed gratitude to the ASA officers and candidates for attending the TSA/ASA Delegation meeting.

25.) Informed members that a call for nominations for appointments to the 2023-2024 ASA Committees will be made in November by the ASA Governance Office. Anyone interested in a letter of support should contact Dr. Kercheville.

26.) Recognized Dr. Crystal Wright for her candidacy for Assistant Treasurer of the ASA.

27.) Recognized Dr. Joy Hawkins for her presentation of the 2022 Betty P. Stephenson Lectureship.

28.) Tabled discussion regarding the appointment and removal of members to and from TSA Committees.

29.) Tabled the motion that the Board be given the ability to use up to $20,000 of its discretionary funds, that the funds may be used for legally appropriate TSAPAC overhead and allow TSA legal counsel the opportunity to make a ruling on whether it is legal for TSA to fund TSAPAC overhead.

30.) Accepted the appointment of Dr. John Scott as the TSAPAC Chair for a term of 3-years.

31.) Recognized Chris Bacak, the TSA Administrative Team, the TSA Education Committee, speakers and presenters for an excellent meeting. After not meeting in-person for two years this year's meeting was a success.

32.) Recognized Chris Bacak and Clayton Devin for their efforts in establishing childcare at the annual meeting.

33.) Accepted the Treasurer's report, funding of $18,500 was approved during this meeting.

34.) Approved February 26, 2023, as the date for the TSA winter board meeting.

35.) Announced February 25, 2023, as the date for the Long Range Planning Retreat.

36.) Noted the dates for the 2023 TSA Anesthesiologists Days at the Capitol are Monday and Tuesday, February 27th & 28th.

37.) Tabled conversation regarding commercial vendor relationships.

NEW MEMBERS

Since October 1, 2022 the TSA Board of Directors approved the applicants below for the membership categories indicated:

ACTIVE MEMBERS
Adler, Adam C
Arango, Daniel
Asghar, Ali
Asghar, Ali
Babbel, Lee
Bentancourth, David
Bernadette, Aaron
Bird, Stephen C.
Boehmer, Drew O
Bolar, Sudhir N.
Burcham, Hannah W.
Cavanaugh, Mark R.
Chou, Jeff D.
DaCosta, Michelle E.
Donahue, Hart R
Emelife, Patrick I
Ford, Dina E.
Ford, Steven R.
Gallegos, Phillip
Gan, Tong J
Garcia, Tony
Gasparian, Gregory G.
Geli, Janos
Gibelyou, Richard L.
Glassman, Ashley M.
Golian, Agnieszka
Gromov, Dmitriy
Grundt, Jessica E.
Guerra, Phillip B.
Haddad, Jebran M.
Jain, Sejal
Keillor, Rebbeka L.
Kwon, Min
Langley, Rhet R
Littles, Joel T
Martin, Simon A.
Martinez, Tamara
McLean, Maranatha R.
Michael, Sandra
Morkos, Michael
Morris, Phillip M
Myers, Khaleah
Oliver, Jodi-Ann M.
Ortiz, Alejandro
Patel, Krishna
Pham, David Quang-Nam
Pham, Sydney H.
Qian, Yuxiao
Rew, Charles A.
Rosenblum, Sahar
Saenz, Nicholas H.
Salah, Hany
Smith, Jason E.
Smith, Lance S.
Song, Kim-Anh
Staheli, Britton B.
Stout, Laura
Suero, Orlando R.
Sullivan, Juliet
Syed, Sannoor
Topper, Stephen M.
Vakharia, Akshay S.
Wyrick, Christine C.
Yu, Suin
Yuska, Jonathan S.

ANESTHESIOLOGIST ASSISTANT MEMBERS
Baxter, Jeremey D.
Beagley, Jennifer
Bekri, Fethi
Ben Salka, Samira
Bennett, Charles
Bryant, Amy N.
Chapman, Matthew A.
Chu, Becky Q.
Combs, Cameron
Dao, Khuong D.
De La Fuente, Thomas Frank
East, Jason D.
Fakhar, Hedi
Fendt, John F.
France, Alex
Hoathian, Michelle
Hostetler, Madison
Ismail, Ammar Q.
Levi, Austin
Li, Shirley
Lozano, Faber D.
Martinez, Brendon
Mericle, Kyle
Oduntan, Tumi
Romero, Jonathan
Ross, Romnii
Shin, Sandra
Simon, Joseph
Tang, Leiming
Townsend, Tyron A.
Tran, Alexander
Tsai, Annabelle S.
Victor, Paige
Wu, Huan
Yang, Angela

RESIDENT MEMBERS
Ahn, Daniel
Alweiss, Mona
Antequera, Alexis
Chen, Kevin M.
Cinclair, Joseph
Cox, Johhnie W.
Cuellar, Waldo
Dhother, Karanvir S.
Diaz, Giancarlo
Esla, Jason S.
Gad, Laura
Gandhavadi, Sarvani
Komandur, Abhinav S.
Kotamarti, Aaron
Linnemeyer, Steven M.
Matulewicz, Antoni L.
Msays, Alexi
Muir, Lorne D.
Ojeaga, Jamal
Ojeda-Prias, Ana
Osuagwu, Kennedy
Ramdass, Eric G.
Skidmore, James
Trinh, Tiimothy Q.

MEDICAL STUDENTS MEMBER
Barnes, Kalan K.
Evans, Jason S.
Gilani, Salaman
Gonzalez, Edson
Hamoudah, Leema
Jameson, Lauren C.
Kong, Justin Sung-Pyo
Momin, Zavher
Monyancha, Diana
Raber, Ethan
Rafati, Yousef
Skaribas, Elena

FUTURE TSA MEETING DATES

2024 ANNUAL MEETING
SEPTEMBER 5-8, 2024
JW MARRIOTT SAN ANTONIO HILL COUNTRY
SAN ANTONIO, TX

2025 ANNUAL MEETING
SEPTEMBER 4-7, 2025
JW MARRIOTT SAN ANTONIO HILL COUNTRY
SAN ANTONIO, TX

2026 ANNUAL MEETING
SEPTEMBER 10-13, 2026
JW MARRIOTT SAN ANTONIO HILL COUNTRY
SAN ANTONIO, TX

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TSA DISTRICT DIRECTORS

District 1	Joseph F. Bryan, II
District 2	Christopher T. Miller
District 3	Brian D. Dewan
District 4	Stacey L. Allen
District 5	Jeffrey S. Richards
District 6	Henry L. Bethea
District 7	January Y. Tsai
District 8	Sherif Z. Zaafran
District 9	Kristina L. Goff
District 10	Mark A. Margolis
District 11	John Y. Ok

TSA DISTRICT BOUNDARIES

The Districts of this Society shall be composed as follows:

District 1. The District will include the counties of Andrews, Armstrong, Bailey, Borden, Brewster, Briscoe, Carson, Castro, Childress, Cochran, Coke, Collingsworth, Cottle, Crane, Crockett, Crosby, Culberson, Dallam, Dawson, Deaf Smith, Dickens, Donley, Ector, El Paso, Fisher, Floyd, Gaines, Garza, Glasscock, Gray, Hale, Hall, Hansford, Hartley, Hemphill, Hockley, Howard, Hudspeth, Hutchinson, Irion, Jeff Davis, Kent, King, Lamb, Lipscomb, Loving, Lubbock, Lynn, Martin, Midland, Mitchell, Moore, Motley, Nolan, Ochiltree, Oldham, Parmer, Pecos, Potter, Presidio, Randall, Reagan, Reeves, Roberts, Schleicher, Scurry, Sherman, Sterling, Stonewall, Sutton, Swisher, Terrell, Terry, Tom Green, Upton, Val Verde, Ward, Wheeler, Winkler, and Yoakum.

District 2. The District will include the counties of Archer, Baylor, Callahan, Clay, Cooke, Denton, Eastland, Foard, Hardeman, Haskell, Jack, Johnson, Jones, Knox, Montague, Palo Pinto, Parker, Shackelford, Stephens, Tarrant, Taylor, Throckmorton, Wichita, Wilbarger, Wise, and Young.

District 3. The District will include the counties of Bastrop, Bell, Blanco, Bosque, Brown, Burnet, Coleman, Colorado, Comanche, Concho, Coryell, Erath, Falls, Fayette, Freestone, Gillespie, Hamilton, Hays, Hill, Hood, Kimble, Lampasas, Lavaca, Lee, Leon, Limestone, Llano, Mason, McCulloch, McLennan, Menard, Milam, Mills, Robertson, Runnels, San Saba, Somervell, Travis, and Williamson.

District 4. The District will include the counties of Atascosa, Bandera, Bexar, Caldwell, Comal, DeWitt, Dimmit, Edwards, Frio, Gonzales, Guadalupe, Karnes, Kendall, Kerr, Kinney, LaSalle, Maverick, Medina, Real, Uvalde, Webb, Wilson, and Zavala.

District 5. The District will include the counties of Aransas, Bee, Brazoria, Brooks, Calhoun, Cameron, Chambers, Duval, Galveston, Goliad, Hardin, Hidalgo, Jackson, Jefferson, Jim Hogg, Jim Wells, Kenedy, Kleberg, Liberty, Live Oak, Matagorda, McMullen, Nueces, Orange, Refugio, San Patricio, Starr, Victoria, Willacy, and Zapata.

District 6. The District will include the counties of Austin, Brazos, Burleson, Fort Bend, Grimes, Madison, Montgomery, Walker, Waller, Washington, and Wharton; and that portion of Harris County that is outside Loop 610.

District 7. The District will include that portion of Harris County defined by the following: North border, Highway I-59; East border, Highway 288; South border, Old Spanish Trail; West border, Main Street.

District 8. The District will include that portion of Harris County inside Loop 610, excluding the area with the following boundaries, which is District 7: North border, Highway I-59; East border, Highway 288; South border, Old Spanish Trail; West border, Main Street.

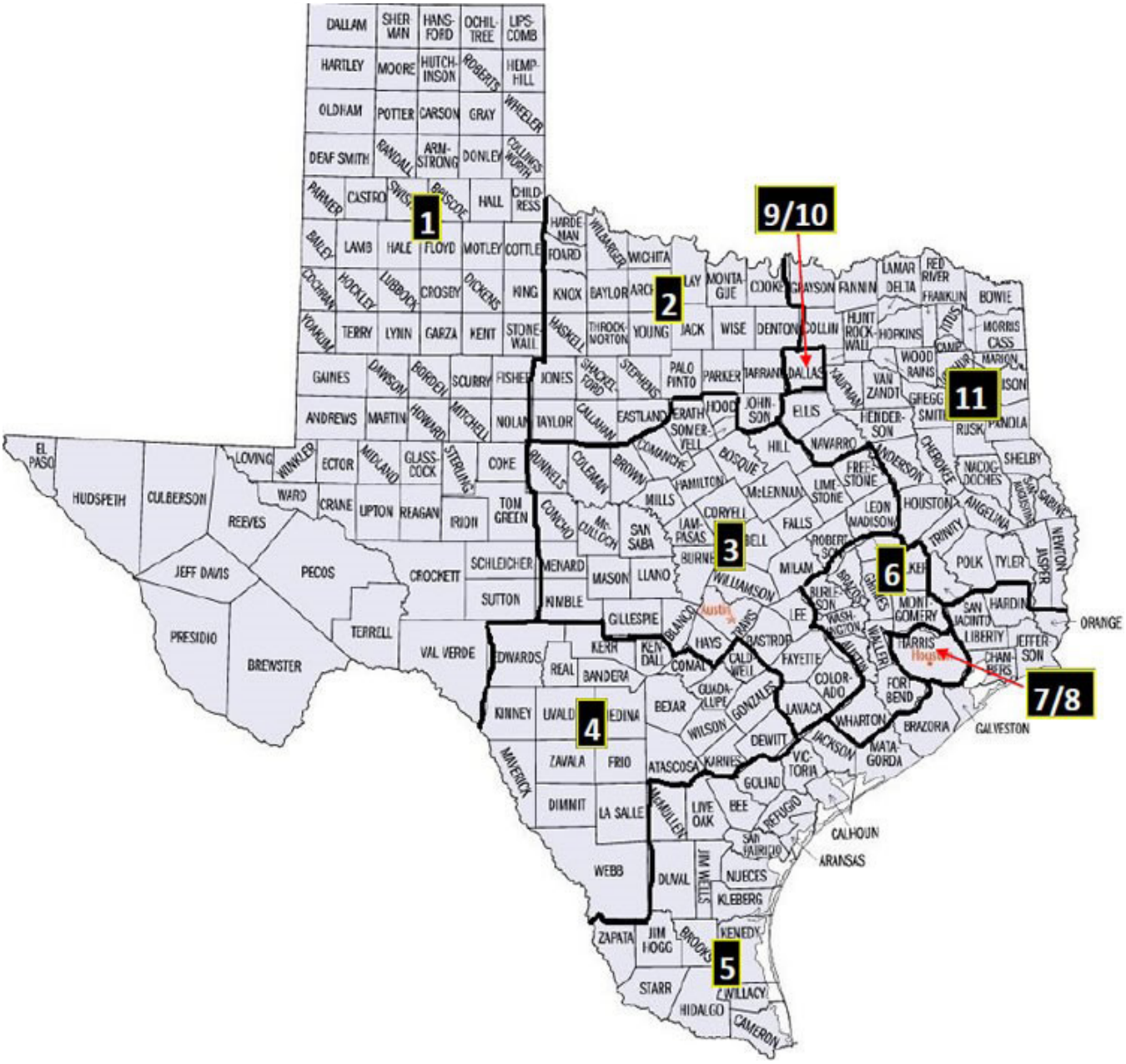
District 9. The District will include that portion of Dallas County west and south of the following boundary line: from the north border of Dallas County, south on the Dallas North Tollway to the intersection of the Dallas North Tollway with I-35E, south on I-35E to the intersection of I-20, east on I-20 to the intersection of I-45 and south on I-45 to the south border of Dallas County.

District 10. The District will include that portion of Dallas County east and north of the following boundary line: from the north border of Dallas County, south on the Dallas North Tollway to the intersection of the Dallas North Tollway with I-35E, south on I-35E to the intersection of I-20, east on I-20 to the intersection of I-45 and south on I-45 to the south border of Dallas County.

District 11. The District will include counties of Anderson, Angelina, Bowie, Camp, Cass, Cherokee, Collin, Delta, Ellis, Fannin, Franklin, Grayson, Gregg, Harrison, Henderson, Hopkins, Houston, Hunt, Jasper, Kaufman, Lamar, Marion, Morris, Nacogdoches, Navarro, Newton, Panola, Polk, Rains, Red River, Rockwall, Rusk, Sabine, San Augustine, San Jacinto, Shelby, Smith, Titus, Trinity, Tyler, Upshur, Van Zandt, and Wood; and that portion of Dallas County east of the 635 Loop and North of I-30.

Adopted September 9, 2011

TSA DISTRICT MAP



DISTRICT 1: Panhandle/West Texas

DISTRICT 2: Fort Worth (Cow Town)/North Texas

DISTRICT 3: Central Texas/The Hill Country

DISTRICT 4: San Antonio (The Alamo City)
South Texas (The Brush Country)

DISTRICT 5: Gulf Coast/Rio Grande Valley
(The Hurricane Magnet)

DISTRICT 6: (The Historic) Brazos Valley

DISTRICT 7: Houston Texas Medical Center

DISTRICT 8: Metro Houston

DISTRICT 9: (Big D) Dallas West

DISTRICT 10: (Big D) Dallas East

DISTRICT 11: Piney Woods/NE Texas