



New Orleans may be old, but it certainly never *gets* old. The Crescent City will serve as the backdrop for the 2001 ASA Annual Meeting, blending history, culture and the latest in anesthesiology education and technology.

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#### SUBSTANCE ABUSE HOTLINE

Contact the ASA Executive Office at (847) 825-5586 to obtain the addresses and telephone numbers for state medical society programs and services that assist impaired physicians.

## VENTILATIONS

#### An Eye for an Eye

n June 11, 2001, we executed convicted terrorist Timothy McVeigh. I use the word "we" because the United States is "us," as in "We the People..." It was the first time in 38 years that the federal government engaged in such activity. In *this* situation, few could argue that the death penalty was too harsh of a sentence for the convicted prisoner. He engaged in extreme political terrorism without remorse and destroyed the lives of thousands of families in Oklahoma City.

McVeigh was "put to sleep" in a manner quite familiar to us as practicing anesthesiologists — with a barbiturate, muscle relaxant and, of course, potassium. If one had viewed the rerun of the Kevorkian-Wallace "60 Minutes" euthanasia segment, which aired a few days prior to the execution, one might have seen death by injection as peaceful, even shockingly uneventful: Movement stopped, eyes closed, muscles relaxed, and it was over. This clean and efficient method of death is in sharp contrast to the historical reports of past executions by hanging, guillotine or electrocution. One can only wince when contemplating too slow of a strangulation, decapitation or prolonged electrical current igniting the condemned prisoner.

Ironically, this execution has coincidentally rekindled enthusiasm for euthanasia and our role as the knowledgeable medical specialty in providing such "services." I am, quite frankly, terrified by having our specialty mentioned in the same sentence as euthanasia or execution. Regardless of your views on these controversial topics, we should not promulgate our specialty's role in such activity. Simply stated: Ending peoples' lives is not the practice of medicine.

Our society has become too comfortable with the death of social misfits, the terminally ill, accidents of conception and paralyzed patients. Moreover, killing is ubiquitous; it occurs in our cities, in foreign countries, in the media, as a means of terrorism and as part of our entertainment. Our ability to render patients unconscious and insensible to the pain of surgery should not be extended into the taking of life. Euthanasia and capital punishment are societal issues, not medical controversies. While physicians serve as experts on fetal development, disease prognosis, pharmacotherapy and aging, it is not logical to assume that they should serve as the practitioners for ending life. The taking of another person's life may be justified by consensus, but it still remains a vestige of a barbaric society. Physicians are trained to preserve life and maintain a quality of living; therein lies the art of healing. Starting an intravenous line and sequentially administering predosed drugs to render a person both unconscious and lifeless take little talent. With the advent of bispectral neurophysiologic monitoring, the task is further simplified for the nonprofessional.

If society wishes to actively end the lives of certain citizens, it is far more economical to train nonhealth care personnel to cannulate veins, push plungers, watch monitors and check a pulse. Let us keep those remaining physicians still in practice divorced from the association of "primum nocere."



Mark J. Lema, M.D., Ph.D. Editor

M.J.L.

## ADMINISTRATIVE UPDATE

#### **Voting Process and Safeguards in the House of Delegates**

Eugene P. Sinclair, M.D., Speaker of House of Delegates

The last presidential election serves as an example of problems associated with voting. If an outcome is close and the process by which decisions are reached leaves room for disagreement over the results, the losing side often questions the accuracy of vote counts and the fairness or integrity of procedures.

The House of Delegates is the primary legislative and governing body of ASA. For the actions of the House to be credible, trust in the integrity of its proceedings and the accuracy of its decisions is essential. The purpose of this article is to explain the voting techniques and safeguards that are used at the House to ensure fairness and accuracy.



Eugene P. Sinclair, M.D.

#### **Consent Calender**

The majority of the reports that are voted on by the House are disposed of by means of a Consent Calendar. A Consent Calendar is a list of reports containing information or recommendations that are regarded as routine, noncontroversial business. The House approves the entire list by General Consent, a procedure that will be explained later. Before a vote is taken on a Consent Calendar, the Speaker asks whether any member of the House wishes to extract a report for separate consideration. If any member of the House requests extraction of a report, the report is removed from the Consent Calendar and considered formally. After all requests for extraction of reports have been heard, the House adopts the entire remaining list of reports by a single vote without debate. The Consent Calendar is an efficient method for disposing of routine business. The right of any member to extract reports for formal consideration is the safeguard against "railroading" business through the House without proper consideration or inaccurate determination of the majority's will.

#### **General Consent**

General Consent is used to dispose of reports that also are routine or noncontroversial but have not been placed on a Consent Calendar. An example would be a report on which no debate occurs when presented to the House. The Speaker will state, "If there is no objection, the report will be approved." Any member of the House may object to

General Consent by stating, "I object." It is not necessary for the member to be recognized or to have a second. The single request is sufficient to require that a vote be taken. If no member objects, the report is approved by General Consent. Again, the right of any member to voice an objection is the safeguard against railroading business through the House without proper consideration.

#### **Voice Vote**

Voice vote is the next most common method of voting in the House. In voice voting, the Speaker calls for those in favor to say "aye" and for those opposed to say "no." If possible, the Speaker determines the outcome. The shortcomings of voice votes are well recognized. Where one sits

in the room, proximity to microphones and how loudly individuals vote contribute to the interpretation of the outcome of a voice vote.

To ensure against the inaccurate determination of a voice vote, the Speaker, if in doubt about the outcome of a voice vote, repeats the vote with another method of voting. Further, if the Speaker announces an outcome, any member of the House who doubts the Speaker's judgment on a voice vote may rise to "doubt the vote" or "call for a division of the assembly." The Speaker will call for a counted vote, unless the member's intent is clearly dilatory. The member does not have to be recognized to make the request, and a second is not required.

#### **Standing Vote**

A standing vote can be used in lieu of a voice vote. If either the Speaker or any member of the House doubts the outcome of a standing vote, a formal counted vote is taken. Tellers who have been appointed and trained by the Vice-Speaker take all counted votes. All tellers are ASA members but may not be voting members of the House. In the case of a standing vote, four teams consisting of two tellers per team pass down each row of delegates to count those favoring a motion. After counting each row, the two tellers on each team compare their counts. If their counts do not

Continued on page 25

# WASHINGTON REPORT

## Jeffords' Defection Alters Dynamics of Senate Patient Protection Debate

Michael Scott, Director Governmental and Legal Affairs

The decision of Senator Jim Jeffords (I-VT) to leave the Republican Party most visibly altered the balance of power in the Senate, placing in the hands of Senator Thomas A. Daschle (D-SD) and the Democrats the opportunity to set that body's legislative agenda. For health care providers, however, perhaps the most significant aspect of the Senator's move will be its effect on the dynamics of debate on and possible passage of patient protection legislation.

Almost seven years have passed since bills were first introduced in the Congress, designed to rein in some of the major operation excesses of managed care organizations (MCOs). As a member of the Patient Access Coalition, ASA was principally active from those earliest days in promoting the so-called "point-of-service" patient option that would give managed care beneficiaries the right to see a specialist of their own choice — outside the MCO network.

Many states have passed patient protection laws covering the point-of-service option and other patient protections, but the problem has always been that state laws could not reach multistate, self-insured plans covered by the Employee Retirement Income Security Act (ERISA). Hence the push in recent years has been to modify ERISA to permit MCOs to be held accountable under federal law.

Patient protection bills passed the Senate and House last year, but they were significantly different in scope and content — with the House bill representing the more aggressive effort to create federal patient protections. Efforts to hold a conference on the two bills proved unavailing, essentially because of opposition

among conservative Republicans in the Senate to reaching any agreement at all.

Soon after the current 107th Congress was organized, Senators John McCain (R-AZ), John R. Edwards (D-NC) and Edward M. Kennedy (D-MA) introduced the Bipartisan Patient Protection Act (S. 283), which contains virtually all the patient protection provisions — including pointof-service — that have been supported by the Patient Access Coalition. In May, a competing bill called the Bipartisan Patients' Bill of Rights Act (S. 889) was introduced by Senators Jeffords (then a Republican), Bill Frist (R-TN) and John B. Breaux (D-LA).

The latter bill assured the same patient protections as the former, but was somewhat more conservative in its approach to the liability of MCOs in the event of denial of care. President Bush indicated that he supported the Jeffords-Frist-Breaux bill, but would veto the McCain-Edwards-Kennedy bill due to MCO liability concerns. The Congressional Budget Office has estimated that adoption of the two bills would respectively result in a 2.9-percent and 4.2-percent increase in managed care premiums when fully phased in over five years.

The American Medical Association (AMA) has supported the more aggressive McCain bill, but ASA and 13 other medical specialty organizations endorsed the Jeffords bill, essentially because it contained the patient protections sought by those groups and, because of the President's support, had the greater chance of passage. Most observers believe that the liability provision of the two bills could be rather easily resolved if the

will existed to achieve a compromise.

With Senator Jeffords' move to independent status, Senator Daschle, now as Majority Leader, has indicated his intent to bring the McCain bill to the Senate floor for debate and a vote in June. The commitment of the prior Senate Republican leadership to schedule early consideration of patient protection legislation was far less clear, and now, for the first time, it appears possible that the Senate may pass a compromise bill within striking distance of various patient protection measures being developed in the House.

# HCFA Changes Its Name to CMS

n June 14, the Health Care Financing Administration (HCFA) changed its name to the Centers for Medicare & Medicaid Services, or CMS. The name change, according to a June 14 Health and Human Services (HHS) press release, represents the first wave of efforts to make CMS more responsive to health care consumers and providers. HHS Secretary Tommy Thompson said he feels that the new name better reflects the mission of the agency: to let patients, physicians and other health care providers know exactly what choices they have for their health care coverage.

The agency will be structured around three "centers" that reflect the agency's lines of business: the Center for Beneficiary Choices, the Center for Medicare Management and the Center for Medicaid and State Operations. The press release also stresses that CMS will provide specific indi-

viduals dedicated to working with each state and territory in the United States and with all organizations that work with CMS' stakeholders.

The agency will launch a \$35 million national media campaign this fall that will highlight the changes and new health care options available. More information on the developments at CMS can be found at <www.medicare.gov> and at (800)-MEDICARE (800-633-4227).

#### Scully Announces Medicare Reforms

In early June, newly confirmed CMS Administrator Thomas A. Scully announced CMS' intention to release in July a package of administrative reforms designed to make the agency more provider-friendly. The announcement was inspired in major part by increasing congressional support for the AMA-supported Medicare Education and Regulatory Fairness Act (MERFA) (S. 452, H.R. 868). As of June 7, the bill enjoyed 33 cosponsors

in the Senate and 200 in the House. ASA, along with other provider organizations, is a MERFA supporter.

MERFA calls for a host of regulatory reforms relating to the provision of and reimbursement for care of Medicare beneficiaries, most of them designed to ease the burden on providers and to lessen the current punitive approach adopted by CMS and its agents in dealing with billing errors. Administrator Scully has said that his agency intends to adopt about half the reforms proposed by MERFA; at the same time, he expressed the intent not to adopt reforms that would lessen the effectiveness of the federal False Claims Act.

A second Medicare reform plan, dealing with the agency programs themselves, is also reported to be on the drawing board at CMS. This potentially would be coupled with development by Congress with a prescription drug benefit for seniors. Few congressional observers believe that such a plan can be passed this year, especially in light of the limited available surplus remaining after pas-

sage of President Bush's \$1.35 trillion tax cut last month.

# Supervision Regulations to Be Drafted by CMS

ealth and Human Services Secretary Tommy Thompson's announcement of May 18, suspending the Clinton rule to eliminate physician supervision of nurse anesthetists under Medicare, contemplated the early publication of a new proposed rule. The new rule is expected to defer the need for supervision to the nation's governors.

As of this writing, the proposed rule has not been published, but ASA understands that it is now under review by the Office of Management and Budget. ASA has been active in contacting Senators and Representatives to explain and offer support for the concept of the Thompson proposal, pending publication of the proposed rule.

New Orleans: You'll Be Swamped With Things to Do

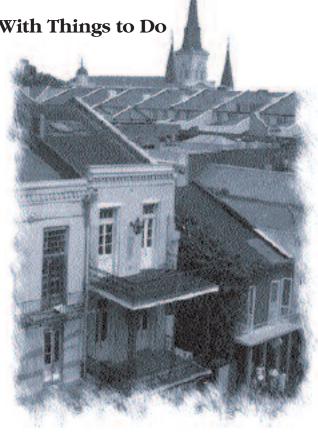
erriam-Webster's Collegiate Dictionary defines the word "jambalaya" as "a mixture of diverse elements." There are about as many tasty recipes for this ubiquitous New Orleans staple as there are people in New Orleans. Oftentimes it consists of everything that is left over from previous dishes: ham, fish, crab, onions, crawfish, okra, garlic, rice and anything else that might be lying around the kitchen. If ever a food could represent a city, jambalaya would represent New Orleans. One gets the sense that New Orleans was thrown together like so much jambalaya. There are swamps and skyscrapers, nightclubs and churches; there is joie de vivre (joy of life), and there are the Cities of the Dead. Yet all these seemingly disparate elements somehow manage to coexist and even flourish together. This homogony of disparate elements is what makes New Orleans one of the most visited cities in the world. It is also what makes it quite possibly the most fascinating city in the world.

Because fun and business so often go hand-in-hand, ASA has chosen New Orleans as the site for its 2001 Annual Meeting. Through its lectures, exhibits and presentations, this year's Annual Meeting will give its participants the best that anesthesiology has to offer. And during the off hours, New Orleans will offer the best in entertainment, food and culture. Here's just a glimpse of the variety that awaits you in the Crescent City.

#### Music

The wildly popular New Orleans rhythm and blues musician Ernie K-Doe once said of his city, "I'm not sure, but I'm almost positive, that all music came from New Orleans." This may be an exaggeration, but it's certainly





true that all types of music are represented here. Louis Armstrong, Jelly Roll Morton, the Neville Brothers and Fats Domino may have made New Orleans' musical heritage legendary, but that heritage continues to be enriched in practically every corner of the city at almost every hour of the day. Establishments such as Tipitina's, Snug Harbor and Preservation Hall represent the best that jazz and blues have to offer — anywhere. Like so many proud traditions in this city, music is infused into the everyday activities of its citizens (and visitors). Bluegrass and zydeco bands will appear suddenly on any given French Quarter street for an impromptu jam session; lone saxophonists play on practically every corner. A leisurely stroll through just one small section of the French Quarter truly can prove to be a lesson in musical and cultural history.

#### Food

As mentioned before, New Orleans is often referred to as a "melting pot." It also has been called "The Spice of



Life City," the "City of Chefs" and "America's European Masterpiece." The more gastronomically inclined will surely see a pattern here: New Orleans associates itself with food as often as possible, and food is a very serious business (well, as serious as a city known as the Big Easy can be about anything). Some of the finest restaurants in the world are located in New Orleans, but New Orleans is less famous for its restaurants than for its attitude. Food is a celebration here; it is a universal language. As a city of immigrants, New Orleans has experienced language barrier problems. In the mid-1800s, immigrants from Africa, Spain, France, Germany, Italy and Croatia brought with them their own foods and their cuisine. They met and mingled and realized that, in one way at least, they spoke the same language: the language of good food. This vast cultural amalgamation gave birth to the fantastic cuisine available today throughout the city. There is a reason that it's so rare to find respected traditional New Orleans dishes offered on the menus of restaurants in, say, New York, Chicago or San Francisco. The reason is this: Others realize that no one does it better than New Orleans.

#### **Architecture**

Despite the fact that the French Quarter makes up only a very small portion of the city proper, one could spend years there and probably never see all the marvels that exist within its borders. Its narrow streets are lined with rows of two- and three-story French- and Spanish-style homes, giving it the feel of a forgotten 18th century European city. But the French Quarter is far from forgotten and far from static. New Orleans is not stuck in time, but rather seamlessly incorporates its past in its day-to-day activities. The best way to see the architectural

marvels of the Quarter is by foot. There's nothing drab here — the homes and businesses are resplendent with bright blues, yellows and reds. Elaborate wrought iron balconies and gates line many of the buildings. In Jackson Square sits the country's oldest active cathedral, the magnificent St. Louis Cathedral, and the 14-foot Andrew Jackson statue, the most photographed statue in New Orleans. An array of walking tours are available that explore the architectural marvels of the one-of-a-kind French Quarter.

The famous Garden District may be best seen by the city's movable museums — the St.

Charles streetcars. For \$1.50, you can enjoy the beautiful, towering oaks and lush foliage that line the lawns of the innumerable antebellum mansions along a 13-mile route of St. Charles Street. These lumbering, clanking, lime-green streetcars have been running continuously for more than 150 years. Even if the spectacular views that appear along the route didn't exist, a ride on these historic landmarks still would be worth much more than the price of the ride.

#### The "Other" Side of New Orleans

Just outside the city lie some of the most pristine and untouched swamplands in the United States. Alligators thrive here, as do numerous turtles, herons, exotic plants and the occasional cougar or black bear. Various companies in New Orleans offer educational and fun tours of unblemished natural lands that have changed little through the centuries.

Although much less wild, the plantations that dot the landscape around New Orleans are no less fascinating and awe-inspiring. Through its social activities program, ASA



# **Emery A. Rovenstine Memorial Lecture:**

Glenn W. Johnson, ASA Executive Director, to Present 'ASA: Education, Science and Advocacy — Past, Present and Future'

Roberta L. Hines, M.D., Chair Section on Annual Meeting

lenn W. Johnson, ASA Executive Director, will present the 2001 Emery A. Rovenstine Memorial Lecture. His lecture, "ASA: Education, Science and Advocacy — Past, Present and Future," will be delivered on Monday, October 15, at 11:15 a.m. at the Morial Convention Center. The lectureship honors distinguished anesthesiologist Emery A. Rovenstine, M.D., past Chair of the Department of Anesthesiology at the New York University Medical Center and Director of Anesthesiology at the Bellevue Hospital.

Mr. Johnson has been actively involved in ASA activities since joining the organization in 1971. He attended Lake Forest College in Lake Forest, Illinois, and graduated in 1962 with a bachelor of science degree in business administration. Follow-

ing graduation, he was employed for seven years as the office manager of a manufacturing company. After a few years, the intellectual stimulation associated with this position waned, and Mr. Johnson joined ASA in search of "challenges." I wonder if he had any idea what the subsequent 30 years would be like? Mr. Johnson's initial title at ASA was Administrative Assistant. His primary responsibilities included working with the Membership Department, the Medical Student Preceptorship Program, Regional Workshops and the Sections on Education and Clinical Care. At that time, continuing medical education and scientific advancement were the primary objectives of ASA. However, the changing landscape of medicine and anesthesiology, particularly the political aspects of organized medicine, were soon to offer new challenges for Mr. Johnson and the ASA staff.

The 1980s were a period of rapid growth for anesthesiology, evidenced by a dramatic increase in membership. For a member who attended the 1980 Annual Meeting, he or she would have been one of the 6,112 registrants who visited 249 exhibit booths. Compare this to the 2000 Annual Meeting, which hosted 17,440 registrants and 749 exhibit booths. During this period of 20 years, Mr. Johnson distinguished himself as a leader among the ASA executive staff. His leadership expertise resulted in his promotion to the position of Director of Administration. In this new position, he continued to work within the Sections on Edu-



Glenn W. Johnson

cation and Clinical Care while becoming increasingly involved with the Board of Directors and the House of Delegates. Although he maintained an overall responsibility for ASA's membership activities, day-to-day oversight of this function was assumed by a new member of the executive staff.

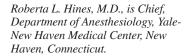
Concurrent with its leadership roles in education and scientific activities, ASA emerged as a major advocate for anesthesiology in the United States. This new venture required the establishment of a Washington office and staff responsible for practice management and lobbying activities. In 1987, Mr. Johnson was promoted to Executive Director, a position he presently holds. In this role, Mr. Johnson serves as the pivotal force for coordinating all ASA's

educational, scientific and political activities.

Mr. Johnson was always interested in architecture and building design. In 1992, a new ASA headquarters facility was designed and built to accommodate expanded ASA activities. This project provided "fertile ground" for him to apply his architectural talents and design ideas. Mr. Johnson hired an architect and literally started brainstorming with a blank sheet of paper, which was then transformed into a three-story, 44,000-square-foot ASA headquarters facility.

When I was gathering information for this article, I asked Mr. Johnson if there were any particular points from

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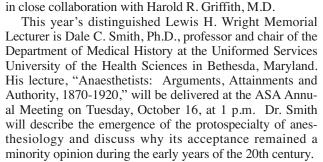


# Lewis H. Wright Memorial Lecture:

Dale C. Smith, Ph.D., to Discuss 'Anaesthetists: Arguments, Attainments and Authority, 1870-1920'

Kathryn E. McGoldrick, M.D., Chair Lewis H. Wright Memorial Lectureship Committee Wood Library–Museum of Anesthesiology

The Lewis H. Wright Memorial Lecture, sponsored annually by the Wood Library-Museum of Anesthesiology, honors its namesake, an indefatigable pioneer in American anesthesiology who was devoted to enhancing the stature of anesthesiology as a clinical science and medical specialty. A dynamic innovator, Dr. Wright was a founding member of the Board of Trustees of the Wood Library-Museum and, in later years, served as its president-emeritus. He also was a founder of the World Federation of Societies of Anaesthesiologists in 1955, working



Born in Orlando, Florida, in 1951, Dr. Smith has accumulated an impressive academic background. He received his B.A. from Duke University and his Ph.D. in History of Medicine from the University of Minnesota. Dr. Smith has written extensively and has delivered numerous lectures nationally and internationally. Among the many eponymous lectures to Dr. Smith's credit was the annual Samuel Clark Harvey Memorial Lecture given in 1991 at Yale University School of Medicine, where he spoke about "Curing



Dale C. Smith, Ph.D.

With Cold Steel: The Emergence of Surgery as a Therapeutic Option, 1880-1930." Other presentations reflective of his eclectic historical interests have explored medicine's place in the university, the Flexner report and its consequences, a historical perspective on surgical training and certification in the United States, the impact of the Civil War on orthopedic surgery, the influence of malaria on military operations and medical history, the role of women in American medicine, the influence of anesthesia on the development of modern surgery and a historical perspec-

tive on medical malpractice litigation in America.

Anyone who has had the good fortune to hear Dr. Smith speak knows that he possesses a savant's reverence for accuracy, provenance and context. Yet his erudition sparkles with a vibrant wit and an unwillingness to be held hostage by the tyranny of convention. An insightful, engaging and provocative speaker, Dr. Smith is fascinated by the romance and humor of history. Nonetheless, he is a consummate realist with no tendency to hide the less savory moments of our past or to give a glossy make-over to historical figures. His lectures provide a palimpsest of historical references, suggesting continually shifting cultural values as well as the political, economic, geographic and social factors that have shaped medicine. Adept at exposing myths and misconceptions, Dr. Smith is not one to package a tidy set of simplistic historical images suggesting that medical history is a neat continuum moving toward perfectly realized objectives. Rather, he reflects an abiding appreciation of the concept that the "real" picture is vastly more intriguing than the retouched and sanitized version.

The Wood Library-Museum of Anesthesiology is honored to have the eminent medical historian Dale C. Smith, Ph.D., as the 2001 Lewis H. Wright Memorial Lecturer. We thank him for his unique gift of infusing life and relevancy into our medical heritage, rather than merely preserving it like an insect in amber.



Kathryn E. McGoldrick, M.D., is Professor of Anesthesiology at Yale University School of Medicine, and Medical Director of Ambulatory Surgery at Yale-New Haven Hospital, New Haven, Connecticut. She is a trustee of the Wood Library-Museum of Anesthesiology.

#### **FAER Honorary Research Lecture:**

#### Debra A. Schwinn, M.D., to Give Inaugural FAER Lecture on 21st Century Research

Carl C. Hug, Jr., M.D., President Foundation for Anesthesia Education and Research

The Foundation for Anesthesia Education and Research (FAER) will sponsor the first FAER Honorary Research Lecture at the 2001 ASA Annual Meeting in New Orleans. FAER has created this annual lectureship as a means of recognizing outstanding scholarship by anesthesiologists and encouraging their careers in research and teaching, which are crucial if anesthesiology is to maintain its reputation as a speciality that strives for excellence and continuous improvement in patient care.



Debra A. Schwinn, M.D.

Dr. Schwinn's lecture "Thinking Out of the Box — Anesthesiology Research in the 21<sup>st</sup> Century" will take place on Monday, October 15, from 2 p.m. to 3 p.m. in room 352 of the Morial Convention Center.

In choosing Dr. Schwinn to deliver the first FAER Honorary Research Lecture, the Foundation has set a high standard for its ensuing honorees. Dr. Schwinn currently is Professor and Director of the Molecular Pharmacology Laboratory in the Department of Anesthesiology at Duke University Medical Center. In 2000, Dr. Schwinn was awarded a Visiting Investigator Program award at the Human Genome Research Institute of the National Institutes of Health to study the role of adrenergic polymorphisms in hypertension. Her research has made significant contributions to the basic understanding and clinical management of cardiovascular regulation and genitourinary pathophysiology, and she continues to work toward an understanding of how genetic differences between people relate to disease outcomes, particularly in the settings of cardiovascular surgery and anesthesia and intensive care. Most importantly, she has mentored 16 fellows who now hold positions in academic medicine and pharmaceutical companies.

Despite her innumerable accomplishments in medicine, anesthesiology was not her first love. Originally, Dr. Schwinn planned to be a concert violinist. She decided to focus on science early in her career, but music is a passion that has never left her. She has taught violin, was a member of a bluegrass band and, while at Stanford University Medical School, played in the Stanford Symphony Orchestra and various chamber music ensembles. She continues to participate in musical groups, most recently with a string quartet in Rochester, New York, while attending the annual meeting of the Association of University Anesthesiologists (AUA).

To Dr. Schwinn, music and science are not disparate elements in her life: "In both science and music, there is a pressure to do well technically; but talent involves going beyond technique to the creation of music that communicates, or in science, to an integrated mechanistic understanding of human disease," Dr. Schwinn said.

Despite her years of research experience and countless contributions to academia, Dr. Schwinn still has found time to be the devoted wife of Robert Gerstmyer for 20 years and an encouraging mother of Anna (13 years)

and Heidi (6 years), who are studying ballet and violin, respectively.

In every aspect of her life, Debra A. Schwinn, M.D., personifies what the FAER Honorary Research Lecture was created to represent. She has combined her extraordinary energy and enthusiasm with solid training in research fundamentals, a supportive academic department and initial funding awards (including a FAER/AUA fellowship and a FAER Research Starter Grant) to achieve an outstanding array of successes in her career as an anesthesiologist, scientist, teacher, mentor, musician, wife and mother.

Carl C. Hug, Jr., M.D., Ph.D., is Professor of Anesthesiology and Pharmacology, Emory University School of Medicine, and Attending Physician in Cardiothoracic Anesthesiology and Intensive Care, Emory University Hospital, Atlanta, Georgia.



# 2001 Annual Meeting Schedule October 13-17, 2001 New Orleans, Louisiana

EVENT	FRIDAY OCTOBER 12	SATURDAY OCTOBER 13	SUNDAY OCTOBER 14	MONDAY OCTOBER 15	TUESDAY OCTOBER 16	WEDNESDAY OCTOBER 17
REGISTRATION		Morial Convention Center				
	3:00 - 9:00	7:30 - 5:00	8:00 - 5:00	8:00 - 5:00	8:00 - 5:00	8:00 - 2:00
SCIENTIFIC				N	Norial Convention Cente	r
PAPERS					9:00 - 5:00	
BREAKFAST					New Orleans Hilton	
PANELS					7:45 - 8:45	
ROVENSTINE				Morial Convention Center		
LECTURE				11:15 - 12:15		
LEWIS H. WRIGHT					Morial Convention Center	
MEMORIAL LECTURE					1:00 - 1:50	
REFRESHER COURSE			l	Morial Convention Cente	er	
AND CLINICAL UPDATE PROGRAM		9:00 - 5:20	9:00 - 5:20	12:40 - 1:30	11:30 - 1:30	11:30 - 1:30
ASA ART, SCIENTIFIC				Morial Convention Cente	er	
AND TECHNICAL EXHIBITS			12:00 - 5:00	9:00 - 4:00	9:00 - 4:00	
CLDWGAL				l l	Norial Convention Cente	r
CLINICAL FORUM				9:00 - 10:30	9:00 - 12:00	9:00 - 12:00
				2:00 - 5:00	2:00 - 5:00	
PROBLEM-BASED LEARNING		7.00 0.45		ans Hilton	10.00 1.15	
DISCUSSIONS		7:30 - 8:45 12:30 - 1:45	7:30 - 8:45 12:30 - 1:45	12:30 - 1:45 3:45 - 5:00	12:30 - 1:45 3:45 - 5:00	
HOUSE OF DELEGATES			New Orleans Marriott 9:00			New Orleans Marriott 8:00
REFERENCE COMMITTEES			New Orleans Marriott 1:00	New Orleans Marriott (if necessary)		
SOCIAL ACTIVITIES		SPECIAL SPOUSE TOURS AND SEMINARS				
HOSPITALITY ROOMS		Morial Convention Center, New Orleans Hilton and New Orleans Marriott 8:30 - 5:00				

77 TO 100	MONDAY	TUESDAY	WEDNESDAY		
EVENT	OCTOBER 15	OCTOBER 16	OCTOBER 17		
	Morial Convention Center and New Orleans Hilton (Refer to the Annual Meeting Program for exact locations.)				
SPECIAL	*Workshop on Advanced Fiberoptic Laryngoscopy	*Workshop on Advanced Fiberoptic Laryngoscopy	Panel on It's Protection, Protection, Protection: Current Status of Organ Preservation in Cardiac Anesthesia		
MEETINGS	9 a.m5 p.m.	9 a.m5 p.m.	9 a.m11 a.m.		
AND	*Workshop on Adult Fiberoptic Laryngoscopy	*Workshop on Adult Fiberoptic Laryngoscopy	Panel on Obstetric Anesthesia: Contemporary Issues		
LECTURES	9 a.m5 p.m.	9 a.m5 p.m.	9 a.m11 a.m. Panel on Practical Interactive TEE Case Presentations		
	*Workshop on Pediatric Fiberoptic Laryngoscopy	*Workshop on Pediatric Fiberoptic Laryngoscopy 9 a.m5 p.m.	Panel on Practical Interactive TEE Case Presentations  9 a.m11 a.m.		
	9 a.m5 p.m. *Workshops on Computing	*Workshops on Computing	Panel on Compliance With HCFA Payors: Keys to Success		
			9 a.m11 a.m.		
	9 a.m5 p.m. *Workshop on Difficult Airway	9 a.m5 p.m. *Workshop on Transesophageal Echocardiography	Panel on Anesthetic Techniques and Outcomes After Intracranial		
	· · · · · · · · · · · · · · · · · · ·		Surgery 9 a.m11 a.m.		
	9 a.m5 p.m.  Panel on Emerging Issues in Regional Anesthesia	9 a.m5 p.m. *Workshop on Considerations in Thoracic Anesthesia	9 a.m11 a.m.  Panel on Level 1 Evidence at Last! Does Combined Epidural/GA		
		· ·	Improve Outcome After Major Surgery?		
	9 a.m11 a.m.  Panel on Critical Care Medicine: New Therapies in the ICU-	9 a.m5 p.m. *Workshop on Detecting and Troubleshooting Malfunctions in	9 a.m11 a.m.  Panel on How to Create an Effective Near-Miss/Adverse Event		
	What the Future Holds 9 a.m11 a.m.	*Workshop on Detecting and Troubleshooting Malfunctions in Anesthesia Delivery Systems 9 a.m12 noon	Reporting System 9 a.m11 a.m.		
	Panel on the Second Century of Hyperbaric Oxygen Therapy 9 a.m11 a.m.	*Workshop on Peripheral Nerve Blocks 9 a.m12 noon	Panel on the "Holy Grails" of Anesthesia Monitoring: Have We Found Them Yet? 2 p.m4 p.m.		
	Panel on I Can Move My Leg, It Doesn't Hurt, Are You Sure They Did	*Workshop on Acupuncture	1 1		
	a Total Knee? Continuous Peripheral Nerve Blocks 9 a.m11 a.m.	9 a.m12 noon	Panel on Expand Your Horizons: A Guide to Selecting and Making Successful Volunteer Contributions in Anesthesiology 2 p.m4 p.m.		
	Panel on Cardiac Arrhythmias: Drugs and Devices	Panel on the Cutting Edge in Patient Safety	Panel on Perioperative Pain		
	9 a.m11 a.m.	9 a.m11 a.m.	2 p.m4 p.m.		
	Panel on Challenges in Pediatric Critical Care	Panel on Vexing Problems and Controversies in Trauma Anesthesia	Panel on Who Will That Masked Person Giving Anesthesia Be? Will		
	9 a.m12 noon	9 a.m11 a.m.	She/He Be an Anesthesiologist, Resident, CRNA, AA or the Lone Ranger? 2 p.m4 p.m.		
	Panel on Complimentary Medicine and Anesthesia-Herbals, Hypnosis, Music and More	Panel on to Transfuse or Not to Transfuse? That is the Question.	Panel on LMA, PAx, Combitube or COPA-A Guide to Selecting and Using Supraglottic Airway Devices 2 p.m4 p.m.		
	9 a.m11 a.m.  Panel on Setting Up a Pain Medicine Practice: Pitfalls and Solutions	9 a.m11 a.m.  Panel on Error and Injury: Recognition, Understanding, Intervention	Panel on How Can Multimedia Enhance Learning in Anesthesia?		
	9 a.m11 a.m.	9 a.m11 a.m.	2 p.m4 p.m.		
	*Workshop on Communications: Media and Speech Training	Panel on Surgical Outcome: Regional Versus General Anesthesia	Panel on the Changing Face of Preoperative Evaluation		
	2 p.m5 p.m.	9 a.m11 a.m.	2 p.m4 p.m.		
	*Workshop on Peripheral Nerve Blocks	Panel on Women in Medicine: Leadership Into the 21st Century	Panel on Current Blood Transfusion Practices: What's New and What's True 2 p.m5 p.m.		
	2 p.m5 p.m.  Workshop on Anasthesia Breathing Circuits: Mechanical	9 a.m12 noon  Panel on Resuscitation From Severe Hemorrhage	2 p.mo p.m.		
	Workshop on Anesthesia Breathing Circuits: Mechanical, Physiological and Functional Aspects 2 p.m5 p.m.	2 p.m4 p.m.			
	FAER Honorary Lecture	Panel on Current Trends in the Management of the High Risk Obstetric Patient			
	2 p.m3 p.m.	2 p.m4 p.m.			
	FAER Panel on Evidence-Based Medicine and the Clinical Practice of Anesthesia 3 p.m5 p.m.	Panel on Adding Clinical Workforce 2 p.m4 p.m.			
	Panel on Scoliosis and Other Greek Words Pediatric Spine Surgery for the New Millennium 2 p.m4 p.m.	Panel on Complications of the Elder Surgical Patient 2 p.m4 p.m.			
	Panel on Safe Neuraxial Anesthesia	Panel on Evidence-Based Outcomes of Interventional Pain Procedures			
	2 p.m4 p.m.	2 p.m4 p.m.			
	Panel on Hot Spots in Quality and Departmental Management	Panel on PACU Problems			
	2 p.m4 p.m.	2 p.m4 p.m.			
	Panel on Issues of Concern to the Aging Anesthesiologist 2 p.m4 p.m.	Panel on Colorful Figures and Moments of Conflict in the History of Anesthesiology 2 p.m4 p.m.			
	Panel on Ethical Challenge: The Problem of Incompetence	Panel on Pediatric Issues			
	2 p.m4 p.m.	2 p.m5 p.m.			
	Panel on Management of Complications Related to Perioperative Pain Control in Pediatric Patients 2 p.m4 p.m.	Panel on So You Want to Be an Author: A Primer for the Budding Academic Physician 2 p.m5 p.m.			
	Panel on the Well-Being of the Physician Healers				
	2 p.m4 p.m.				
	Forum on the Writing of the History of Anesthesiology 2 p.m5 p.m.				

<sup>\*</sup> Those special meetings and lectures listed above that appear in **boldface** with an asterisk require tickets for attendance. All other special meetings and lectures listed above do not require tickets, and you do not have to register for them in advance. However, only those registrants wearing their name badges will be allowed into the meeting rooms.

#### 1,375 Reasons to Attend the Annual Meeting

Arnold J. Berry, M.D., Chair Committee on Scientific Papers

he Committee on Scientific Papers (see box) has selected 1,375 abstracts for presentation at the 2001 Annual Meeting in New Orleans, Louisiana. These scientific papers will be presented in either a poster or posterdiscussion format with each session containing abstracts on a single theme grouped by subject content. The poster sessions, each lasting two or three hours, will be held on Monday and Tuesday, October 15 and 16, and will consist of 30 abstracts each. Abstract authors will be present with their posters throughout the session so that attendees may discuss the work. Two facilitators, experts in the general topic and familiar with the specific studies being presented, will be available at each poster session to interact with authors and attendees. The poster-discussion sessions, lasting 90 minutes, will be held Monday through Wednesday, October 15-17, and will contain eight abstracts each. The posters will be available for review for the first 30 minutes of the session, followed by the discussion portion that will be coordinated by two moderators. The presenters, some using slides, will spend approximately two to three minutes commenting on the key findings of their studies. The moderators will then open the study to questions and discussion from all participants.

#### **Submission and Selection Process**

All abstracts were submitted and graded electronically using a Web-based process. ASA worked closely with representatives of Marathon Multimedia, Inc., Minneapolis, Minnesota, who managed the submission and grading Web sites. Each abstract was reviewed and graded by at least three members of one of the 15 subcommittees. Of the 1,892 abstracts submitted, 72.8 percent were selected for presentation. Subcommittee chairs then grouped the



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#### **Scientific Paper Subcommittees and Chairs**

Ambulatory and Geriatric Anesthesia Kathryn E. McGoldrick, M.D.

Anesthetic Action and Biochemistry Jonas S. Johansson, M.D.

Clinical Circulation Lee A. Fleisher, M.D.

Clinical Neurosciences Susan Black, M.D.

Critical Care and Trauma M. Christine Stock, M.D.

Drug Disposition
Steven L. Shafer. M.D.

Equipment/Monitoring/Engineering Technology J. Jeffrey Andrews, M.D.

Experimental Circulation David J. Cook, M.D.

Experimental Neurosciences and Biochemistry *Robert A. Pearce. M.D.* 

Local Anesthesia and Pain Terese T. Horlocker, M.D.

Neuromuscular Transmission *Cynthia A. Lien, M.D.* 

Obstetric Anesthesia and Perinatology David J. Birnbach, M.D.

Patient Safety/Practice Management/History/Education Susan L. Polk, M.D.

Pediatric Anesthesia Gopal Krishna, M.D.

Respiration David O. Warner, M.D.

accepted abstracts into sessions containing presentations on similar themes. The submission and selection processes have been significantly expedited through the use of this electronic format.

All abstracts presented at the Annual Meeting will be published on a CD-ROM that will be included with the September issue of *Anesthesiology*. The CD-ROM will contain both the 2000 and 2001 abstracts, which will be searchable by topic and author. In addition to the CD-ROM, the full abstracts will be accessible for review via the ASA and *Anesthesiology* Web sites and at computer kiosks in the Morial Convention Center in New Orleans during the ASA Annual Meeting. Since there will be no printed version of the abstracts, the amount of text permitted in the abstract was increased over that of the previous year.

#### **Journal Symposium**

The 2001 Journal Symposium, sponsored by the editorial board of *Anesthesiology*, will be held on Tuesday, October 16, from 9 a.m. to 12:30 p.m. The symposium "Cellular and Molecular Control of Sleep: Relevance for Anes-

thesiology," was organized by Mervyn Maze, M.B., and James C. Eisenach, M.D., who will also serve as moderators. Eight papers have been selected for presentation at this session.

I would like to thank the subcommittee members and chairs for their expertise and the time that they devoted to reviewing these scientific papers and organizing the 72 sessions. These abstracts are a wonderful example of the most current research and scholarly work being performed by members of our specialty. The committee hopes that you will find the presentations to be of value and encourages you to attend the sessions, talk with the authors and interact with the moderators and facilitators as they review the posters.

## Emery A. Rovenstine Memorial Lecture

Continued from page 7

his 30 years at ASA that he would like to highlight. His response exemplifies his dedication and commitment to ASA and its members: "Aside from having witnessed rather phenomenal growth, I have been most impressed with the dedication of ASA's leadership. Not only the President, but all of the officers, members of the Board of Directors and House of Delegates and committee chairs and members have given freely of their time and effort to improve the specialty in numerous ways from presidents testifying to Congress to academicians lecturing at the Annual Meeting. What is probably most difficult to put into words is the pride I have in ASA and its members. I cannot imagine that a finer organization or a finer group of individuals could exist. My initial impression when I joined ASA was the incredible dedication and thirst for knowledge displayed by the mem-

bers, and if anything, that impression has just become more heightened over the years. The willingness of members to give something back to their profession challenges all of us on the staff to be certain that opportunities are not squandered."

The Emery A. Rovenstine Memorial Lecture honors the memory of one of our greatest anesthesiologists. It is quite appropriate and fitting that this year's lecture honors another great member of our anesthesia community. We are indeed fortunate to have someone of Mr. Johnson's integrity, intellect and dedication looking out for ASA and all of us. This lecture provides a perfect forum for all the members to express their gratitude to Glenn W. Johnson for 30 years of exemplary guidance and friendship.

# Refresher Course, Clinical Update and Basic Science Review Program

Donald S. Prough, M.D., Chair Committee on Refresher Courses

The Refresher Course Lecture and Clinical Update Program will continue the long ASA tradition of providing a concentrated, clinically relevant didactic series on Saturday, October 13 and Sunday, October 14, with additional presentations during mid-days on Monday, Tuesday and Wednesday, October 15-17.

This year, for the first time, on Saturday, October 13, the program will include a novel, additional educational series — the Basic Science Review Program. The new series will consist of six lectures covering a broad range of topics that are fundamental to the practice of perioperative medicine. Adrian W. Gelb, M.D., will discuss the principles of control of the cerebral circulation. Ronald G. Pearl, M.D., will review matching of ventilation and perfusion in the lung. Edward R. Sherwood, M.D., will provide an overview of current concepts regarding the inflammatory response. Robert N. Sladen, M.B., will review the physiology of urine formation. James M. Sonner, M.D., will examine the mechanisms of anesthetic action. David C. Warltier, M.D., will provide an overview of the control of myocardial function.

The Refresher Course Lectures and Clinical Updates consist of 99 lectures that address the entire spectrum of clinical practice and practice management. Airway management, a core skill in the practice of anesthesiology, will be addressed by six speakers. Jonathan L. Benumof, M.D., will examine the ASA Difficult Airway Algorithm. David Z. Ferson, M.D., will review the use of the laryngeal mask airway. Carin A. Hagberg, M.D., will discuss current concepts in the management of the difficult airway. Steven C. Hall, M.D., will address recognition and management of the pediatric patient with a difficult airway. Robert K. Stoelting, M.D., will review current perspectives on preop-



Donald S. Prough, M.D., is Professor and Chair, Rebecca Terry White Distinguished Chair, Department of Anesthesiology, University of Texas Medical Branch, Galveston, Texas.

erative oral intake and the risk of aspiration of gastric contents. Michael M. Todd, M.D., will discuss the implications of cervical spine anatomy and function for the anesthesiologist.

Cardiovascular topics will once again be an important aspect of the program. Jeffrey S. Balser, M.D., will review antiarrhythmic therapy. Paul G. Barash, M.D., will discuss monitoring of perioperative myocardial ischemia. Michael K. Cahalan, M.D., will examine the role of transesophageal echocardiography in cardiac surgical patients. John E. Ellis, M.D., will address management of myocardial ischemia. Lee A. Fleisher, M.D., will summarize current concepts regarding preoperative assessment of the patient with cardiac disease. Glenn P. Gravlee, M.D., will discuss new approaches to cardiac surgery. William E. Hurford, M.D., will address current perspectives on the therapeutic use of nitric oxide. William E. Johnston, M.D., will review the use of drugs to support blood pressure and cardiac output. Jonathan B. Mark, M.D., will discuss effective use of central venous pressure monitoring. Michael J. Murray, M.D., will review evaluation and perioperative management of hypertensive patients. Charles W. Otto, M.D., will address current concepts in cardiopulmonary resuscitation. Scott T. Reeves, M.D., will review the role of transesophageal echocardiography in noncardiac surgery. Myer H. Rosenthal, M.D., will discuss the management of cardiogenic, hyperdynamic and hypovolemic shock. Marc A. Rozner, M.D., will address pacemakers and implantable cardioverter-defibrillators. Linda J. Shore-Lesserson, M.D., will discuss hematologic aspects of cardiac surgery. Jeffery S. Vender, M.D., will review the use of pulmonary arterial catheters and mixed venous monitoring.

Because of the increasing importance of pain management and regional anesthesia in anesthesia practice, the Refresher Course Lecture and Clinical Update Program will include 15 lectures on those topics. Christopher M. Bernards, M.D., will discuss the use of intrathecal and epidural opioids. David J. Birnbach, M.D., will review combined spinal and epidural anesthesia for labor anesthesia. David L. Brown, M.D., will provide an update on brachial plexus blocks. John F. Butterworth IV, M.D., will discuss current concepts of the action of local anesthetics and misconceptions regarding their use. William R. Camann, M.D., will address the question of the influence of regional anesthesia on the progress and outcome of labor. F. Kayser Enneking, M.D., will summarize the use

of regional anesthesia for orthopedic surgery. James C. Eisenbach, M.D., will review current concepts of pain physiology and pharmacology. Hugh C. Gilbert, M.D., will provide an overview of complications and controversies in regional anesthesia. Terese T. Horlocker, M.D., will discuss the diagnosis and prevention of peripheral nerve injury following regional anesthesia. Spencer S. Liu, M.D., will discuss continuous plexus blockade. Michael F. Mulroy, M.D., will review indications for and contraindications to regional anesthesia. Joseph M. Neal, M.D., will address the question of whether regional anesthesia makes a difference in perioperative outcome. Mark C. Norris, M.D., will review the safety and success of epidural anesthesia during labor. Julia E. Pollock, M.D., will provide advice on techniques to increase the success of regional anesthesia. Santhanam Suresh, M.D., will discuss the use of regional anesthesia for pediatric patients.

Issues central to the clinical management of ambulatory anesthesia will be the focus of nine lectures. Jeffrey L. Apfelbaum, M.D., will discuss current controversies in outpatient anesthesia. Charles J. Coté, M.D., will review preparation, premedication and induction of anesthesia in children. Peter J. Davis, M.D., will review the pharmacology of newer agents useful in pediatric anesthesia. Richard F. Kaplan, M.D., will discuss sedation and analgesia of pediatric patients undergoing procedures outside the operating room. Patricia A. Kapur, M.D., will address challenges occurring in the postanesthesia care unit. Walter G. Maurer, M.D., will assess considerations related to the cost and quality of preoperative evaluation. Phillip E. Scuderi, M.D., will discuss postoperative nausea and vomiting. Peter S. Sebel, M.B., will address awareness during general anesthesia. Rebecca S. Twersky, M.D., will review issues related to recovery and discharge of ambulatory surgical patients.

In addition to these topic areas, three lectures will address topics related to allergy, infection and inflammation; 30 presentations will focus on anesthesia techniques; five will discuss issues related to coagulation, endocrine, metabolic and fluid management; 19 will address critical care issues; 11 will review technology, monitoring and equipment; five will discuss geriatric anesthesia; six will discuss medicolegal and ethical issues; 11 will address neurosurgical anesthesia; eight will review current concepts in obstetric anesthesia; 11 will examine operating room management and practice management; eight will discuss pedi-

atric anesthesia; 12 will address pharmacologic issues; 12 will review issues related to postoperative management; 11 will address preoperative preparation; and six will discuss emergency or trauma anesthesia.

We are honored that these outstanding individuals have agreed to share their experience and expertise with ASA membership at the 2001 ASA Refresher Course Lecture, Clinical Update Program and Basic Science Review Program. As Chair of the ASA Committee on Refresher Courses, I am indebted to the hard work and critical insights offered by members of the Committee and especially to Dr. Apfelbaum, Vice-Chair of the Committee. The Committee has recommended a total of 105 speakers and topics that should address the wide variety of needs of our membership for timely, clinically relevant information. We look forward to seeing you in New Orleans.

#### **Technical Exhibit Program**

uring ASA's Annual Meeting on October 13-17, 2001, in New Orleans, the Technical Exhibit Program will be held from Sunday through Tuesday, October 14-16. Approximately 300 companies are expected to participate.

Exhibits will be open from noon to 5 p.m. on Sunday, October 14 and from 9 a.m. to 4 p.m. on Monday and Tuesday, October 15 and 16, in Halls G-I1 in the Morial Convention Center.

Annual Meeting attendees are encouraged to visit the exhibits, which add another dimension to the educational opportunities of the meeting. Exhibitors also contribute vital support to ASA and the Annual Meeting.

Registrants for the 2001 Annual Meeting, except exhibitors and spouses, will be provided with encoded name badges for information retrieval by exhibitors. Exhibitors will be able to use the encoded badges to record names and mailing addresses of registrants who wish to receive further information. It is, of course, entirely at the discretion of individual attendees whether or not they would like to receive further information from exhibiting companies.

#### Panels and Workshops Cover Issues From A to Z

Jeffrey B. Gross, M.D., Chair Committee on Panels

The Committee on Panels is pleased to announce an expanded program of panels and workshops at this year's Annual Meeting. There will be a total of 46 panels, 12 workshops and nine clinical forums, with a diversity of topics sufficient to arouse just about anyone's curiosity. In keeping with the successful format introduced last year, each panel will be two hours in duration; in most cases this will allow a bit of extra time at the conclusion of the formal presentations for "schmoozing" with the panelists. A new feature this year is the addition of goal-oriented learning objectives to the description of each panel in the Annual Meeting program. We hope that this will help members choose panels that will meet their specific requirements.

In making your Annual Meeting travel plans, please keep in mind that the panel and workshop program runs from Monday morning, October 15, through Wednesday afternoon, October 17. Some of our most popular panels will be held on Wednesday, so why not plan to enjoy an extra day of New Orleans hospitality and participate in a Wednesday panel or workshop as well?

As in the past, this year's panel program will include old favorites in addition to timely new additions that reflect continuing changes in the science of anesthesiology as well as the environment in which we practice. For example, Bobbie J. Sweitzer, M.D., will moderate a panel on "Complementary Medicine and Anesthesia — Herbals, Hypnosis, Music and More." Many of our patients are using or requesting complementary therapy, and this discussion offers the opportunity to obtain the latest information on these techniques.

Considering the continuing flux of the regulatory environment, the panel "Hot Spots in Quality and Departmental Management" by John M. Zerwas, M.D., should be partic-



Jeffrey B. Gross, M.D., is Professor of Anesthesiology and Pharmacology, University of Connecticut School of Medicine, Farmington, Connecticut.

ularly timely for those whose practices are about to be reviewed by internal or external accrediting agencies. Theodore J. Sanford, Jr., M.D., will moderate a session on a topic that is near, if not dear, to all our hearts: "Compliance with HCFA Payors: Keys to Success." If you are concerned about medical direction requirements and the possibility of inadvertent "kickbacks," this is the panel for you.

The expanding roles of regional anesthesia in the operating room and for postoperative pain management will be addressed in several panels. F. Kayser Enneking, M.D., will moderate a session titled "I Can Move My Leg, It Doesn't Hurt, Are You Sure They Did a Total Knee?" where both inpatient and outpatient applications of continuous peripheral nerve blocks will be discussed. Jeffrey A. Grass, M.D., will moderate a panel on "Surgical Outcome: Regional Versus General Anesthesia" that will address the effect of regional anesthesia on the outcomes of thoracic, gastrointestinal, peripheral vascular and aortic surgery. In keeping with the trend toward development of evidencebased models for clinical practice, John C. Rowlingson, M.D., will chair a session titled "Evidence-Based Outcomes of Interventional Pain Procedures" that will introduce the concept of evidence-based medicine while addressing such issues as radio frequency neuroablation and spinal cord stimulation. On a more practical note, David C. Mackey, M.D., will discuss "Setting Up a Pain Medicine Practice: Pitfalls and Solutions." Our younger patients will be the focus of a panel by Charles B. Berdé, M.D., on complications associated with spinal, epidural and patient-controlled analysis in the pediatric population.

The health status and competence of physicians will be addressed in several new panels. Jonathan D. Katz, M.D., will moderate a session on "The Well-Being of The Physician Healers." If you have been concerned about the effect of an "on-call" night on your clinical performance the next day, this is the panel for you! A related topic, "Ethical Challenge — The Problem of Incompetence" will be discussed by Stanley H. Rosenbaum, M.D., and his panelists as they define "incompetence," and suggest strategies for dealing with it among our colleagues in anesthesiology and other specialties.

History buffs will find several panels to be particularly inviting. Enrico M. Camporesi, M.D., chairs a program on "The Second Century of Hyperbaric Oxygen Therapy," while Douglas R. Bacon, M.D., will discuss "Colorful Figures and Moments of Conflict in the History of Anesthesi-

ology." If you happen to know what *letheon* is (or if you want to find out), you will not want to miss this interesting discussion.

In the present climate, workforce issues are of particular concern. Philip Liu, M.D., will moderate a panel titled "Who Will That Masked Person Giving Anesthesia Be? Will She/He Be an Anesthesiologist, Resident, CRNA or the Lone Ranger?" Or perhaps you will find the panel by Robert E. Johnstone, M.D., "Adding Clinical Workforce," more useful.

The workshop program will include a number of triedand-true favorites. George J. Sheplock, M.D., and Michael P. Smith, M.D., will once again present their popular computer workshops. Everything from basic Internet use to advanced applications of spreadsheet, word processing and slide presentation programs will be covered in these sessions, which include the opportunity for hands-on experience.

If you want to refresh your skills in troubleshooting problems with the latest anesthesia machines, plan to attend the workshop titled "Detecting and Troubleshooting Malfunctions in Anesthesia Delivery Systems," by Jan Ehrenwerth, M.D. And who among us would not benefit from the hands-on experience offered by Terence Rafferty, M.D., in his workshop "Transesophageal Echocardiography"?

Several workshops will help participants hone their crit-

ical airway management skills. Allan P. Reed, M.D., will present his "Difficult Airway Workshop" that will include supervised practice with devices and techniques including Bullard laryngoscopes, Wu scopes, esophageal-tracheal combitubes, lighted stylettes, cricothyroid puncture and retrograde intubation. James T. Roberts, M.D., and Stephen F. Dierdorf, M.D., will host workshops on basic and advanced adult fiberoptic intubation techniques, while Charles D. Nargozian, M.D., and Catherine P. Krucylak, M.D., will provide hands-on instruction in pediatric fiberoptic laryngoscopy.

The purpose of this summary is merely to whet your appetite: Space does not permit enumeration of the wide variety of presentations that will be available. Check your Annual Meeting registration booklet or program book for additional choices as well as the exact times and locations of your favorites. Please remember that some of the workshops require advance registration.

On behalf of the Committee on Panels, thanks goes out to all ASA members who proposed panels and workshops for our consideration. I would like to express my personal gratitude to the members of the Committee who did an outstanding job in selecting and coordinating a timely and diverse group of presentations for this year's Annual Meeting. See you all in New Orleans!

#### **Annual Meeting Placement Service**

This year, the Annual Meeting Placement Service will allow attendees to view practice opportunities on interactive multimedia units. Kiosks will be located in the ASA Resource Center in Hall I2-J at the Morial Convention Center and will be operational from Friday, October 12, through Wednesday, October 17. Refer to the Annual Meeting registration booklet or program book for specific times. Users can search by geographic area, job title or keyword. The information can be printed on site on laser printers. Locations with available positions will be able to browse applications submitted by attendees seeking a position. This information also can be printed on site.

Applications may be completed online at <www.asahq.org/Placement/homepage.html>. Here, you can complete the application, assign yourself a password and make any necessary changes to your information. Forms should be completed by October 5. If you do not have Internet access, an application form can be requested by telephoning ASA at (847) 825-5586. Forms can also be completed at the Annual Meeting, where personnel will be available to assist attendees with entering their information.

#### **Breakfast Panels: Nutrition and Knowledge**

Charles W. Otto, M.D., Vice-Chair Section on Annual Meeting

The Breakfast Panels, sponsored by the nine major subspecialty societies, are one of the most popular educational activities at the ASA Annual Meeting. They provide an excellent early-morning stimulus, both nutritionally and educationally. The panels will meet on Monday, October 15, Tuesday, October 16 and Wednesday, October 17 from 7:30 a.m. to 8:45 a.m. each day. Three panels will be available on each day.

On Monday morning, the Section on Anesthesiology of the American Academy of Pediatrics will present an "Update on Pediatric Resuscitation" moderated by Jayant K. Deshpande, M.D. This is sure to be interesting and topical because new guidelines for cardiopulmonary resuscitation were published last year, and new pediatric advanced life support courses are currently being rolled out. At the same time, the American Society of Regional Anesthesia and Pain Medicine panel will feature "Teaching Regional Anesthesia in the New Millennium — Will Hands-On Techniques Become Obsolete?" This program, chaired by Marc B. Hahn, D.O., will explore new hands-on teaching techniques as well as nonpatient-based technology. Also on Monday morning, the Society of Neurosurgical Anesthesia and Critical Care will present "Defining Outcomes in Neuroanesthesiology." Moderated by Mary A. Cheng, M.D., this panel will discuss outcome assessment associated with brain protection and seizure surgery as well as neuropsychological testing.

The offerings continue on Tuesday morning with the Society for Obstetric Anesthesia and Perinatology featuring "Obstetric Anesthesia 2001." This panel, moderated by Valerie A. Arkoosh, M.D., will provide insights into coding and American College of Obstetricians and Gynecologists guideline issues and discuss the safety of regional anesthe-

sia in preeclampsia. "Cerebral Injury Associated with Cardiac Surgery" is the timely topic of the panel sponsored by the Society of Cardiovascular Anesthesiologists, moderated by Gary W. Roach, M.D. Panel members will explore the manifestations, etiology and amelioration of cerebral injury in the setting of cardiopulmonary bypass. The American Society of Critical Care Anesthesiologists will present "Emerging Ethical Issues in Critical Care Medicine," moderated by Christopher C. Young, M.D. This panel is guaranteed to evoke audience participation in discussions about genetic engineering, cutting-edge therapies and differences between European and American ethical views.

A fitting start to the last day of the meeting will be provided by the panels on Wednesday morning. Becoming an effective team player is an important part of the education of an anesthesiologist. The Society for Education in Anesthesia will provide insights into achieving this goal with a panel moderated by Armin Schubert, M.D., titled "Interpersonal and Communication Skills — How to Select For, Teach and Evaluate This 'Core Competency.'" The practical aspects of starting and running a successful practice is the focus of the panel "Office-Based Anesthesia: Rules and Regs, Nuts and Bolts, Bread and Butter," sponsored by the Society for Ambulatory Anesthesia and moderated by Thomas W. Cutter, M.D. Continuing a theme from last year's panel, the Society for Technology in Anesthesia will present "Awareness Monitors Meet the Press: Point and Counterpoint." Moderated by Charlotte Bell, M.D., this topic should be of great interest to attendees, exhibitors and iournalists alike.

The Breakfast Panels are efficient educational opportunities with which to start your weekdays at the Annual Meeting. We hope you are as excited about them as we are. Remember, space is limited at these very popular offerings, so be sure to register early.



Charles W. Otto, M.D., is Professor of Anesthesiology and Associate Professor of Medicine, University of Arizona College of Medicine, Tucson, Arizona.

#### **Clinical Forum Program Offers Diversity**

Gregory K. Unruh, M.D., Chair Committee on Clinical Forum

The Clinical Forum sessions at the 2001 ASA Annual Meeting will be held Monday through Wednesday, October 15-17, at the Morial Convention Center in New Orleans, Louisiana. Last year's forums were informative, interactive, thought-provoking and fun! We believe the sessions this year will live up to the standard set last year. The Clinical Forum format is designed to allow a panel of experts to delve into designed cases informally and to discuss clinical management decisions.

Remember, Clinical Forums are a chance to interact with and question the experts, and the sessions are free! Of special note this year, the Clinical Forum on Anesthesia for Neurosurgery will be conducted by a double panel, and the session will be modeled after the "Survivor" television program. Panelists will be voted "off the island" by the audience for their case-based management decisions. It should be fun!

The Clinical Forum cases will be printed in the 2001 Annual Meeting program so participants may review and study them prior to attendance. Some of the forums will provide an expanded case summary and an outline of the important and controversial issues. Each Clinical Forum session is scheduled for 90 minutes, and the moderator will be keenly interested in facilitating audience discussion with the panelists. We took your suggestions and evaluations and incorporated them into this year's program. The forums will be exciting, and we look forward to seeing you there!

The 2001 Clinical Forum Committee has assembled the following forums for this year's Annual Meeting:

**Pediatric Anesthesiology Clinical Forum:** *Moderator*: Linda J. Mason, M.D., Loma Linda University Medical Center, Loma Linda, California.

**General Anesthesia and Trauma Clinical Forum:** *Moderator*: David A. Lubarsky, M.D., Duke University, Durham, North Carolina.

Cardiovascular and Thoracic Anesthesia Clinical Forum: *Moderator*: Steven L. Lillehaug, M.D., University of Iowa Hospital & Clinics, Iowa City, Iowa.

Obstetric Anesthesia Clinical Forum: *Moderator*: Linda S. Polley, M.D., University of Michigan Medical School, Ann Arbor, Michigan.

**Outpatient/Geriatric/PACU:** Walter G. Maurer, M.D., Cleveland Clinic Foundation, Cleveland, Ohio.

Neuroanesthesia Clinical Forum: *Moderator*: Gregory J. Crosby, M.D., Harvard University, Boston, Massachusetts.

**Ethics Clinical Forum:** *Moderator*: Gail A. Van Norman, M.D., University of Washington, Seattle, Washington.

**Pain Management Clinical Forum:** *Moderator*: Daniel B. Carr, M.D., Pain Management Program, New England Medical Center, Boston, Massachusetts.

Critical Care Clinical Forum: Moderator: Michael J. Murray, M.D., Ph.D., Mayo Clinic, Rochester, Minnesota.

Gregory K. Unruh, M.D., is Associate Professor and Director, Anesthesiology Resident Education, Kansas University Medical Center, Kansas City, Kansas.



#### From Hard Science to Software

Andranik Ovassapian, M.D., Chair Committee on Scientific and Educational Exhibits

The Scientific and Educational Exhibits will be presented at the ASA Annual Meeting in New Orleans, Louisiana, from Sunday afternoon, October 13, through Tuesday, October 16, 2001. These exhibits offer the opportunity for anesthesiologists to interact with experts, exchange ideas and express their views on a variety of topics.

The scientific and educational exhibits consist of two parts. The larger part includes peer-reviewed exhibits about the practice of anesthesiology, perioperative medicine, pain management and education. A much smaller part contains administrative exhibits with valuable information about the activities of a number of nonprofit organizations and societies.

Seven exhibits present various issues related to airway management. Tracheal intubation with video Macintosh blade makes it possible for both the endoscopist and the assistant who applies external pressure to observe the effect of external laryngeal manipulation. Two exhibits demonstrate techniques, devices and video presentation of airway management. The exhibits "Difficult Airway Cart" and "Difficult Airway System" demonstrate the role of a well-organized and well-equipped mobile airway cart. The organizational infrastructure necessary for effective management of a failed intubation also is described. The wireguided endobronchial blocker applied for single lung ventilation in pediatric patients is being presented for the first time. The role of the laryngeal mask airway in urological patients and teaching airway skills also are presented.

Pain management and regional anesthesia are the focus of several exhibits. The use of ultrasound technology for imaging peripheral nerves and the needle during performance of nerve blocks is a novel technique that may improve the success of nerve blocks. Epidural analgesia in



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infants, organizing an acute pain management service, the role of posterior tibial nerve block for a painful calcaneal spur and continuous epidural anesthesia for modified radical mastectomy complete the list of these exhibits.

Several educational exhibits focus on interactive hypermedia and computer-generated programs. Among them are the teaching of transesophageal echocardiography, anesthesia for major vascular surgery and introduction to anesthesia theory and practice. Other presentations include the role of a personal digital assistant (PDA) for collection of perioperative data, a PDA-compatible Web site and PDA-run software for taking a history and performing a physical examination on a Spanish-speaking patient.

The administrative exhibits remind us of the valuable work of a number of nonprofit organizations and societies. ASA, the International Anesthesia Research Society and the Postgraduate Assembly present anesthesiology as a progressive, safety driven, multifaceted medical specialty. REMEDY and Teaching Anesthesia in Developing Countries emphasize humanitarian missions. Subspecialty exhibits will be presented by the Society for Airway Management, the Society for Education in Anesthesia, the American Society of Critical Care Anesthesiologists and the Society for Ambulatory Anesthesia.

The members of the Committee on Scientific and Educational Exhibits will review the exhibits on Sunday afternoon and Monday morning, after which three exhibits will be selected for first-place or merit awards. Criteria include originality, clinical relevance, scientific merit and visual impact. Registrants are encouraged to visit the exhibits to review the interesting and diverse topics related to the practice of anesthesia and pain management. When visiting the exhibits, look for first-place and merits ribbon winners and congratulate them on their hard work and contribution to the ASA Annual Meeting.

The committee thanks the members who have contributed to this section of the ASA Annual Meeting. My sincere thanks to members Brian A. Cason, M.D., Gregory J. Crosby, M.D., Julian M. Goldman, M.D., John B. Leslie, M.D., Stephen R. Longo, M.D., Jerome F. O'Hara, M.D., Andrew D. Rosenberg, M.D., Juraj Sprung, M.D., Erin A. Sullivan, M.D., and Yaser Wafai, M.D., who all have devoted a considerable amount of time to serve on this committee and to execute their duties fairly.

#### **PBLD Program Takes Active Stance on Learning**

Meg A. Rosenblatt, M.D., Chair Committee on Problem-Based Learning Discussions

The Problem-Based Learning Discussion (PBLD) Program is celebrating its 10th year as an integral educational forum at the ASA Annual Meeting. Small group discussions of problem-oriented cases promote active learning in an informal environment. Moderators assist learners in identifying the key issues of the case and help the group in a process of self discovery. Many adult learners prefer this format, which requires active involvement, to the traditional passive assimilation of lectures. Tremendous numbers of attendees who return to the program each year are a testament to the success of the PBLD programs.

A record number of unsolicited cases were submitted by the ASA membership and were reviewed and evaluated by the PBLD committee. The result of this open-call process is that 45 percent of the 124 cases chosen for presentation this year are new to the program. The majority of older cases have been updated, with a trend toward improved scholarship. These updates and improvements should allow cases to be used in other academic venues or by those unable to attend the PBLD session themselves.

As usual, many experts will be facilitating sessions covering an extensive variety of topics this year. Managed care, clinical research and ethics discussions are interspersed among a wide spectrum of clinical cases. Sessions considering patients from pretermers through geriatrics are offered in an array of clinical settings from traditional to novel nonoperating room arenas. Discussions involving cutting-edge science and therapies are also included. The category of "education" has been added to the PBLD index, offering a forum for those interested in challenges in medical student and resident teaching.

Those who purchase PBLD tickets though preregistration will receive their "homework," which consists of objectives, a case with leading questions and a reference list in hard copy form mailed to their homes, allowing adequate time for participants to develop their own approach to the clinical problem prior to the meeting. This year, for the first time, PBLD participants will receive the entire 2001 PBLD Case Discussion program on CD-ROM.

PBLD sessions will be held at the New Orleans Hilton Hotel from Saturday, October 13 through Tuesday, October 16. Breakfast sessions will be held on Saturday and Sunday from 7:30 a.m. to 8:45 a.m. Luncheon sessions will be held Saturday through Tuesday from 12:30 p.m. to 1:45 p.m. Refreshment sessions will be held on Monday and Tuesday from 3:45 p.m. to 5 p.m. Food services will be

available 30 minutes prior to the onset of the sessions.

The tickets will be \$30 for the breakfast sessions, \$50 for the luncheon sessions and \$20 for the refreshment sessions. Sessions are filled on a first-come, first-served basis, so register early and list alternative choices in the event that your primary choice is sold out.

The members of the PBLD committee have implemented many of the suggestions garnered from the previous years' evaluations and worked to continue to expand the scope and quality of the cases. The result is a program that promises to be exciting. We invite and encourage all attendees of the 2001 Annual Meeting to attend one (or more) of the PBLD sessions.





#### 2001 Art Exhibit 'Down by the Riverside'

Jerry J. Berger, M.D., Chair Committee on Art Exhibits

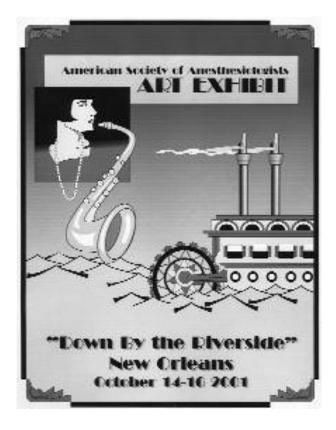
he ASA Committee on Art Exhibits is thrilled to announce the theme for the 2001 Annual Meeting Art Exhibit: "Down by the Riverside," which is, of course, inspired by our location in New Orleans, Louisiana. This theme offers artists and writers a unique opportunity to produce and enter their work in a well-defined category. So use your imagination, and dust off those water scenes, fountains and boats, or create something that inspires you and enter your work in the art exhibit. As always, works may be entered into the following categories: painting oil, acrylics, watercolor, tempura and gouache; photography - color and black and white; graphic works on paper — drawings, prints and pastels; sculpture — found objects, crafts including needlework, weaving, pottery, stained glass, jewelry, construction, metal work; literature; and junior exhibit (under 18).

A new category for this year is digital photography. Here is a chance for you computer wizards to show your fellow anesthesiologists just how good you are with a camera and mouse. Another new addition is an educational/instructional exhibit on one aspect of art. This year we will have a silk-screening exhibit.

Our judges have been selected for both art and literature. Sam Losavio is Assistant Director of the Louisiana Arts and Science Center in Baton Rouge, Louisiana. Mr. Losavio is an artist and former National Endowment for the Arts award recipient. Diane Losavio is the Executive Director of the Louisiana Association of Museums. Shelley Mickle (literature) is a world-renowned writer of several books, including *Mom's on the Loose, Queen of October* and *Replacing Dad*, which was produced as a television movie. The judges will award ribbons for first-place, second-place and third-place and honorable mention in each



Jerry J. Berger, M.D., is Associate Professor of Anesthesiology, University of Florida, Gainesville, Florida.



listed category and also in the show's "Down by the Riverside" theme. Junior exhibitors will receive ribbons, and a viewers' choice award will be given for the entry that was most enjoyed by the viewing public.

We hope to continue to entertain ASA members with the talents of their colleagues and their families. As always, it is the art and literature that makes the exhibit interesting. It is open to all members of ASA, their spouses and children. So get out those paintbrushes, open the craft drawer and dig way into the closets to come up with something to enter. No work is too small or large to exhibit. Remember that work is not only entered into the theme but into several other categories.

We are ahead of schedule this year and have completed the logo for the exhibit. This has been printed as a preview in this article. We will have T-shirts printed with this logo for sale at the exhibit for \$10. Be the first person at the meeting to proudly show your interest. The exhibit will be open from noon on Sunday, October 14, until 4 p.m. Tuesday, October 16.

Please visit the ASA Web site at <www.asahq.org/AnnMtg/artguidelines.htm> for the entire set of rules and regulations for the exhibit. You may enter up to six works per person.

I am pleased to be serving in my first year as chair of the ASA Art Exhibit. A new and pivotal person in this event is Kelly Spaulding of the University of Florida. She will coordinate the registration of entries and the actual exhibit

setup. I look forward to meeting the artists and viewing public and strive to continue the great legacy of art exhibited over the past 34 ASA Annual Meetings. Get ready for a great art exhibit in New Orleans. Come and rest, relax, refresh and renew yourself between your hectic academic schedule.

# New Orleans: You'll Be Swamped With Things to Do Continued from page 6

offers tours of the Houmas House and Nottoway plantations. The Nottoway Plantation is the largest plantation home in the South, encompassing 54,000 square feet of grandeur and nostalgia among some of the most beautiful acreage in the country.

Perhaps in a tribute to the final departure of many of New Orleans' citizens, you may want to visit the city's famous cemeteries, or "Cities of the Dead." In typical New Orleans fashion, they are like no other cemeteries you will ever see. Here, the dead are buried above ground — a legacy of the inhospitably boggy ground upon which the city stands. Many families spared no expense in the elaborate construction of their loved ones' final resting places. The result is a magnificent display, a living and lasting tribute to the varied personalities and cultures that made New Orleans so alive, so diverse and so fun.

#### **Regulations Governing Assignment of Tickets**

The Refresher Course Lectures and Clinical Update Program will be presented at the 2001 ASA Annual Meeting, Saturday through Wednesday, October 13-17, 2001. The lectures will be held in the Morial Convention Center.

A reservation form was included with the Annual Meeting registration materials sent in June. The form allows you to list choices for obtaining lecture tickets. The price of tickets for each lecture is \$10 for all registrants.

The 2001 Annual Meeting Refresher Course Lectures book containing summaries of the lectures, also available on CD-ROM, will be distributed free of charge at the Annual Meeting site to those who purchase four or more lecture tickets. Additional copies will be available at the meeting for \$15 per copy. The 2001 Annual Refresher Course Lectures book or CD-ROM will be distributed at the Annual Meeting instead of through the mail to ensure

that each registrant purchasing four or more tickets receives the book and to save on escalating mailing costs. The registration area will be open from 3 p.m. to 9 p.m. on Friday, October 12. This schedule will enable participants to register prior to the lectures.

Tape recording will not be permitted during the lectures. Anyone planning to attend any of the Refresher Courses should make reservations at the earliest possible date. Requests will be filled as they are received at the ASA Executive Office.

# Special Airline Arrangements, Car Rentals Offered

elta Air Lines, United Airlines and International Travel Service (ITS), in cooperation with ASA, have made special arrangements to offer Annual Meeting participants discount air fares for the 2001 Annual Meeting in New Orleans, Louisiana.

Both United Airlines and Delta Air Lines will offer a 10-percent discount on unrestricted coach fares or a 5-percent discount on the lowest applicable fares, including first-class tickets. An additional 5 percent will be added to the above discounts if tickets are purchased 60 days in advance.

In some cases, the discounts allowed by Delta and United may not be the most economical fare, depending on the routing and special promotion fares available. Delta and United will confirm the lowest rates at the time reservations are made. If you normally use the services of a travel agent, your agent may place your reservations through a toll-free number to obtain the same discount.

For reservations and information, call Delta Air Lines toll-free: (800) 241-6760, mentioning account number 171359A. Call United Airlines toll-free: (800) 521-

4041, mentioning account number 557FO. Call ITS toll-free: (800) 621-1083. When making reservations, mention that you will be attending the ASA Annual Meeting in New Orleans.

Rental cars are available at reduced rates through Avis Rent-a-Car and Budget Rent-a-Car. For Avis, call toll-free: (800) 331-1600 and mention account number J096028. For Budget, call toll-free: (800) 722-3773 and mention account number U063610. Discounted rates are extended one week before to one week after the ASA Annual Meeting dates.

When making your reservations, please mention that you are attending the ASA Annual Meeting on October 13-17 to receive the special reduced rate.

## **Voting Process and Safeguards in the House of Delegates**

Continued from page 2

agree, they recount the row. When the counts agree, they count the next row assigned to their team. After all teller teams have completed counting those in favor of the motion, they repeat the process to count those opposed to the motion. When each teller team has completed its counts, it reports to the Chief Teller who compiles the reports of the four teller teams into a single report. The Chief Teller and an assistant together compile the four individual team reports and must arrive at the same totals before the Tellers' Report is submitted to the Speaker. Finally, the Chair of the Credentials Committee verifies the total number of certified delegates seated at the time of the vote. This number is reconciled with the total vote count to ensure that the total number of votes does not exceed the number of delegates seated.

Although this method of counting ensures accuracy, surrounding delegates may influence how some members vote during a standing vote. Demeter, in the Manual of Parliamentary Law and Procedure (the Parliamentary Authority for the ASA House of Delegates until the 1992 Annual Meeting), says, "Voting by voice, show of hands and standing vote are automatic processes of open voting. They are intended to enable all members to see how the other members vote on a motion. Theoretically, such open voting processes are tests of loyalty, courage and constancy." Although most of us do not regard open voting as an act of courage, it is easy to think of circumstances where a member might vote differently if the vote would not be known by all. Such circumstances are the rationale for voting by ballot or for opposing such a method in some circumstances.

#### **Ballot Vote**

Ballot voting on a report may be ordered by a vote from the House. In the case of officer elections, the Bylaws specify that a ballot vote be used. The requirements for acceptable counting of ballots are:

- 1. ballots are secret;
- 2. all votes are counted;
- 3. no member's vote is counted more than once;
- 4. the vote count is correct.

At the House, the secrecy of a ballot is ensured by each voting member shielding the ballot from view by others while marking it. Each member then folds the marked ballot and personally gives it to the teller assigned to pass

down that row of delegates. This ensures that all ballots are collected and that no member can submit more than one ballot.

After all ballots are collected by the four teller teams, the polls are closed and no additional ballots will be accepted. The four teller teams bring the ballots to the Chief Teller's table where they are divided into roughly three equal batches. Tellers divide into three teams of three tellers each. Each team takes one of the three batches.

Ballots are sorted by each team into stacks for Candidate X, Candidate Y, etc., or into stacks for "aye" and "no" votes, as appropriate. The votes are tallied twice to assure accuracy, and the result is recorded with one teller counting, while a second teller tallies votes and the third teller observes. Each team then records and reports its totals to the Chief Teller in the same manner as is done for a standing vote, assuring an accurate tally. One teller checks the Chief Teller's arithmetic. Total votes submitted by each team are added and compared to total votes cast, added by candidate, as a final check on the count. Lastly, the number of total votes cast and the delegate count are reconciled as explained above.

These processes have evolved over many years and are based on the concerns and constructive comments that members have expressed to Speakers of the House. All ASA members can be confident that the decisions of the House are reached fairly and that the will of the majority is accurately determined.

# SUBSPECIALTY NEWS

# Society for Education in Anesthesia: Losing None at SEA

Armin Schubert, M.D., President Society for Education in Anesthesia

n estimated 5,000 U.S. anesthesiologists are affiliated with academic programs. In one way or another, therefore, they may face issues related to teaching. SEA's mission statement clearly indicates that the society's priority lies in supporting anesthesiologists involved in teaching. Its purpose is to help teaching anesthesiologists in the diffi-

cult task of educating young physicians despite growing clinical demands, Residency Review Committee requirements and regulatory constraints. SEA's meetings, committees and initiatives are meant to help teaching anesthe-



siologists be properly informed, grow professionally and accumulate academic achievement.

What are the most important resources of SEA that can help anesthesiology teachers? Table 1 summarizes educational meetings, committees, publications and other resources of the society. It also suggests the value each resource can potentially provide for teaching anesthesiologists.

SEA works closely with other organizations such as ASA, the International Anesthesia Research Society (IARS) and the Foundation for Education and Research (FAER) to promote education in anesthesiology. Committed SEA members contribute actively in ASA; for example, members serve on the Medical Student, Problem-Based Learning Discussion (PBLD) and Outreach Education Committees. SEA members also have contributed in a major way to ASA meetings and regional workshop pro-



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grams. SEA organizes a breakfast panel at the ASA Annual Meeting. This year, it is scheduled for Wednesday, October 17, and will address the topic "Communication and Interpersonal Skills," one of the newly required core competencies to be selected for, taught and assessed during residency training. Through a liaison with the IARS board

of directors, SEA's presence at the IARS Annual Meeting has become possible. SEA leadership has participated in an advisory capacity with FAER and has contributed in the area of education grant review. Through

its online journal <www.jepm.org> and print publications, SEA also encourages anesthesiologists to take advantage of FAER education grants.

SEA's resources are made more accessible through the society's professionally managed Web site <www.seahq.org>. Through this Web site, SEA members and others can renew or apply for membership, subscribe to publications, register for meetings and keep up-to-date on new developments in anesthesia education.

Future educational resources SEA intends to develop include a CD-ROM for medical students interested in anesthesiology, which features educational goals and teaching

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#### Footnotes for Table 1 (Page 27)

<sup>1</sup> Topics at a recent meeting have included information technology in anesthesia education, promotion of trainee problem-solving and thinking, innovative teaching in regional anesthesia and pain management, a tutorial on evaluating for core competencies, research in medical education, due process in residency, as well as "teaching tune-up" and simulation workshops.

<sup>2</sup> Topics recently delivered by SEA speakers have included resident recruitment and evaluation, faculty development, intraoperative teaching, lecturing techniques, small group teaching and problem-based learning.

<sup>3</sup> SEA, P.O. Box 11086, Richmond, VA 23230-1086

Table 1: SEA Resources for the Teaching Anesthesiologist			
	TIMING & VENUE	DESCRIPTION	VALUE
CME MEETINGS			
Annual Fall Meeting	Friday before ASA Annual Meeting	One-day update on current issues in anesthesia education; some workshops	Networking; professional development; teaching portfolio
Annual Spring Meeting	Yearly, May or June; generally in partner- ship with an academ- ic medical center	Three-day comprehensive meeting and workshops covering a wide range of issues for anesthesiology teachers <sup>1</sup>	Networking; professional development; teaching portfolio
SEA Teaching Workshop	Spring, every two years	Five-day intensive, interactive workshop with small-group teaching, opportunity to practice successful teaching methods and on-site feedback	Professional development
PUBLICATIONS			
Anesthesia Education	Published twice yearly	Society's newsletter	Nonpeer-reviewed publications
Journal of Education in Perioperative Medicine (JEPM)	Two or three issues yearly	Peer-reviewed online journal of SEA <www.jepm.org>; publishes original articles, reviews of education techniques and tools, critical analyses and editorials; separate nonpeer-reviewed repository of miscellaneous contributions</www.jepm.org>	Peer-reviewed publications
Journal of Clinical Anesthesia (JCA)	JEPM section in JCA appears twice yearly	Official print journal of SEA; publication of selected peer-reviewed JEPM contributions published simultaneously with JEPM	Peer-reviewed, indexed (Index Medicus) publications
Medical Student Guide to Anesthesiol- ogy Residency Pro- grams	Copyrighted booklet available for pur- chase from SEA <sup>2</sup>	Overview of anesthesiology as a specialty from medical students' perspective	Teaching material for rotating medical students
COMMITTEES	Convene at annual Spring and Fall meetings		Teaching portfolio; professional development
Education Resources		Developing and disseminating SEA's lasting education resources	
Medical Student Edu- cation		Developing model medical student curriculum for anesthesia	
Resident Curriculum		Developing curricular approach to fulfilling new Residency Review Committee competency requirements	
Resident Evaluation		Discussing best strategies for residency evaluation	
Simulation in Anes- thesia Education		Concerned with integration of full-scale simulation teaching into residency training	
Faculty Development		Focusing on faculty support and recognition; teaching portfolios	
Research in Anesthesia Education		Solicit and evaluate education abstracts; supporting education research initiatives	
TEACHING AWARD	Duke Award present- ed annually at Fall Meeting	Recognizes major contributions in anesthesia education at a national level	Competitive national award
TRAVELING	Available throughout the year	On request, SEA makes available its best speakers to academic programs wishing to provide faculty development for teachers <sup>3</sup>	Resource to programs; faculty development

## PRACTICE MANAGEMENT

The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), annually combines all the millions of claims for physicians' (Medicare Part B) services into databases that are available to researchers. ASA purchases the anesthesia, pain management and critical care data, which we use principally in connection with our ongoing efforts to obtain better Medicare anesthesia conversion factors.

# Highest Volumes and Dollars — Anesthesia

In 1999 (CMS takes at least a year to release the data), the most frequently performed anesthetic was for cataract surgery: 1,919,816 out of a total of 9,721,571 anesthesia services, or 20 percent, were for Current Procedural Terminology' (CPT) code 00142. Table 1 lists the total number of claims allowed (as opposed to "submitted") for the top 10 codes.

In all, Medicare spent \$1,391,374,257 on anesthesia services in 1999. The single costliest procedure in terms of total spending on anesthesiologists' claims was anesthesia for a coronary bypass artery graft (CABG, CPT code 00562) for a total of \$106,405,941. Cataract surgery was a close second with \$100,085,471. The order was reversed when all specialties' claims were factored in.

Thus CABG costs Medicare more, although the number of 00562 procedures by anesthesiologists is just 17 percent of the number of 00142 claims. Average payment for a CABG was \$532.71; average payment for a cataract removal was \$88.21. Table 2 identifies the 10 anesthesia procedures on which Medicare spent the greatest total amounts in 1999. Note that the totals include other specialties besides anesthesiology. Medicare spent \$36,834 for CABG anesthesia claims submitted by orthopedic surgeons, for example, and \$128,127 on internists. This is probably a good illustration of the "dirty data" phenomenon. Overall, the Medicare claims database is reliable, but there is definitely some "noise" in the hundreds of millions of claims that are filed.

# How Much Is Medicare Spending on Anesthesia Services?

Karin Bierstein, Assistant Director of Governmental Affairs (Regulatory)

#### Pain Medicine and Other Nonanesthesia Services

Medicare paid \$405,662,589 for pain medicine services (CPT codes in the range 62269-64680) performed by all specialties in 1999. Claims submitted by anesthesiologists netted \$110,572,864. For those procedures performed more than 50 percent of the time by anesthesiologists, total spending on our specialty came to \$67,885,128. The highest volume pain medicine service performed by anesthesiologists was for "epidural injection of substance other than

anesthetic, lumbar or caudal" (the code number reported in 1999 was 62289; it has been superseded by 62311), with 410,316 claims allowed for a total cost of \$42,360,479. HCFA allowed a total of 582,481 claims filed by all specialties. Among anesthesiologists, the daily epidural management code 01996 was in second place with 339,116 procedures, and trigger points (20550) came in third with 201,024 claims. More than 102,600 continuous epidural injections (then 62279, now 62319) and nearly 85,000 single-shot epidurals (then 62278, now 62311) were allowed.

Other than the add-on code, the most frequently allowed nerve block was the lumbar facet joint injection (then 64442, now 64475); 55,758 claims were filed by anesthesiologists. Anesthesiologists also performed 35,446 neurolytic injections of the lumbar facet joint nerve.

Among all the other services and procedures performed by anesthesiologists, the placement of a central venous catheter (36489) represented the highest volume. Nearly 340,000 claims were allowed in 1999. We submitted fewer than 2 percent of all the critical care claims paid by Medicare (31,670 for the first hour [99291] and 4,471 for the half-hour add-on code [99292]).

# What do the data show about use of the –QZ modifier?

As anesthesiologists became ever more concerned with compliance with Medicare medical direction rules, ASA suspected that many groups would choose to bill all or most care-team services as "CRNA service without med-

Table 1. The 10 Highest Frequency Medicare Anesthesia Services

Code	Description	Total Allowed Frequency	Anesth Allowed Frequency
00142	Anesthesia, Proc on Eye; Lens Surgery	\$1,919,816	\$1,057,932
01996	Daily Management, Epidural/Subarachnoid Drug Administration	379,836	339,116
00840	Anesthesia, Intraperitoneal Proc, Lower Abdomen, W/ Laparoscopy; NOS	389,534	245,509
00790	Anesthesia, Intraperitoneal Proc, Upper Abdomen, W/ Laparoscopy; NOS	384,750	244,564
00910	Anesthesia, Transurethral Proc (W/ Urethrocystoscopy); NOS	338,428	206,715
00562	Anesthesia, Heart, Pericardium Surgery W/ Pump	244,612	183,530
00400	Anesthesia, Extremities, Anterior Trunk, Perineum, Integumentary	255,887	158,527
01402	Anesthesia, Open Proc on Knee Joint; Total Knee Replacement	219,783	135,304
01480	Anesthesia, Open Proc, Bones, Lower LegAnkle/Foot; NOS	193,177	123,525
01844	Anesthesia, Vascular Shunt/Shunt Revision, Any Type	181,348	118,208

ical direction," using the –QZ modifier. Taking the example of cataract surgery, 6,098,604 cataract anesthetics were performed by anesthesiologists in 1999 (and fewer than 30,000 of these were performed in physicians' private offices, incidentally). A startling total of 230,000 cataract anesthetics were billed by other physicians. Almost half of the anesthesia services for cataracts were billed with the –QZ modifier. Similar proportions are showing up for other CPT codes. This seems to validate our hypothesis that many anesthesiologists who employ nurses (and are thus able to collect Medicare payments on their behalf) are using –QZ, which pays the full Medicare allowable even when they are in fact supervising the nurses.

It is perfectly understandable that anesthesiologists do not want to risk having a Medicare auditor determine that they did not fulfill perfectly all of the requirements for submitting a "medical direction" claim. Fortunately, CMS is aware of this unforeseen use of the –QZ modifier and knows that the huge majority of anesthesia services continues to involve supervision by an anesthesiologist. It is, however, an unintended use of –QZ, not necessarily an improper one as far as CMS is concerned. CMS has never

issued any statement on whether a practice may, or may not, use –QZ for incomplete medical direction.

On the other hand, more and more local Medicare carriers are establishing policies circumscribing the use of the "nonmedically directed nurse anesthetist" modifier so that it does not become the default form of billing. For example, Trailblazer in Texas initially announced that it would disallow the use of –QZ altogether for incomplete medical direction. The carrier medical director tempered his position after discussions with an attorney representing many anesthesia practices and with ASA staff. An official statement was scheduled to appear in the June carrier newsletter indicating that –QZ would be allowed, but that it should be only used as a fallback. Anesthesiologists are expected to aim for full compliance with the medical direction rules since medical direction is the "industry standard." QZ would apply in the occasional instance where events prevent the anesthesiologist from completing the service that he or she had intended.

In the same vein, the new carrier medical director for CIGNA in North Carolina responded to an inquiry from the same attorney (David Vaughn, Esq.) with the following:

Table 2. The 10 Highest Total Cost Medicare Anesthesia Services			
Code	Description	Total Allowed Charges	Anes Total Allowed Charges
00562	Anesthesia, Heart, Pericardium Surgery W/ Pump	\$130,306,979	\$106,405,941
00142	Anesthesia, Proc on Eye; Lens Surgery	\$169,339,626	\$100,085,471
00790	Anesthesia, Intraperitoneal Proc, Upper Abdomen, W/ Laparoscopy NOS	\$72,739,619	\$50,226,381
00840	Anesthesia, Intraperitoneal Proc, Lower Abdomen, W/Laparoscopy; NOS	\$72,620,921	\$49,517,275
01402	Anesthesia, Open Proc on Knee Joint; Total Knee Replacement	\$44,222,304	\$29,540,367
01214	Anesthesia, Open Proc Involving Hip Joint; Total Hip Replacement/Revision	\$37,473,035	\$25,856,469
00350	Anesthesia, Proc on Major Vessels, Neck; NOS	\$33,103,391	\$24,131,741
00630	Anesthesia, Proc in Lumbar Region; NOS	\$34,627,253	\$23,677,982
01844	Anesthesia, Vascular Shunt/Shunt Revision, Any Type	\$29,698,594	\$21,108,178
01230	Anesthesia, Open Proc Involving Upper Two-Thirds, Femur; NOS	\$28,797,895	\$20,183,392

"The short answer is that it is acceptable for the CRNA to bill in his/her name when incomplete supervision has been the situation (the seven elements have not been met). That said, I would add a few caveats .... we would not want to see this used as a 'back door' to increasing the ratio of nurse anesthetists to anesthesiologists."

Anesthesia groups using the –QZ modifier for incomplete medical direction should familiarize themselves with their own carriers' views — and should also recognize that the situation is fluid.

#### Criminal Conviction for Practicing Medicine With a Nurse's License

Texas nurse anesthetist who owned and ran a private nursing clinic at which she performed hypnotherapy and other pain management services had misrepresented herself as a licensed physician, and the state court of appeals recently affirmed the decision of the trial court sentencing the nurse to jail.

According to the evidence, the nurse held a doctor of medicine degree from Mexico and was a certified registered nurse anesthetist in Texas as well as a certified hypnotherapist. In treating a "patient" who carried a concealed microphone and transmitted the conversation to a patrol car, the nurse introduced herself as "Doctor Weyandt" and quite intentionally sought to create the impression that she was a physician. The treatment provided for the shoulder pain alleged was to attach and turn on a peripheral nerve stimulator and increase the electrical current until the "patient" complained and asked her to stop. The nurse also tried unsuccessfully to hypnotize the "patient" and suggested that she drink a specific herbal tea.

Following the visit, police investigators with a warrant found several containers of drugs in the treatment room, including lidocaine, which can only be administered on physicians' orders.

The appellate court rejected five distinct challenges to the conviction, including unconstitutional vagueness of the statute proscribing the unlicensed practice of medicine. It upheld a sentence involving one year in jail, probated for two years; 100 hours of community service; 21 days in the Harris County jail and requirement that the nurse post a sign at any place of employment stating that she is not a licensed physician.

#### CROSSWALK TM Update

arly copies of the 2001 *CROSSWALK*<sup>TM</sup> contained a number of links to which the editors have made recent amendments. The following surgical codes correspond to the anesthesia codes (0XXXX) listed here rather than to those which may appear in copies distributed in February.

Surgical	Anesthes	<u>ia</u>
35190		
35450		
36834		
64718		
43846		(alternate)

We identified these codes because  $CROSSWALK^{TM}$  users contacted us with questions about the changes. We welcome information about other possible errors. It is difficult for the small group of volunteers from the Committee on Economics responsible for the  $CROSSWALK^{TM}$  to

achieve complete accuracy, but every effort is made to clarify and correct any inconsistencies that are brought to our attention. Your alerts, addressed to Sharon Merrick at <s.merrick@asawash.org>, will be very helpful.

#### **Source Materials:**

- The spreadsheets containing the Medicare anesthesia claims statistics are available on the ASA Web site at <www.asahq.org/NEWSLETTERS/2001/7\_01/pm0701.htm>.
- The Anesthesia Auditor, newsletter edited by David Vaughn, J.D., C.P.C., 8480 Bluebonnet, Suite B, Baton Rouge, LA. To subscribe, call 225-769-1320.
- Weyandt v. Texas, 14-98-00194CR (14<sup>th</sup> Ct. App., December 7, 2000)

#### Society for Education in Anesthesia: Losing None at SEA

Continued from page 26

steps for common anesthetic procedures. A medical student curriculum outline has recently been completed and is being refined. SEA's Committee on Faculty development is developing a blueprint for a teaching portfolio. Finally, lasting materials from SEA's continuing medical education meetings will become part of SEA's resource arsenal to help anesthesiology educators accomplish their complex tasks by being able to refer to an archived array of topics from meeting syllabi or live recordings.

As residency programs gear up to train more residents in the near and intermediate future, more teaching anesthesiologists will be needed. Support for teaching faculty will, therefore, likely assume increased importance. It is hoped that teachers in our specialty will increasingly make use of resources such as those available through SEA.

#### STATE BEAT

#### State Legislative Report: CT, IL, LA, NM, NY, RI, SC

S. Diane Turpin Assistant Director of Governmental Affairs (State)

by the time this column goes to press, most state legislatures will have adjourned for the year, with only a handful of states remaining in session until the end of the calendar year. It is significant that in the 2001 legislative session, anesthesiologists have been successful in maintaining physician involvement in the provision of anesthesia care throughout the country. In fact, patient safety standards have been strengthened in some states. Additionally, more states are focusing on office-based surgery and anesthesia requirements, and two more states have approved licensure requirements for anesthesiologists' assistants (AAs). The most recent activity follows.

**Connecticut** S.B. 1024, legislation to require the accreditation of office-based surgical facilities, was signed into law on May 31, 2001. The new law, supported by the Connecticut Society of Anesthesiologists, requires that any office or unlicensed facility operated by a licensed practitioner or group must be accredited if moderate sedation/ analgesia, deep sedation/analgesia or general anesthesia, as defined by ASA, is administered. The approved accrediting agencies include the Medicare program, Accreditation Association for Ambulatory Health Care, American Association for Accreditation of Ambulatory Surgery Facilities and the Joint Commission on Accreditation of Healthcare Organizations. Failure to obtain accreditation subjects a physician to disciplinary proceedings, including restriction, suspension or revocation of a license, or limitation on the right to practice medicine.

**Illinois** As reported in the May 2001 NEWSLETTER, Illinois adopted regulations that permit nurse anesthetists to provide anesthesia services in the office setting only if the supervising physician has training and experience in the delivery of anesthesia services to patients. The physician must either have clinical privileges to administer anesthesia services in a hospital or ambulatory surgical treatment center or must complete specified continuing medical education (CME) in the subject area. For conscious sedation, the physician shall complete a minimum of eight hours of CME within each three-year license renewal period in delivery of anesthesia, including the administration of conscious sedation. For deep sedation, regional anesthesia and/or general anesthesia, a physician shall complete a minimum of 34 hours of CME in the delivery of anesthesia services within each three-year license renewal period.

The Illinois Association of Nurse Anesthetists has filed a lawsuit to prevent the implementation of the regulations. The nurse anesthetists claim that the regulations exceed the scope of the Nursing and Advanced Practice Nursing Act and are arbitrary and capricious. They also claim that the Department of Professional Regulation failed to publish proposed regulations for public comment in violation of the Administrative Procedures Act. The lawsuit alleges that the regulations create a disincentive for physicians to work with nurse anesthetists in the office setting and an incentive for physicians to use anesthesiologists. Furthermore, the nurse anesthetists allege that the regulations will increase the cost to patients for services that "could be more efficiently delivered by [nurse anesthetists]."

**Louisiana** H.B. 1765, which would have eliminated the current requirement for nurse anesthetists to practice only under the direction and supervision of a physician or dentist, was soundly defeated. The Louisiana Society of Anesthesiologists devoted significant time and attention to defeat this bill and to maintain the physician direction and supervision requirement.

H.B. 1828, legislation that would prohibit the practice of anesthesiologists' assistants (AAs), passed the House. H.B. 1828 stated as follows: "the practice of medicine, surgery or midwifery' shall not include the delegation of any medical tasks or duties related to the selection, delivery or administration of anesthesia, except as explicitly provided for in R.S. 37:1360.31(A)(2)." The bill was amended on the House floor to allow delegation to a physician, nurse anesthetist or a physician assistant acting within the authorized scope of practice but not to an AA or any other provider. If the bill passes, anesthesiologists would be the only physicians who would be restricted in their ability to delegate tasks to other providers. The objective of this bill, advanced by the nurse anesthetists, is to prevent anesthesiologists from delegating any authority to AAs. The Lousiana State University (LSU) Health Services Center plans to open a school in January 2002 to train AAs. The Louisiana Society of Anesthesiologists has vigorously opposed the bill. At this writing, the bill is pending on the Senate floor.

**New Mexico** In the May 2001 *NEWSLETTER*, I reported the passage of H.B. 337, which grants prescriptive authority to nurse anesthetists. The Board of Nursing must

adopt rules concerning a prescriptive authority fomulary for nurse anesthetists based on their scope of practice. The Board of Nursing, in collaboration with the Board of Medical Examiners, will develop the formulary. Prior to the passage of H.B. 337, nurse anesthetists were required to function "under the direction of and in collaboration with a licensed physician, osteopathic physician, dentist or podiatrist." Under the new law, nurse anesthetists are required to function "in an interdependent role as a member of a health care team in which the medical care of the patient is directed by a licensed physician, osteopathic physician, dentist or podiatrist licensed in New Mexico." (Emphasis added.) Nurse anesthetists are to collaborate with a licensed physician, osteopathic physician, dentist or podiatrist concerning the anesthesia care of the patient. "Collaboration" is defined as "the process in which each health care provider contributes his respective expertise. Collaboration includes systematic formal planning and evaluation between the health care professionals involved in the collaborative practice agreement." The state's hospital regulations remain unchanged. These regulations require nurse anesthetists to administer anesthetics only under the supervision of the operating practitioner.

New York S. 4923/A.8749, advanced by the New York State Society of Anesthesiologists, preserves and strengthens existing requirements for supervision of nurse anesthetists. The bill would allow nurse anesthetists to administer anesthesia under the supervision of an anesthesiologist who is immediately available or under the supervision of the operating surgeon, dentist, oral surgeon or podiatrist performing the procedure, who is physically present, to the extent such person is authorized by law to administer anesthesia. The legislation would establish standards for "immediately available," "supervision" and "physically present" for hospitals, ambulatory surgical centers and private office settings.

S. 4653/A.8537, advanced by the nurse anesthetists, would eliminate the current requirement that an anesthesiologist, operating practitioner, oral surgeon, dentist or podiatrist supervise a nurse anesthetist. These bills would expand the scope of practice of nurse anesthetists by allowing them to independently administer anesthesia, practice pain management, prescribe narcotics and execute other medical regimens.

Rhode Island The Department of Health proposed amendments to the nursing regulations that retain the requirement for physician supervision of nurse anesthetists. However, under the proposed amendments, the governing board of a licensed hospital (or, in the case of a clinic or office, a licensed anesthetist, physician or dentist) determines the scope of practice of nurse anesthetists. The Rhode Island Society of Anesthesiologists will provide comments.

The Department of Health also proposed amendments to the hospital regulations. The amendments require that anesthesiology departments/services in hospitals must be under the direction of a board-certified anesthesiologist. These amendments also would allow a certified nurse-midwife acting within his/her scope of practice and as authorized by the governing body to administer anesthesia.

Legislation drafted to undercut the office-based surgery regulations adopted by the Department of Health last year passed the Senate and is pending in the House. The bill would prohibit regulations from identifying which anesthesia provider (anesthesiologist or nurse anesthetist) may provide a particular service. As reported in previous columns, (February and April *NEWSLETTERs*) the Rhode Island Association of Nurse Anesthetists has filed a lawsuit challenging regulations that require a board-certified anesthesiologist to be responsible for developing certain policies and procedures in the office setting and requires the operating physician and a board-certified anesthesiologist to concur in writing prior to the surgery that an ASA Class III patient is an acceptable candidate for a surgical procedure in the office setting. The litigation is pending.

**South Carolina** The South Carolina Society of Anesthesiologists was successful in its efforts to obtain licensure for AAs. S.B. 343 was signed into law on May 29, 2001. AAs may perform medical tasks and services pursuant to a written practice protocol under the direction of an anesthesiologist. AAs may engage in the following functions and duties: obtain relevant preoperative health history by record or chart review and by direct contact with the patient in the preoperative period; present preoperative health information to the supervising anesthesiologist for the collaborative formulation of an anesthesia plan; perform initial acute cardiopulmonary resuscitation in lifethreatening situations as directed by a physician; initiate

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## RESIDENTS' REVIEW

# **Keeping Anesthesiology Research Alive**

Basem B. Abdelmalak, M.D. Committee on Research

"...faith, if it does not have works, is dead."

— James 2:17

If eel the same way about anesthesiology: If it does not have research, it is dead. The leadership of ASA has realized the importance of scientific research and has encouraged it. As a result, major advances in the field of anesthesiology have occurred. For example, the Institute of Medicine (IOM), in its 1999 report "To Err Is Human," stated that "Anesthesiology has successfully reduced anesthesia mortality rates from two deaths per 10,000 anesthetics to one death per 200,000-300,000 anesthetics administered. This success was accomplished through a combination of technological changes, information-based strategies and dedicated anesthesiologists with special interest in science, research and true dedication to patient care."

One major focus of ASA is to encourage young anesthesiologists to embark on a career in research. To this end, ASA formed the Committee on Research, and recently I have been honored to represent our resident component as an adjunct member of this committee. I wish to inform you of my recent experiences with this committee and provide some hints to help those of you who may consider applying for a research grant from the Foundation for Anesthesia Education and Research (FAER). In addition, several research resources and opportunities are available throughout ASA for residents and junior staff.

The ASA Committee on Research, chaired by Michael K. Cahalan, M.D., Salt Lake City, Utah, meets biannually. One of its members, C. Alvin Head, M.D., Boston, Massachusetts, was the first resident member appointed to this committee. Some of the committee's most important functions are to judge the annual ASA residents' essay contest,



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review and score FAER grant proposals for the New Investigator Award, Research Starter Grant and the Education Grant in both basic and clinical sciences.

At my first committee meeting, I sat next to some of the most respected leaders of anesthesiology research to participate in the process of reviewing grant proposals. In addition, I was able to witness the sincere efforts of the various committee members as they tried to detect the strengths and weaknesses of each grant proposal. Their constructive criticisms of the grant are meant to encourage and direct junior researchers toward the right way of conducting sound scientific research.

I have learned a lot about the process of grant review and would like to share some insider hints with you. Not only can these tips help you write a more solid proposal, they also may prevent delays in the review process and perhaps even outright rejection by reviewers:

- Choose a novel question to investigate, one that needs to be answered.
- Choose an appropriate mentor(s) with special expertise in your study area, even if you have to go outside your institution.
- The title and the abstract should clearly reflect your study methods or your expected outcome(s).
- Make sure you meet all the criteria and requirements before you submit.
- If you are re-submitting, make sure that you have addressed all the concerns of the previous reviewers.
- A strong organized write-up on your first attempt is instrumental in this process. Allow yourself adequate time to write the grant and let senior advisors carefully review and edit your work prior to submission.
- A scientific background and previous research experience by the grant candidate are always noted; however, novel, well-thought-out proposals by first-timers are equally welcome. In my short time on the committee, I have already seen one grant by a novice research candidate, and it was met with much enthusiasm.
- Be aware of the tremendous research opportunities and grants that are available to junior investigators. Table 1 outlines not only the Web sites where you can get more information about the ASA residents' essay contest but also research opportunities offered by related organizations

Web Sites Offering Research Opportunities for Junior Anesthesiology Researchers			
Research Opportunity	Organization	Web site	
Residents' Essay Contest	ASA	www.asahq.org/Profinfo/residessay.htm	
Research Starter Grant New Investigator Award Anesthesiology Research Fellowship	Foundation for Anesthesiology Education and Research (FAER)	www.faer.org	
NIH Grants	National Institutes of Health (NIH)	www.grants.nih.gov/grants/index.cfm	
APSF Grant Program	Anesthesia Patient Safety Foundation (APSF)	www.gasnet.org/societies/apsf/foundati on/guidelines/guidelines.html	
Academic Research Organization Grants for Outcomes Studies	International Anesthesia Research Society	www.iars.org/aro.html	
Research Starter Grants	Society of Cardiovascular Anesthesiologists (SCA/IREF)	www.scahq.org/sca3/grants.shtml	

In conclusion, the research committee is in place to encourage and support residents and junior staff to begin a rewarding career in academic anesthesiology. ASA is here to support your efforts, and we need more young researchers in this difficult time of limited financial reimbursements. Take advantage of the vast research opportunities that are available to you as an ASA member. Further-

more, I would encourage all my colleagues to get involved with their ASA component societies at the state level and work their way up to the national level. Personally speaking, it is a priceless experience to join ASA committees such as the Committee on Research. I have enjoyed it. It is a great learning experience, and I wish for all my colleagues to have the opportunity to experience it for themselves.

# State Legislative Report: CT, IL, LA, NM, NY, RI, SC

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medically directed, multiparameter monitoring before anesthesia and in other acute care settings; use current advanced treatment modalities to effect the prescribed anesthetic plan during the procedure; support the patient upon emergence and recovery from an anesthetic, by airway intervention or ventilatory support, and administer any support medication and fluids; and participate in

administrative, educational and research activities as appropriate. An AA may practice only under the supervision of a physician who is actively and directly engaged in the clinical practice of medicine as an anesthesiologist. An anesthesiologist may not supervise more than two AAs at any one time.



# New Enhancement to 'Calendars for Meetings' on ASA Web Site

In our continuing efforts to improve ASA's Web site, we now offer a searchable "Calendars for Meetings." This new feature allows users to search for an event by month, year, category type or a combination of both. Additional capabilities allow the user to list all events, request a

change to a current listing or submit an event to the ASA calendar administrator using a convenient online submission form. Links to individual meeting details are provided from each search result page.

This new feature can be accessed directly at <a href="http://events.asahq.org">http://events.asahq.org</a> or through ASA's homepage <a href="http://ewww.asahq.org">www.asahq.org</a> under the "Continuing Education" icon.

We are confident that this new enhancement will provide ASA Web site visitors with quicker access to important ASA and anesthesiologyrelated event information.

Comments and suggestions for improvement are welcome and can be directed to the ASA Web Administrator at <webmaster@asahq.org>.

Printed copies of the "Calendars for Meetings" will be sent to ASA members in July. Other items of interest, including information on the Overseas Teaching Program and Medem Web services, will be enclosed in this mailing.

# **Component Society News**

# Fourth \$500,000 IARS Frontiers in Anesthesia Research Award

The Board of Trustees of the International Anesthesia Research Society (IARS) announced the fourth recipient of the \$500,000 IARS Frontiers in Anesthesia Research Award at the 75th Clinical and Scientific Congress on March 17, 2001, in Fort Lauderdale, Florida. The award was established by IARS in 1994 to "foster innovation and creativity by an individual scientist in the field of anesthesiology." The fourth recipient is Mark A. Schumacher, Ph.D., M.D., University of California-San Francisco (UCSF), San Francisco, California. Dr. Schumacher's research project is titled "Stretch-Inactivated Channels in Pain Transduction." He is Assistant Professor in the Department of Anesthesia and Perioperative Care at the UCSF School of Medicine.

# National Leadership Award From the Federation of State Medical Boards

The Federation of State Medical Boards of the United States, Inc., Dallas, Texas, has named Thomas A. Joas, M.D., recipient of its 2001 John H. Clark, M.D., Leadership Award. The award was established in 1986 in memory of

the Federation's 61st president. This annual award recognizes individuals who have demonstrated outstanding leadership, a commitment to advancing the public good and dedication to the field of medical licensure and discipline at the state and national level. Dr. Joas will accept this prestigious award at a special ceremony during the Federation's Annual Meeting on April 21 in Atlanta, Georgia.

Dr. Joas will be recognized for his outstanding leadership and service to the medical regulatory community and the Federation of State Medical Boards. As a member of the Committee to Review The Elements of a Modern State Medical Board, his participation was invaluable in the outlining of a foundation

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#### **Component Society News**

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for medical board structure. He also served as a member of the Program, Finance, Telemedicine and Nominating Committees and the Special Committee on Professional Conduct and Ethics.

On the state level, Dr. Joas has served in many leadership roles. He is a past president of the Medical Board of California, the California Society of Anesthesiologists, the San Diego Society of Anesthesiologists and the San Diego Surgical Society. He also is the past chair of the Board of Governors of the American College of Anesthesiolo-

gy and the ASA Peer Review Committee. Currently, Dr. Joas serves as president of the Division of Licensing for the Medical Board of California and is proud of the legislative initiatives he has developed for office-based surgery.

As an educator, Dr. Joas was an assistant clinical professor at the University of California-San Diego, for 14 years. He has served on the teaching staff of Mercy Hospital and Medical Center in San Diego since 1974.

Dr. Joas received his medical degree from the University of Mani-

toba in Winnipeg, Canada, and completed his residency at the University of California's Department of Anesthesiology in San Francisco.

#### In Memoriam

Notice has been received of the death of the following ASA members:

Abraham Alpin, M.D. Beverly Hills, California September 15, 2000

Yvetot Antoine, M.D. Freeport, New York November 19, 2000

Robert E. Goyette, M.D. Rolling Hills Estates, California May 3, 2001 Theodore J. Heyneker, M.D. Winston-Salem, North Carolina

April 15, 2001

Donald A. Reid, M.D. Norman, Oklahoma May 25, 2001

Jose T. Reyes, M.D. St. Louis, Missouri April 19, 2001 James S. West, M.D. Los Angeles, California April 23, 2001

George H. White, Jr., M.D. Louisville, Kentucky October 19, 2000

# LETTERS TO THE EDITOR

#### Vital Sign of the Times

In regards the letter by Honarato F. Nicodemus, M.D., about the "fifth" vital sign in the February *NEWSLETTER*, I would agree with him in his conclusion: Not yet. Not ever, in fact. Maybe it is just an urban myth that the Joint Commission on Accreditation of Healthcare Organizations proposed pain assessment as the fifth vital sign, but if they did, it just shows how shortsighted they are, albeit however well-intended.

As it has been said, vital signs are vital, i.e., immediately vital to life. My pocket American Heritage dictionary defines vital as "Necessary to the continuation of life." I always considered the fifth vital sign to be the  ${\rm SpO}_2$  (the hemoglobin-oxygen saturation as read by the pulse oximeter), which must be further qualified by specifying the associated  ${\rm FiO}_2$ , on room air to be the truest indication of the patient's "vital" status.

It is amazing to me how often in the medical record I read history and physicals, to say nothing of progress notes and consult notes, that are completely lacking any notation of vital signs other than the ubiquitous "VSS" (vital signs stable). Perhaps as a critical care physician, I am sensitive to small nuances of how the patient is doing in an overall sense.

I do not know any other way of demonstrating that in just a few words than by specifying the vital signs, especially in sick patients. Further, if the patient's problem is at all pulmonary-related, the SpO<sub>2</sub> on room air tells you all you need to know about the acuity of the problem, whether it is respiratory (related to oxygenation) or ventilatory (related to adequacy of breathing). Even the pulmonary notes I read are most commonly lacking notation about the SpO<sub>2</sub>. It makes one wonder what people think the priority is. It obviously is not the "vital" issue.

Keep up the good work!

Leo I. Stemp, M.D. Mount Laurel, New Jersey

#### A Gas Price We Cannot Afford

I had just returned from my two-week U.S. Navy Reserve duty where we received extensive NBC (nerve, biological, chemical) training with emphasis on anthrax, smallpox and sarin gas. In the middle of the night, we donned gas masks and mission-oriented protective poster (MOPP) suits for mock drills while attempting to function and provide anesthesia in a field hospital. My first reading after arriving home was your March 2001 "Ventilations," "Death in a Droplet." For one minute, I thought you might have been with us at Camp Pendleton, and you had me reaching for a gas mask.

So thank you for the timely editorial. Certainly a lot of my physician colleagues came away from our training convinced of the imminent reality of a bioterrorist attack. We strongly recommend anyone who remains unconvinced to just watch a recent PBS frontline program on the biologic and chemical terrorism threat, which detailed the Soviets' Biopreparet program with chilling clarity as well as our lack of preparedness at even a federal level. In fact, a resource for your call to action might include the military active duty and reserve anesthesiologists who have performed many gas masks drills in gas chambers (the military calls them "confidence chambers") on military bases across the country.

Michael S. O'Connor, D.O. University Heights, Ohio

# The Golden Rule: Get Out of School?

Ludos to Roy G. Soto, M.D., for his thought-provoking editorial in the March 2001 *NEWSLETTER*! Like Dr. Soto, I also am a recent graduate and thought about going into academia, but I did not because I actually disagree with virtually all of his arguments. It is refreshing nonetheless to see an academic anesthesiologist who actually

The views and opinions expressed in the "Letters to the Editor" are those of the authors and do not necessarily reflect the views of ASA or the NEWSLETTER Editorial Board. Letters submitted for consideration should not exceed 300 words in length. The Editor has the authority to accept or reject any letter submitted for publication. Personal correspondence to the Editor by letter or e-mail must be clearly indicated as "Not for Publication" by the sender. Letters must be signed (although name may be withheld on request) and are subject to editing and abridgment.

enjoys teaching and enjoys being in the operating room.

Fortunately, I had several outstanding attendings during residency who were exemplary role models. It was very tempting to follow in their footsteps. However, with two kids to support and living in Southern California, which has a very high cost of living, I would have found it financially impossible to give my family the life they deserved on an academic salary. So I went into private practice and have found it to be extremely challenging and rewarding. I have also had the luxury of *not* working with nurse anesthetists.

I do not think my situation is unique. In conversations with colleagues all across the country, it seems that academic institutions are losing attendings to the private sector at a rapid pace. I believe that how we address this issue will play a critical role toward the future of our specialty. Perhaps we can consider innovative partnerships between academia and the private sector — and bridge the "towngown" gap.

Steve C. Yun, M.D. Irvine, California

# Have We Bitten the Hands That Feed Us?

I have just finished reading the article "Where Have All the Anesthesiologists Gone?" by Gifford Eckhout, M.D., and Armin Schubert, M.D., in the April 2001 ASA NEWSLETTER. While I agree entirely with their analysis of the current shortage of anesthesia providers, I must respectfully disagree with their analysis of how we got to this point. Their article attributes the current shortage to a 1994 study suggesting an oversupply and pressure to reduce specialist training to 50 percent of students.

I believe that this analysis overlooks a major factor that got us here. In the mid- to late-1980s, there was a dramatic expansion of most anesthesia residency programs. Many programs more than doubled in size. Part of this was based on projections that such an expansion was needed to provide all physician anesthesia. Unfortunately, as this increased number of residents finished training, many found that the job market could not easily accommodate them. This was when ASA discontinued the placement interview service at the Annual Meeting because there

were so few jobs for so many applicants. As this trend became obvious, many qualified students avoided anesthesia because of legitimate concerns about their employability. The reduction in residency slots over the past few years occurred because those slots could not be filled. Having talked to many residents in the past years — including several from the author's Cleveland Clinic — who were desperate for a job, and having talked to dozens of students who were interested in anesthesia but could see the result on the job market of the too rapid expansion of training slots, I hope that our specialty does not ignore our own role in creating the current situation.

Robert J. Donahue, M.D. Akron, Ohio

# **Sharks Among Us**

I would like to make you aware of a major problem that exists out here in the world of community anesthesia practice: We have become our own worst enemy!

I have a contract at a small, two-operating room surgicenter in the Northwest. There has been a persistent attempt by another anesthesiologist to interfere with my practice by offering to "take over." He actually includes in his cover letter to the administrator at the center that he has "proven experience in taking over and improving existing anesthesia practices." The audacity and pomposity is overwhelming.

I wish there were some way that our own Society could and would police itself, raise the ethics bar and educate such individuals that the impact of this behavior has huge ramifications! I have a family and other financial responsibilities. I do not need unsolicited, underhanded and unseemly attempts by members of my own Society to wrest my practice away!

Anonymous New England

## FAER REPORT



# **FAER Partners With Anesthesiology Societies, Part II**

The following article is part II of a listing of FAER recipients and the organizations that have sponsored them. Part I appeared in the May 2001 NEWSLETTER.

nesthesiology societies make significant contributions to progress in anesthesiology. Although each organization has unique objectives, they all share common values and goals. Central to these common goals are the advancement of anesthesiology and the improvement of patient care. This shared vision unites various anesthesia societies and is furthered by their commitments to education, research and their ongoing partnership with FAER. These societies have sponsored several researchers through FAER. Some of the most recent people and projects are listed below.

# Society for Obstetric Anesthesia and Perinatology — Obstetric Anesthesia and Perinatology Endowment Fund

**Ellen M. Lockhart, M.D.**, Duke University, "Progesterone as an Endogenous Neuroprotectant"

**Barbara L. Leighton, M.D.**, Weill Medical College of Cornell University, "Mechanisms of Epidural-Associated Labor Slowing"

#### Society for Pediatric Anesthesia

**Zeev N. Kain, M.D.**, Yale University, "Preoperative Anxiety in Preschool Children: Parental Presence at Induction of Anesthesia"

Ronald S. Litman, D.O., University of Rochester, "Breathing Patterns During Conscious and Deep Sedation in Children"

**Robert T. Wilder, M.D., Ph.D.**, Children's Hospital, Boston, "Mechanisms of Tachyphylaxis to Local Anesthetics"

**Neil E. Farber, M.D., Ph.D.**, Medical College of Wisconsin, "The Role of Nitric Oxide in Modulating Volatile Anesthetic-Induced Actions on Intracerebral Microvessels"

Wanda C. Miller-Hance, M.D., University of California-San Francisco, "Impact of Intraoperative Transesophageal Echocardiography on Anesthetic and Surgical Management of Pediatric Patients with Congenital and Acquired Heart Disease"

**Shu-Ming Wang, M.D.**, Yale University, "Postoperative Nausea and Vomiting in Children: An Alternative Treatment Modality"

Both the International Trauma Anesthesia and Critical Care Society and the Society for Office-Based Anesthesia have contributed to FAER. We are optimistic that relevant proposals will be submitted for review.

In addition to thanking the subspecialty societies for their collaboration, the Foundation wishes to express gratitude to several other anesthesia societies that partner with and contribute to FAER.

The **Association of University Anesthesiologists** has supported 17 new investigators and, like ASA, has been supporting FAER since FAER's inception.

The Academy of Anesthesiology, the Association of Anesthesia Clinical Directors, the Association of Anesthesiology Program Directors, the Society of Academic Anesthesiology Chairs and the Society for Technology in Anesthesia annually continue to support FAER both financially and with insight into the needs of the specialty.

ASA has been the largest single contributor and major sponsor of FAER. It provides finances, administrative services and leadership to FAER. ASA has donated almost \$12 million to FAER, which made possible the sponsorship of numerous investigators and has enhanced the endowment fund.

The partnership that all these groups have forged with FAER confirms a commitment to the future, a farsightedness, optimism and, above all, a fundamental belief in the importance of anesthesiology and the anesthesiology professional in the health care field of tomorrow.