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The views expressed herein are those of the authors and do not necessarily represent or reflect the views, policies or actions of the American Society of Anesthesiologists.

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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.

Orlando, Florida, and the ASA 2002 Annual Meeting are a perfect match. As the number one tourist destination on earth, Orlando offers unbeatable entertainment value, and the Annual Meeting will again offer the best that anesthesiology education and technology have to offer.

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Anesthesiology Aphorisms – 5th Installment

Is there a better way to enjoy summer reading than picking up a copy of that ever-controversial, avant-garde *ASA NEWSLETTER* to read the next installment of aphorisms? This wildly popular editorial is the collective wit and personal preferences of ASA members, who submit their "pocket" axioms for daily survival.

In this issue, I have included some excerpts from a book by Ezzat I. Abouleish, M.D., titled *Moments With the Pen*. It is pleasant reading with pertinent thoughts for anesthesiologists at any level of practice regarding life's passages. Read on for this installment of selected witticisms, proverbs, axioms and conundrums!

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

- Better to plan than to react!
- Plan for the worst, deal with the best.
- All patients have a midazolam deficiency. Young or old, hot or cold, midazolam on the hour, every hour, easy to remember, hard to forget, lest you forget — they won't.
- The less the indications, the greater the complications.
- Better to keep your mouth shut and have everyone think you are a fool, than to open it and remove all doubt.
- Ability and voice decibel level are inversely proportional.
- Work-aholism leads directly to family withdrawal.
- The harder I work, the luckier I get.
- Accept that some days you're the pigeon and some days you're the statue.
- Everyone eventually gets the reputation they deserve.
- The tattoo-to-tooth ratio is an important indicator.
- No one will fault you for too many monitors.
- Never underestimate the power of preoperative anesthetic persuasion.
- There is no such thing as too much I.V. access.
- Perfect anesthesia can't overcome poor surgical technique.
- Regional anesthesia is like a lazy cheetah: it can be spotty and may not work; general anesthesia always works.
- Planning for emergence begins with the incision.
- Airway trumps anything.
- Don't poke a skunk.
- Even a blind squirrel finds a nut once in a while.
- All substances are poisons; there is none which is not a poison. The right dose differentiates a poison from a remedy." (Paracelsus [1493-1541]).

From the late Bob Bauer, M.D., a pharmacologist before becoming a physician and eventually a professor at UCLA:

- "Always remember, everything we give to our patients is a poison. Everything. Well, except oxygen. But come to think of it, oxygen is lethal at five parts per million." (He told this story enough times to qualify it as an aphorism. Most UCLAns will recognize it, anyway.)
- Nothing is as inconspicuous as good anesthesia, nothing so obvious as its absence.
- You never have to apologize for a good result.

Continued on page 24

Accreditation and Other Fantasies

Thomas H. Cromwell, M.D., Secretary

Call it burdensome bureaucracy, bureaucracy run amuck or bureaucracy justifying its own existence. I think you get the picture, but let me clarify.

Thomas H. Cromwell, M.D.

Case in Point:

A large hospital on the West Coast with 1,500 physicians on the medical staff. The anesthesiology department consists of 50 anesthesiologists, most of whom trained at the University of California-San Francisco; all are board-certified, many have subspecialty training and six are now echocardiography-certified. The hospital has a clinical load of 12,000 cases per year including cardiac and liver transplantation. Bottom line: good department with excellent clinical care. I can vouch for this as I had the opportunity to chair the department for 17 years.

Over those years, I suffered through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) reviews every three years and was able to maintain a sense of perspective at these intrusions by realizing that they were merely audits that had little to do with true quality of care. Everyone concerned, including the reviewers, seemed to realize that the entire process was just another bureaucratic nuisance, the results of which could be ignored until the next review three years later. At least these intrusions did not interfere with patient care, so go ahead and humor them, we told ourselves.

Then something changed!

We have now undergone three separate reviews within the past six months with a fourth threatened "at a moment's notice." What reviewers used to recognize as minor infractions in record keeping that had little relevance to patient care have now been escalated into major deficiencies that threaten an institution's deemed status for Medicare's Conditions of Participation. In other words, you are not capable of caring for Medicare patients. If it was not so ludicrous, and given the level of reimbursement, my response would be, "Throw me into the briar patch!"

Actual Scenario:

Survey #1 — 11/5/01. JCAHO/ California Department of Health Services (DHS).

Results: No criticisms for department of anesthesiology.

Survey #2 — 1/8/02. "Validation survey" by DHS, this time at the behest of the Centers for Medicare & Medicaid Services (CMS) but conducted by essentially the same individuals as the review two months previous, finds seven pages of deficiencies that involve such things as failure to have postoperative notes completed by the **same** anesthesiologist who delivered the anesthetic and insufficient narcotic accountability according to a plan acceptable to that particular reviewer. One interesting criticism stated: "A review of one of 30 orders revealed that an oxygen saturation reading was obtained on a hospice patient without a physician's order." A heinous infraction to be sure.

Survey #3 — 5/21/02. JCAHO follow-up survey. Formal report pending.

Survey #4 — DHS, again at the behest of CMS. Threatened "at any time."

Something is dreadfully wrong with the above-cited scenario! We are caught between three warring bureaucracies (JCAHO, DHS and CMS), each accusing the other of inadequate review. The process that ostensibly accredits an institution to provide optimal patient care is in reality little more than documentation of paper trails by agencies of government that have no ability to assess true quality of care and resort to mere audits of postoperative notes and narcotic documentation. In my 25 years of experience with JCAHO reviews, the reviewing team has never included an anesthesiologist, they have never talked to an anesthesiologist about quality of care nor have they ever actually come into an operating room to directly observe anesthesia delivery. Yet they have the *audacity* to declare the quality of care appropriate or otherwise!

Hospitals divert egregious amounts of staff time and money from badly needed improvements to prepare for reviews, hire armies of former nurses/administrators-turned-"consultants" and perform endless mock surveys. Review teams are infested with rogue reviewers who are free to interpret regulations as they see fit, a task in which they are given significant latitude considering Medicare

Continued on page 5

'Tripartisan' Senate Bill Introduced to Provide Confidentiality to Reporting of Medical Errors

Michael Scott, J.D., Director
Governmental and Legal Affairs

On June 5, Sens. James M. Jeffords (I-VT), Bill Frist (R-TN), John B. Breaux (D-LA) and Judd Gregg (R-NH) introduced S. 2550, the Patient Safety and Quality Improvement Act, a bill designed to provide confidentiality and peer-review protections for medical error reports by physicians and other health care providers. ASA was among a large number of medical associations to endorse the bill upon its introduction.

The bill provides that patient safety information would be privileged and confidential, meaning that it would not be subject to subpoena or discovery in court proceedings. The information also could not be disclosed pursuant to a request under the federal Freedom of Information Act nor could it be used to take adverse personnel actions. State laws providing greater protections would not be pre-empted.

The bill is not intended to change the current right of plaintiffs in professional liability actions to obtain, as at present, access to medical records. Protection would extend to the medical data banks, sought to be maintained by medical groups such as ASA, to help analyze the source of medical errors. ASA currently engages in such activity through the analysis of closed claims obtained from professional liability insurers but has been investigating development of a data bank under which members could directly report possible medical errors on a confidential basis.

The bill enjoys the support of a wide range of provider groups, including hospitals, insurers and the Joint Commission on Accreditation of Healthcare Organizations. Both Health and Human Services Secretary Tommy G. Thompson and Treasury Secretary Paul H. O'Neill have endorsed the bill in principle. Rep. Nancy L. Johnson (R-CT), chair of the House Ways and Means Health Subcommittee, expects to introduce parallel House legislation in the immediate future. Given the wide support for the principles of the bill, a reasonable chance exists for adoption before the 107th Congress adjourns.

House Committees Mark Up Medicare Reform Legislation

Legislation to ameliorate the projected further cuts in Medicare physician reimbursement is expected to make its way to the House floor before the Independence Day recess. As proposed by the chairs of the relevant House Committees — Ways and Means and Energy and Commerce — positive conversion factor adjustments of about 2 percent for 2003, 2004 and 2005 would replace, at a budget cost of about $20 billion, the currently projected negative adjustments of 5.7 percent, 5.7 percent and 2.8 percent. By the time this column is published, ASA members will have received a *President's Update* that will provide further details.

As a member of the Coalition for Fair Medicare Payment, ASA gave a qualified endorsement of the proposal, making clear that it and other members of the Coalition regarded the legislation as merely an interim solution forced by existing federal budget difficulties. In a separate letter of qualified endorsement, ASA also drew attention to the severe gap in Medicare reimbursement between anesthesiology and other specialties and urged support for its current efforts to gain an adjustment of anesthesia work values under the Medicare Fee Schedule.

In cooperation with the American Association of Nurse Anesthetists, the members of which are reimbursed under the Medicare Fee Schedule in the same manner as anesthesiologists, ASA has been involved in a congressional campaign to gain support for its efforts with the Centers for Medicare & Medicaid Services (CMS). As of this writing, more than 40 House members had joined in a letter to CMS urging revaluation of anesthesia work, especially in light of the current shortage of anesthesia providers in most parts of the country.

As many ASA members are aware, the American Medical Association/Specialty Society Relative Value Update Committee (RUC) sent a recommendation to CMS in late April which, if extrapolated to the entire family of anesthesia codes, would represent a 10-percent increase in the Medicare anesthesia conversion factor. ASA understands that CMS has included language in its proposed 2003 rule on the Medicare Fee Schedule that would permit CMS, if it should so decide, to put new values into place effective January 1, 2003. ASA is engaged in active discussions with CMS at this time, and a final CMS decision is expected in October or sooner.

Emery A. Rovenstine Memorial Lecture:

Burton S. Epstein, M.D., to Present 'ASA's Efforts in Developing Guidelines for Sedation and Analgesia for Nonanesthesiologists'

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

Burton S. Epstein, M.D., Professor Emeritus in Anesthesiology and Pediatrics, George Washington University School of Medicine, Washington, D.C., will present the 2002 Emery A. Rovenstine Memorial Lecture. His lecture will be presented on Monday, October 14, at 11:15 a.m. at the Orange County Convention Center, Orlando, Florida. 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 Bellevue Hospital.

Burton S. Epstein, M.D.

Dr. Epstein is a native of Washington, D.C., and received his undergraduate and medical education at George Washington University, graduating in 1957 as a member of Alpha Omega Alpha. After a rotating internship at Philadelphia General Hospital, Philadelphia, Pennsylvania, he completed his anesthesiology residency at the Hospital of the University of Pennsylvania, Philadelphia, including a fellowship in pulmonary physiology. He then spent two years as Chief of Anesthesia at the U.S. Army Surgical Research (Burn) Unit, Brooke Army Medical Center, Fort Sam Houston, Texas.

Following his military service, Dr. Epstein embarked upon a distinguished career as a medical educator. He returned to the University of Pennsylvania for one year as an Associate in Anesthesia and then returned to George Washington University where he spent the rest of his professional career. He achieved the rank of Professor of Anesthesiology in 1970, Professor of Anesthesiology and Child Health and Development in 1974 and was appointed the Seymour Alpert Professor of Anesthesiology from 1985-97. He served as Chair of the Department of Anesthesiology at Children's National Medical Center from 1974-83 and the Chair of the Department of Anesthesiology at George Washington University Medical Center from 1985-90. He currently is Professor Emeritus in Anesthesiology and Pediatrics.

As indicated by his titles and duties, Dr. Epstein has had a very active career in academic anesthesiology. He has authored or co-authored more than 70 original publications, book chapters and review articles. He is recognized as a leading authority on pediatric and ambulatory anesthesia, presenting invited lectures and visiting professorships throughout the world. He has presented 14 Refresher Course Lectures and has been a frequent participant in panels and Problem-Based Learning Discussions at ASA annual meetings. He served as an Associate Examiner for the American Board of Anesthesiology from 1971-96 and was the Representative to the Council of Medical Specialty Societies from the Society of Academic Anesthesiology Chairs from 1987-91.

Dr. Epstein has been a leading figure in the growth of ambulatory anesthesia as an area of special interest in anesthesiology. He was a founding member of the Society for Ambulatory Anesthesia (SAMBA) and served as its President in 1987-88. He served as SAMBA's delegate to the ASA House of Delegates from 1990-98 and received the SAMBA Distinguished Service Award in 1998.

Throughout his career, Dr. Epstein has shown steadfast devotion to ASA. His service began as a member of the Committee on Medical Student Preceptorships in 1966. He has served on 25 different committees or task forces and chaired seven. He served as the Chair of the Sections on Education (1972), Annual Meeting (1980) and Clinical Care (1994-01) and Board of Governors of the American College of Anesthesiologists (1981-82). He has served important roles as a member of the American Medical Association Section Council on Anesthesiology (1975-81), a member of the Food and Drug Administration Anesthesia Advisory Board (1976-81), a representative to the Hospital

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

Accreditation Program, Professional and Technical Advisory Committee of the Joint Commission on Accreditation of Healthcare Organizations (1987-92) and representative to the Residency Review Committee in Anesthesiology of the Accreditation Council for Graduate Medical Education (1993-99).

For his many contributions to ASA, Dr. Epstein was awarded the ASA Distinguished Service Award in 1999. To quote John B. Neeld, Jr., M.D., ASA Past President, at the time of that award: "Dr. Epstein is perhaps best known and most appreciated as the man to whom ASA turns when difficult and potentially divisive issues call for the wealth of knowledge and sound judgment of one whose selfless devotion to the specialty is unmatched and unquestioned."

Not only has Dr. Epstein served on and chaired some of the most important and controversial committees and task forces of the organization, he chaired the Committee on Standards of Care when our specialty pioneered national standards. He chaired the Task Force on Anesthetist Relations and served on the committees on Strategic Planning and Performance-Based Credentialing and Peer Review. Most recently, he chaired the Task Force on Structure and Governance and successfully shepherded the recommended changes through the House of Delegates when previous attempts at restructuring had been unsuccessful.

Throughout his career, Dr. Epstein has repeatedly demonstrated that he has a keen awareness of the special place of anesthesiology in the house of medicine and that he has that unique ability to communicate his dedication to others.

The Emery A. Rovenstine Memorial Lecture honors one of our great anesthesiologists who is known for his dedication, vision and loyalty to the specialty. It is quite appropriate that this year's lecturer fits the same description.

Administrative Update: Accreditation and Other Fantasies

Continued from page 2

regulations now comprise, believe it or not, 350,000 pages — four times larger than the Internal Revenue Service code. Hospitals seek the latest buzzwords that seem to be in vogue for reviewing teams, and hospital administrators, in their zeal to placate reviewers, accept interpretations without challenge, no matter how irrational or bizarre. Worst of all, the public assumes that the seal of approval by the regulatory agency is a guarantee of optimal medical care, but studies indicate there is no relationship whatsoever. Despite extensive efforts by ASA, a number of state components, the American Medical Association and others to interject some rational thought into this process, it is getting worse.

Having participated in various forms of peer review over the years, I am an enthusiastic supporter, provided it is indeed *peer* review. It must:

- Be conducted by *clinicians* familiar with standards of practice, not self-proclaimed "experts" who are not anesthesiologists and have no knowledge regarding the practice.
- Include extensive on-site discussion and observation of actual practice, not a chart review for the presence of a postoperative note.
- Be constructive with intent to improve clinical practice, not be punitive, suspicious and destructive as is currently the case.
- Follow established guidelines developed by professional societies.

In short, it should mimic the Anesthesia Consultation Program of ASA!

Detractors (government) will scoff at the idea as self-serving and expensive. It is my guess that it would be considerably less expensive than the current government process, and the results would be productive and mean something. The business of regulatory review by government agencies has crossed the line from an intended functional process to improve patient care to a hopelessly ineffective, costly, appalling process that threatens, not improves, patient care.

Enough is enough! We should stand up and be counted!

Lewis H. Wright Memorial Lecture:

David J. Wilkinson, M.B.B.S., F.R.C.A., to Discuss 'Barts, Books, the Blues and Beyond: The Story of Christopher Langton Hewer'

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 in close collaboration with Harold R. Griffith, M.D.

David J. Wilkinson, M.B.B.S.

This year's distinguished Lewis H. Wright Memorial Lecturer is David J. Wilkinson, M.B.B.S., Consultant Anaesthetist at St. Bartholomew's Hospital, London, England. Dr. Wilkinson graduated from St. Bartholomew's Hospital Medical School and, except for a brief hiatus at the Princess Margaret and Royal Perth Hospitals in Perth, Australia, he has spent most of his illustrious professional life at Bart's. A fellow of the Royal College of Anaesthetists, he served there in an impressive array of positions, including medical director of the Day Surgery Centre (1986-96) and chair of the Department of Anaesthesia (1997-00). Additionally, Dr. Wilkinson is a member of the Executive Committee of the World Federation of Societies of Anaesthesiologists and is Honorary Treasurer of the Association of Anaesthetists of Great Britain and Ireland. Moreover, his exceptional leadership skills were recognized by his election as President of the Confederation of European National Societies of Anaesthesiologists (2002-04).

An eminent medical historian, Dr. Wilkinson served from 1982-95 as Curator of the Charles King Collection of Historical Anaesthetic Apparatus of the Association of Anaesthetists of Great Britain and Ireland, and he was Honorary Archivist of the Association of Anaesthetists of Great Britain and Ireland from 1994-01. His extensive bibliography includes scholarly manuscripts on such important topics as the historical development of resuscitation in the United Kingdom as well as the history of such pivotal advances as tracheal intubation, inhaled anesthetic agents, anesthetic equipment and trauma anesthesia.

Daunting as it is to attempt to encapsulate Dr. Wilkinson's numerous accomplishments in a few brief words, it is even more difficult to convey what a lucid, concise and authoritative speaker he is. Dr. Wilkinson is able to glide eruditely and seemingly effortlessly across several intellectual disciplines to provide crisp, new insights for his audience. Combining a polished style with formidable substance, Dr. Wilkinson formulates stimulating and deeply thoughtful lectures.

For the 2002 lecture, Dr. Wilkinson will discuss "Barts, Books, the Blues and Beyond: The Story of Christopher Langton Hewer." This eclectically titled lecture will be delivered at the ASA Annual Meeting on Tuesday, October 15, 2002, at 1 p.m. in the Orange County Convention Center, Orlando, Florida.

Appointed to the staff of St. Bartholomew's at age 24 as "Administrator of Anaesthetics," Christopher Langton Hewer (1896-1986) collaborated with H.E.G. Boyle, M.D., with whom he co-authored the text *Practical Anaesthetics*. Hewer was devoted to patient safety issues and purportedly included among his patients such luminaries as Winston Churchill, George Bernard Shaw and various members of the royal family. Largely responsible for the introduction of trichloroethylene as an alternative to flammable ether and potentially hazardous chloroform during World War II,

Continued on page 11

Kathryn E. McGoldrick, M.D., is Professor and Chair, Department of Anesthesiology, New York Medical College, Valhalla, New York.

FAER Honorary Research Lecture:

James C. Eisenach, M.D., to Discuss the Translation of Research Into Clinical Practice

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

The Foundation for Anesthesia Education and Research (FAER) will sponsor the second annual FAER Honorary Research Lecture at the 2002 ASA Annual Meeting in Orlando, Florida. FAER has created this annual lectureship as a means of recognizing outstanding scholarship by anesthesiologists and encouraging young anesthesiologists to consider careers in research and teaching, which are crucial if anesthesiology is to maintain its reputation as a medical specialty continuously striving for excellence in patient care.

James C. Eisenach, M.D.

Dr. Eisenach's lecture, "From Childbirth to Cancer Pain and Back Again — Translational Pain Research," will take place on Monday, October 14, from 2 p.m. to 3 p.m. in Room 330 A-C of the Orange County Convention Center.

Dr. Eisenach is the Francis M. James III Professor of Anesthesiology and Vice-Chair for Research at the Wake Forest Medical Center in Winston-Salem, North Carolina. By every benchmark, Dr. Eisenach is a prolific researcher in laboratory and clinical investigations, teacher and mentor, caring and highly competent clinician, efficient and effective administrator and active participant in anesthesiology organizations. The common questions are: How does he do it all, and how does he do it so well?

His accomplishments since 1986 as a scientist and mentor can be tabulated: National Institutes of Health (NIH) research grants totaling $13.5 million plus $1.2 million in other awards; 124 peer-reviewed, original research articles of which 45 percent are devoted to clinical investigations; mentoring of 38 students in research, including 29 M.D.s and seven Ph.D.s; 43 visiting professorships, including 17 in nine countries abroad.

He has served as an editor of *Anesthesiology* and the *Journal of Pain*, a member of grant review committees (ASA Committee on Research, NIH Surgery-Anesthesia-Trauma Study Section, V.A. Merit Review Committee), associate examiner for the American Board of Anesthesiology (ABA) and question writer for the ABA Pain Management Certification Examination; consultant to the Food and Drug Administration Anesthesia and Life Support Advisory Committee, and as the committee chair, director or officer in anesthesia organizations, including ASA, the Association of University Anesthesiologists, the Society for Obstetric Anesthesia and Perinatology and the American Society of Regional Anesthesia and Pain Medicine, for which he is now the President-Elect.

At Wake Forest he is recognized as a savvy and skillful clinical anesthesiologist in the surgical, obstetrical and pain management arenas, where he spends about one-fourth of his professional time and effort. As Vice-Chair for Research, he has established a strong research project review and approval mechanism, dealt with such sensitive issues as space and resource allocation and serves on university committees dealing with student mentoring, conflicts of interest and animal care. He is the only anesthesiologist in the United States to serve as the principal investigator for an NIH-funded Pain Research Center.

No one is quite sure how he manages to do all of the above with a pleasant smile and gentlemanly manner and still make time to bicycle daily with regular touring trips in the United States and abroad, scuba dive with his wife, 14-year-old son and 17-year-old daughter, read mysteries and adventures in French (which he speaks fluently) and enjoy the fine qualities of French cuisine. Perhaps the "French style" superimposed on his Midwestern upbringing and California educational experiences give him the balanced,

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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.

2002 Annual Meeting Schedule
October 12-16, 2002
Orlando, Florida

EVENT	FRIDAY OCTOBER 11	SATURDAY OCTOBER 12	SUNDAY OCTOBER 13	MONDAY OCTOBER 14	TUESDAY OCTOBER 15	WEDNESDAY OCTOBER 16
REGISTRATION	Orange County 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 PAPERS				Orange County Convention Center 9:00 - 5:00		
BREAKFAST PANELS				Rosen Centre 7:45 - 8:45		
ROVENSTINE LECTURE				Orange County Convention Center 11:15 - 12:15		
LEWIS H. WRIGHT MEMORIAL LECTURE					Orange County Convention Center 12:50 - 1:50	
REFRESHER COURSE AND CLINICAL UPDATE PROGRAM		Orange County Convention Center 9:00 - 5:20	9:00 - 5:20	12:40 - 1:30	11:30 - 1:30	11:30 - 1:30
ASA ART, SCIENTIFIC AND TECHNICAL EXHIBITS			Orange County Convention Center 12:00 - 5:00	9:00 - 4:00	9:00 - 4:00	
CLINICAL FORUM				Orange County Convention Center 9:00 - 10:30 2:00 - 5:00	9:00 - 12:00 2:00 - 5:00	9:00 - 12:00
PROBLEM-BASED LEARNING DISCUSSIONS		Rosen Centre 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			Peabody Orlando 9:00			Peabody Orlando 8:00
REFERENCE COMMITTEES			Peabody Orlando 1:00	Peabody Orlando (if necessary)		
SOCIAL ACTIVITIES		SPECIAL SPOUSE TOURS AND SEMINARS				
HOSPITALITY ROOMS		Orange County Convention Center, Peabody Orlando and Rosen Centre 8:30 - 5:00				

EVENT	MONDAY OCTOBER 14	TUESDAY OCTOBER 15	WEDNESDAY OCTOBER 16
SPECIAL MEETINGS AND LECTURES	**Orange County Convention Center, Peabody Orlando, Rosen Centre and Rosen Plaza** *(Refer to the Annual Meeting Program for exact locations.)*		
	***Workshop on Communications 8 a.m. – 11 a.m.**	***Workshop on Adult Fiberoptic Laryngoscopy 8 a.m. – 5 p.m.**	Panel on Perioperative Allergy and Anaphylaxis 9 a.m. – 11 a.m.
	***Workshop on Adult Fiberoptic Laryngoscopy 8 a.m. – 5 p.m.**	***Workshop on Pediatric Fiberoptic Laryngoscopy 8 a.m. – 5 p.m.**	Panel on Current Blood Transfusion Practices: Recent Advances 9 a.m. – 11 a.m.
	***Workshop on Pediatric Fiberoptic Laryngoscopy 8 a.m. – 5 p.m.**	***Workshop on Advanced Fiberoptic Laryngoscopy 8 a.m. – 5 p.m.**	Panel on Laryngeal Mask Airway: Pharyngeal Airway or Combitube: A Guide to Selecting and Using Supraglottic Airway Devices 9 a.m. – 11 a.m.
	***Workshop on Advanced Fiberoptic Laryngoscopy 8 a.m. – 5 p.m.**	***Workshop on Computing 9 a.m. – 5 p.m.**	Panel on What's New in Neuroanesthesia 9 a.m. – 11 a.m.
	***Workshop on the Difficult Airway 9 a.m. – 5 p.m.**	***Workshop on Considerations in Thoracic Anesthesia 9 a.m. – 5 p.m.**	Panel on Now We Are Being Asked to Measure What We Teach: Developing Innovative Assessment Programs 9 a.m. – 11 a.m.
	***Workshop on Computing 9 a.m. – 5 p.m.**	***Workshop on Management of the Difficult Pediatric Airway: Practical Tools 9 a.m. – 5 p.m.**	Panel on Local Anesthetic Toxicity – The ASRA Consensus Conference of 2001 9 a.m. – 11 a.m.
	***Workshop on Noncardiac Clinical Application of TEE 9 a.m. – 12:30 p.m.**	***Workshop on Peripheral Nerve Blocks 9 a.m. – 5 p.m.**	Panel on Geriatric Anesthesia: Big Problems With Little Cases 1 p.m. – 3 p.m.
	***Workshop on Peripheral Nerve Blocks 9 a.m. – 12 noon**	***Workshop on Acupuncture 9 a.m. – 12 noon**	Panel on Recent Advances in Resuscitation and Management of the Acutely Ill Hemodynamically Complicated Patient 1 p.m. – 3 p.m.
	***Workshop on Pain Management Techniques: Using Fluoroscopy in the Pain Clinic 9 a.m. – 12 noon**	Panel on Regional Anesthesia in Ambulatory Surgery: Expanding Its Application 9 a.m. – 11 a.m.	Panel on Women in Medicine: Leadership Into the 21st Century 1 p.m. – 3 p.m.
	Panel on You, Too, Can TIVA. Essentials of Total Intravenous Anesthesia 9 a.m. – 11 a.m.	Panel on Perioperative Problems in Pediatric Anesthesia 9 a.m. – 11 a.m.	Panel on Preoperative Patient Care – More Than Just "Clearing" for Surgery 1 p.m. – 3 p.m.
	Panel on Noninjection Techniques for Pain Management 9 a.m. – 11 a.m.	Panel on Preoperative Testing: How Should I Apply the Update to the AHA/ACC Perioperative Cardiovascular Evaluation Guidelines and the ASA Advisory on Preanesthetic Evaluation? 9 a.m. – 11 a.m.	Panel on Regional Anesthesia Techniques for Postoperative Pain Management: A Word From the Experts 1 p.m. – 3 p.m.
	Panel on Anesthetic Management of Innovative Procedures in Vascular, Cardiac and Thoracic Surgery 9 a.m. – 11 a.m.	Panel on Practice Management Challenges 9 a.m. – 11 a.m.	Panel on Review and Update of the 1998 ASRA Consensus Statements on Neuraxial Anesthesia and Anticoagulation 1 p.m. – 3 p.m.
	Panel on 10 Key Issues for Inhalational Anesthetics 9 a.m. – 11 a.m.	Panel on Occupational Concerns for Anesthesiologists 9 a.m. – 11 a.m.	Panel on Preoperative Echocardiography 1 p.m. – 3 p.m.
	Panel on Anesthesia for Combat Conditions 9 a.m. – 11 a.m.	Panel on Office-Based Anesthesia (OBA) – Current Status 9 a.m. – 11 a.m.	
	Panel on Anesthesia Equipment Issues: 2002 9 a.m. – 11 a.m.	Panel on Anesthesia in Europe: How Different Is It From U.S. Practice? 9 a.m. – 11 a.m.	
	Panel on Drugs, Doctors and Data – Problems and Solutions 9 a.m. – 11 a.m.	Panel on Hospital Sedation Officer: What Anesthesiologists Need to Know 2 p.m. – 4 p.m.	
	Panel on How Can I Keep Playing the Cardiovascular Anesthesia Game When They Keep Changing the Rules? Evolution and Developments in CV Anesthesia 9 a.m. – 11 a.m.	Panel on Obstetric Anesthesia Update 2 p.m. – 4 p.m.	
	***Workshop on Considerations in Thoracic Anesthesia 2 p.m. – 5 p.m.**	Panel on Vexing Problems and Controversies in Trauma Anesthesia 2 p.m. – 4 p.m.	
	***Workshop on Management of Critical Incidents and Team Interactions in Simulation 2 p.m. – 5 p.m.**	Panel on Guinea Pigs and Grandeur: Clinical Research at a Crossroads 2 p.m. – 4 p.m.	
	***Workshop on TEE 2 p.m. – 5:30 p.m.**	Panel on Civility and Professionalism in Anesthesia 2 p.m. – 4 p.m.	
	Panel on Pro and Con: Fluid Preloading and Combined Spinal-Epidural Analgesia for Obstetrics 2 p.m. – 4 p.m.	Panel on Management of Mass Casualty Incidents 2 p.m. – 4 p.m.	
	Panel on Anesthetic and Critical Care Issues in Solid Organ Transplantation 2 p.m. – 4 p.m.	Panel on What Happens When My Injured Patient Sues Me? 2 p.m. – 4 p.m.	
	Panel on Critical Care Medicine: An Update 2 p.m. – 4 p.m.	Panel on Coming Full Circle: The Recrudesce of Ideas in Anesthesiology 2 p.m. – 4 p.m.	
	Panel on QA? Sedation? A 2002 JCAHO Survival Kit 2 p.m. – 4 p.m.	Panel on Pediatric Techniques: The How and the Why 2 p.m. – 4 p.m.	
	Panel on Disability Issues for the Anesthesiologist 2 p.m. – 4 p.m.		
	Panel on Complementary and Alternative Medicine – The Good, the Bad and the Ugly 2 p.m. – 4 p.m.		
	Forum on the History of Anesthesiology 2 p.m. – 5 p.m.		
	FAER Panel – Anesthesiology and Palliative Medicine – Is It Part of Our Mission? 3 p.m. – 5 p.m.		

* 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.

Refresher Course, Clinical Update and Basic Science Review Program

Jeffrey L. Apfelbaum, M.D., Chair
Committee on Refresher Courses

ASA is proud to bring back its intense, clinically significant Refresher Course Lecture and Clinical Update Program, which provides anesthesiologists with information on the newest developments in anesthesiology and other related medical fields. This year's meeting will take place on Saturday, October 12, and Sunday, October 13, with additional presentations during mid-days on Monday, Tuesday and Wednesday, October 14-16.

The Refresher Course Lectures and Clinical Updates consist of 111 lectures that address the entire spectrum of clinical practice and practice management. Anesthesia techniques will be a major focus of this year's presentations. **Steven J. Barker, Ph.D., M.D.**, will address recent developments in oxygen monitoring. **Susan Black, M.D.**, will discuss anesthesia for spine surgery. **Edmond Cohen, M.D.**, will review new developments in thoracic anesthesia. **John C. Drummond, M.D.**, will examine anesthesia for intracranial aneurysm surgery. **Joy L. Hawkins, M.D.**, will address anesthesia for the pregnant patient undergoing nonobstetric surgery. **Jerome M. Klafta, M.D.**, will discuss how to make one-lung anesthesia work. **Craig M. Palmer, M.D.**, will review obstetric emergencies and anesthetic management. **Raymond C. Roy, M.D., Ph.D.**, will examine the anesthetic management of the elderly patient. **Alan Jay Schwartz, M.D.**, will address anesthetic issues related to body temperature.

Cardiovascular topics will once again be an important aspect of the program. **Solomon Aronson, M.D.**, will discuss the role of transesophageal echocardiography in noncardiac surgery. **Jeffrey R. Balser, M.D., Ph.D.**, will review antiarrhythmic therapy. **Paul G. Barash, M.D.**, will examine sequential monitoring of myocardial ischemia in the perioperative period. **Michael K. Cahalan, M.D.**, will address the role of transesophogeal echocardiography in cardiac surgical patients. **David H. Chestnut, M.D.**, is to discuss problems with blood pressure, blood loss and blood patches in obstetric anesthesia. **Daniel J. Cole, M.D.**, will review anesthesia for carotid surgery. **John E. Ellis, M.D.**, will examine management of myocardial ischemia. **Lee A. Fleisher, M.D.**, will address 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 review current perspectives on the therapeutic use of nitric oxide. **William E. Johnston, M.D.**, will examine the use of drugs to support blood pressure and cardiac output. **Steven N. Konstadt, M.D.**, will address anesthetic considerations for the patient with heart disease undergoing noncardiac surgery. **Jonathan B. Mark, M.D.**, will discuss effective use of central venous pressure monitoring. **Michael J. Murray, M.D., Ph.D.**, will review evaluation and preoperative management of hypertensive patients. **Charles W. Otto, M.D.**, will examine current concepts in cardiopulmonary resuscitation. **Scott T. Reeves, M.D.**, will address the role of transesophogeal echocardiography in noncardiac surgery. **Myer H. Rosenthal, M.D.**, will discuss the management of cardiogenic, hyperdynamic and hypovolemic shock. **Marc A. Rozner, M.D., Ph.D.**, will review pacemakers and implantable cardioverter-defibrillators. **Linda J. Shore-Lesserson, M.D.**, will examine hematologic aspects of cardiac surgery. **Jeffery S. Vender, M.D.**, will address the use of pulmonary arterial catheters and mixed venous monitoring.

The topic of critical care medicine will be discussed by numerous presenters. **Valerie A. Arkoosh, M.D.**, will discuss what anesthesiologists needs to know about neonatal resuscitation. **Elizabeth C. Behringer, M.D.**, will review the role of the anesthesiologist as a perioperative consultant in the intensive care unit. **Michael J. Bishop, M.D.**, will examine the successful management of bronchospasm. **Marie E. Csete, M.D.**, will address anesthesia for liver transplantation. **Peter Rock, M.D.**, will review the evaluation and perioperative management of the patient with respiratory disease, and **Avery Tung, M.D.**, will examine perioperative management of the patient with acute respiratory distress syndrome (ARDS).

Because of the increasing importance of pain management and regional anesthesia in anesthesia practice, the Refresher Course Lecture and Clinical Update Program will include approximately 16 lectures on those topics. **Christopher M. Bernards, M.D.**, will address the use of intrathecal and epidural opioids. **David J. Birnbach, M.D.**, will review combined epidurals anesthesia for labor

Jeffrey L. Apfelbaum, M.D., is Professor and Chair, Department of Anesthesia and Critical Care, University of Chicago Hospitals, Chicago, Illinois.

anesthesia. **David L. Brown, M.D.**, will provide an update on brachial plexus blocks. **John F. Butterworth IV, M.D.**, will examine 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. Eisenach, M.D.**, will discuss 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 review the diagnosis and prevention of peripheral nerve injury following regional anesthesia. **Richard F. Kaplan, M.D.**, will examine the sedation and analgesia of pediatric patients undergoing procedures outside the operating room. **Spencer S. Liu, M.D.**, will address continuous plexus blockade. **Michael F. Mulroy, M.D.**, will discuss indications for and contraindications to regional anesthesia. **Joseph M. Neal, M.D.**, will review the question of whether regional anesthesia makes a difference in perioperative outcome. **Mark C. Norris, M.D.**, will examine the safety and success of regional anesthesia. **Linda J. Rice, M.D.**, will address practical postoperative pain management for children. **Timothy J. Brennan, M.D., Ph.D.**, will discuss acute pain management.

Issues central to the clinical management of ambulatory anesthesia will be the focus of four lectures. **Jeffrey L. Apfelbaum, M.D.**, will review current controversies in outpatient anesthesia. **Irene P. Osborn, M.D.**, will examine anesthesia for diagnostic and interventional radiology. **Phillip E. Scuderi, M.D.**, will address postoperative nausea and vomiting. **Rebecca S. Twersky, M.D.**, will discuss issues related to recovery and discharge of ambulatory surgical patients.

Pharmacology is always an important issue at the program. **John F. Butterworth IV, M.D.**, will examine agents, actions and misconceptions of local anesthetics. **P. Allan Klock, Jr., M.D.**, will address drug interactions for the anesthesiologist. **Edmond I. Eger II, M.D.**, will review the role of pharmacology of inhaled agents in anesthesia. **Adrian W. Gelb, M.D.**, will discuss control of cerebral circulation. **William E. Hurford, M.D.**, will address current concepts of inhaled nitric oxide. **Jonathan Moss, M.D., Ph.D.**, will review pain relief without side effects using peripheral opiate antagonists.

For the second year in a row, Sunday's program on October 13 will include a novel additional educational series — the Basic Science Review Program. The new series will consist of 12 lectures covering a broad range of topics that are fundamental to the practice of perioperative medicine. **Charles B. Berde, M.D., Ph.D.**, will review mechanisms of action of local anesthetics. **Talmage D. Egan, M.D.**, will discuss recent advances in the pharmacology of intravenous anesthetic agents. **Adrian W. Gelb, M.D.**, will address the principles of control of cerebral circulation. **Jeffrey B. Gross, M.D.**, will examine how and why we breathe. **Ira S. Kass, Ph.D.**, will review brain metabolism and mechanisms of cerebral ischemia. **Ronald D. Miller, M.D.**, will discuss what makes neuromuscular junctions and muscles work and not work. **Stanley Muravchick, M.D., Ph.D.**, will address physiological

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Lewis H. Wright Memorial Lecture

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Christopher Langton Hewer is perhaps best known as the author and later editor of *Recent Advances in Anaesthesia and Analgesia*, the first edition of which appeared in 1932 and the 14th in 1982, before he retired as he approached his 90th year! Without doubt, the verve, infectious enthusiasm and compelling vibrancy of Dr. Wilkinson will ensure that Christopher Langton Hewer is not consigned to the periphery of anesthesia history.

The Wood Library-Museum of Anesthesiology is honored to have the extraordinarily gifted Dr. David Wilkinson as the 2002 Lewis H. Wright Memorial Lecturer. And we thank him for preserving, illuminating and promulgating the human as well as the scientific and technical heritage of our unique specialty.

Plan on Some Panels at the ASA; Make Reservations Without Delay!

Jeffrey B. Gross, Committee on Panels Chair
(I certainly hope to see you there)

If you're coming to Orlando for the meeting in the fall
There's a panel that has something sure to interest one and all.
We listened to your comments and the program did extend,
To include more of the workshops that you wanted to attend.

This year we'll have more sessions for thoracic and echo
So if you have an interest, there's no reason not to go!
Adult and kiddie airways, and fiberoptic too,
Nerve blocks and computers, there's a workshop just for you.

Take the mystery out of history with Drs. Bacon and the rest
Or learn about drug allergies; Carol Hirshman is the best!
If your hospital's about to have a Joint Commission visit,
We have a panel just for you — A JCAHO "Toolkit."

Want to do a spinal on a patient whose blood's thin?
Dr. Horlocker's panel will review the risks of heparin.
Your patient's legs are aching after spinal lidocaine?
Mike Mulroy's panel will explore post-subarachnoid pain.

To get more information on the gases we are giving
Visit Dr. Eger's panel — he's the best expert who's living.
You'll learn the latest info on just how these gases work
And about some hidden pitfalls that behind the scenes may lurk.

Avoiding noxious gases for an operatic diva?
Infusion experts will explain just how "You too can TIVA."
Concerned about a fire from a laser that is hot?
Our equipment panel tackles what is safe and what is not.

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

If your patient's heart's a flutter but he still needs surgery,
Lee Fleisher's got the info on what workup there should be.
ASA and AHA have both developed guidelines;
Should we use them in the O.R. or commit them to the sidelines?

When a patient over 90 needs repairing of the arm,
Our geriatric panel will discuss avoiding harm.
What tests are needed preop, and what values should we see
To help these fragile patients make a quick recovery?

You say you have a patient with intolerable pain,
But giving him narcotics leads to secondary gain?
To block COX-2 or stabilize the membranes of the nerves,
Jeff Katz's panel gives this stuff the treatment it deserves.

We all know what's been happening to our insurance rates
As they spiral ever higher throughout the 50 states.
Dr. Domino's panel will embark to take us on that journey
Insurer, claims manager, expert too, and even defense attorney.

The potential for mass casualties from chemicals or germs
Requires that we be prepared in no uncertain terms.
Steve Barker's got a panel that will help us respond faster
To triage, transport, screen and treat the victims of disaster.

The RRC requires that we constantly assess
Each resident's new learning and the speed of their progress.
Dave Wilks has got a panel that will put this in our reach;
They'll offer lots of options on "How to Measure What We Teach."

When a child needs biopsy of a retrosternal mass
Without the right precautions, you can fall right on your face.
Visit Dr. Coté's panel, for the latest information
On caring for young patients who are in this situation.

If you're somewhat out of practice and your skills are not the best
In caring for those patients who need surgery of the chest,
Come to Dr. Cohen's workshop and you'll practice all the skills
That you'll need to care for patients who have pulmonary ills.

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Breakfast Panels: Nourishment for the Mind and Body

Arnold J. Berry, M.D., Vice Chair
Section on Annual Meeting

The Breakfast Panels are among the most popular offerings at the ASA Annual Meeting since attendees can start their day with a combination of nutrition and outstanding educational opportunities. This year in Orlando, Florida, these panels, sponsored by nine subspecialty societies, will be held at the Rosen Centre Hotel from 7:30 a.m. to 8:45 a.m. on Monday, October 14; Tuesday, October 15; and Wednesday, October 16. Three panels will be presented concurrently each morning [see Table].

On Monday, the **Society for Education in Anesthesia** will present "Teaching Anesthesiologists the Core Competency of Systems-Based Practice." At this session, three experts in graduate medical education will discuss teaching the core competency of systems-based practice in training programs. The **Society for Ambulatory Anesthesia** has planned the panel "Roughing It: Anesthesia for Off-Site Ambulatory Procedures." This session will address the multiple challenges associated with providing anesthesia care for procedures outside the operating room. Rounding out the Monday morning program, the **Society for Technology in Anesthesia** has organized the panel "Anesthesia Information Management Systems Meet the Press: Point and Counterpoint." This panel will provide information on the cost of information management systems and their possible role in operating room organization and patient safety.

The offerings continue on Tuesday morning with the **Section on Anesthesiology of the American Academy of Pediatrics** presenting a timely discussion of "Forbidden Fruit: The Use of 'Black Box Warning' Drugs in Pediatric Anesthesia." This session will consider the recent Food and Drug Administration warnings regarding drugs commonly used in pediatric anesthesia practices. Information on one of the most common forms of regional anesthesia will be presented in "Brachial Plexus Anesthesia: Essentials of Our Current Understanding," sponsored by the **American Society of Regional Anesthesia and Pain Medicine**. The third panel being presented on Tuesday morning is "Central Nervous System Injury: Adult and Pediatric," organized by the **Society of Neurosurgical Anesthesia and Critical Care**. This session will focus on the management of spinal cord and traumatic brain injuries.

The three panels on the last day of the meeting provide the most current information from the areas of critical care medicine, cardiac anesthesia and obstetric anesthesia. "Transfusion Issues in Patients With Cardiovascular Disease" will be presented by the **Society of Cardiovascular Anesthesiologists**. This timely panel will focus on the risks of transfusion and guides for assessing the need for

Annual Meeting Breakfast Panels

Monday, October 14

- *Teaching Anesthesiologists the Core Competency of Systems-Based Practice* — Society for Education in Anesthesia
- *Roughing It: Anesthesia for Off-Site Ambulatory Procedures* — Society for Ambulatory Anesthesia
- *Anesthesia Information Management Systems Meet the Press: Point and Counterpoint* — Society for Technology in Anesthesia

Tuesday, October 15

- *Forbidden Fruit: The Use of "Black Box Warning" Drugs in Pediatric Anesthesia* — American Academy of Pediatrics Section on Anesthesiology.
- *Brachial Plexus Anesthesia: Essentials of Our Current Understanding* — American Society of Regional Anesthesia and Pain Medicine.
- *Central Nervous System Injury: Adult and Pediatric* — Society of Neurosurgical Anesthesia and Critical Care

Wednesday, October 16

- *Transfusion Issues in Patients With Cardiovascular Disease* — Society of Cardiovascular Anesthesiologists
- *New Therapeutics in the Perioperative Period* — American Society of Critical Care Anesthesiologists
- *Clinical Dilemmas in Obstetric Anesthesia* — Society for Obstetric Anesthesia and Perinatology

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Arnold J. Berry, M.D., is Professor of Anesthesiology, Emory University School of Medicine, Atlanta, Georgia.

Annual Meeting Scientific Papers Sessions: 73 Venues to Assimilate and Exchange Knowledge

Kenneth J. Tuman, M.D., Chair
Committee on Scientific Papers

The Committee on Scientific Papers selected 1,377 abstracts for presentation at the ASA 2002 Annual Meeting in Orlando, Florida. These abstracts will be presented in 36 poster and 36 poster-discussion sessions, in addition to a journal symposium session. Each session is arranged by subject matter, and knowledgeable experts will facilitate all scientific abstract presentations. The poster sessions, containing 30 abstracts and lasting two hours, will be held on Monday, October 14, through Wednesday, October 16. Abstract authors will be present throughout the session to discuss their work with attendees, and expert facilitators will be available at each poster session to interact with the abstract authors and attendees. The poster-discussion sessions, containing eight abstracts and lasting 90 minutes, will be held on these days. The posters will be available for review for the initial 30 minutes of each poster-discussion session followed by a discussion of each study coordinated by two expert moderators who also will invite dialogue and questions from attendees.

Electronic Submission, Selection and Presentation

All abstracts were submitted and graded electronically by the 15 scientific papers subcommittees (see listing in box) using an efficient Web-based process. Based upon the evaluation of the subcommittees, 81 percent of the 1,686 abstract submissions (received from 40 countries) were accepted and grouped into sessions containing presentations on similar topics. We are indebted to the 165 ASA members who have volunteered substantial time and expertise to serve on these subcommittees. Although space precludes citation of their names in this article, the subcommittee members will be listed in the front of the 2002 Annual Meeting program.

All abstracts presented at the ASA Annual Meeting will be published on a CD-ROM that will be included with the September issue of *Anesthesiology*, but unlike previous years, no print version of the abstracts will be distributed. The CD-ROM will contain the 2000, 2001 and 2002 Annual Meeting abstracts, which will be searchable by topic and author, as well as the abstracts presented at the Society of

Kenneth J. Tuman, M.D., is the Max Sadove, M.D., Professor and Vice-Chair, Department of Anesthesiology, Rush Medical College at Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois.

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.

Obstetric Anesthesia and Perinatology and American Society of Critical Care Anesthesiologists meetings in Orlando on Friday, October 11. The Annual Meeting abstracts will be accessible on the ASA Web site <www.asahq.org> and the *Anesthesiology* Web site <www.anesthesiology.org> and also during the Annual Meeting at several computer kiosks at the Orange County Convention Center in Orlando, where attendees will be able to print a paper copy of abstracts for reference while attending specific scientific paper sessions.

Journal Symposium

The 2002 Journal Symposium "Mechanism-Based Diagnosis and Therapy of Chronic Pain," sponsored by the editorial board of *Anesthesiology*, will be conducted from 9 a.m. to 12:30 p.m. on Tuesday, October 15. James C. Eisenach, M.D., and Srinivasa N. Raja, M.D., who also will serve as moderators for the eight papers that have been selected for presentation in this session, organized the symposium.

The Committee on Scientific Papers anticipates that you will find this year's scientific paper presentations valuable. We encourage you to attend these meeting sessions, which represent the most current research and scholarly efforts in the medical discipline of anesthesiology. Interacting with the authors of these research papers and with the moderators and facilitators is a wonderful way to gain knowledge and exchange ideas, and we hope that you will find the time to benefit from the tremendous intellectual opportunities offered in these sessions.

Technical Exhibit Program

During the ASA Annual Meeting on October 12-16, 2002, in Orlando, Florida, the Technical Exhibit Program will be held from Sunday through Tuesday, October 13-15. Approximately 300 companies are expected to participate.

Exhibits will be open from noon to 5 p.m. on Sunday, October 13, and from 9 a.m. to 4 p.m. on Monday and Tuesday, October 14 and 15, in Halls C-E in the Orange County 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 2002 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.

FAER Honorary Research Lecture

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unassuming and self-effacing demeanor that his family, friends and colleagues admire so much.

Dr. Eisenach is a great role model for young anesthesiologists who combined a career in academic anesthesiology with a solid family life and the enjoyment of people and activities outside the practice of medicine. FAER is privileged to recognize Dr. Eisenach's achievements as it strives to promote the generation of new knowledge in the broad spectrum of anesthesiology, to advance health and patient care and to foster innovation through career devel-

2002 Clinical Forum Program: Getting Better Because of Your Input

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

The Clinical Forum sessions at the 2002 Annual Meeting will be held Monday, October 14, through Wednesday, October 16, at the Orange County Convention Center, Orlando, Florida. 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 offer a chance to interact with and question the experts, and the sessions are free!

Of special note, Gregory J. Crosby, M.D., and Michael M. Todd, M.D., will reprise last year's neuroanesthesia "Survivor" clinical forum, where panelists were voted "off the island" by the audience for their case-based management decisions. It was fun last year and should be exciting again this year.

The Clinical Forum cases will be printed in the 2002 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 to those who attend. 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 from last year and incorporated them into this year's program. The forums will be exciting! We will look forward to seeing you there with your thoughts and questions!

The 2002 Committee on Clinical Forum has assembled the following forums for this year's Annual Meeting:

Adult Ambulatory/Geriatrics and Recovery Room Clinical Forum: *Moderator*: Lydia A. Conlay, M.D., Ph.D., Temple University Medical School, Philadelphia, Pennsylvania.

Pediatric Anesthesiology Clinical Forum: *Moderator*: Myron Yaster, M.D., Johns Hopkins University, Baltimore, Maryland.

General Anesthesia and Trauma Clinical Forum: *Moderator*: Richard P. Dutton, M.D., University of Maryland School of Medicine, Baltimore, Maryland.

Cardiovascular and Thoracic Anesthesia Clinical Forum: *Moderator*: Solomon Aronson, M.D., University of Chicago, Chicago, Illinois.

Obstetric Anesthesia Clinical Forum: *Moderator*: Alan C. Santos, M.D., St. Luke's-Roosevelt Hospital, Columbia University, New York, New York.

Neuroanesthesia Clinical Forum: *Moderator*: Gregory J. Crosby, M.D., and Michael M. Todd, M.D., University of Iowa, Iowa City, Iowa.

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

Pain Management Clinical Forum: *Moderator*: Ann C. Still, M.D., University of Alabama at Birmingham, Birmingham, Alabama.

Gregory K. Unruh, M.D., is Associate Professor and Director, Anesthesiology Residency Education, Department of Anesthesiology, Kansas City University Medical Center, Kansas City, Missouri.

Science and Humanity: Expressed Side by Side

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

During the 2002 Annual Meeting in Orlando, Florida, 28 peer-reviewed scientific and educational exhibits covering many aspects of anesthesia practice will be displayed. Among the topics they cover are the education of anesthesiologists and patients, the sedation of children and morbidly obese patients, a new delivery system for inhalation anesthetic agents, new application of older techniques for gas delivery, and new and old monitoring systems.

The exhibit area will be open from noon on Sunday, October 13, through Tuesday, October 15. These exhibits offer the opportunity for participants to interact with experts, exchange ideas and express their views on a variety of topics.

Among the exhibits that will give participants a better understanding of inhalation anesthesia are a new anesthetic vaporizer, an ecologically friendly anesthetic delivery system, safe conduct and simple determination of anesthetic absorption during closed-circuit anesthesia and a novel oxygen-delivery and gas-sampling device.

The issue of safety in anesthetic practice is addressed in at least three exhibits: the dangers of putting the wrong anesthetic into a vaporizer, anesthetic management of thyrotoxicosis and ultrasound-guided central venous cannulation.

Two exhibits present the value of the Internet and handheld computers in informing patients about medicine and helping anesthesiologists safely execute their daily responsibilities. Rapid access to patient information, a quick reference to pharmacology and interaction of drugs and a review of rare diseases are other examples of exhibits that make the Annual Meeting a valuable learning experience.

As in previous years, the issue of airway management is well-represented in this year's scientific exhibits. Among the exhibits on the topic of airway management are a better angle for viewing the larynx during intubation, the role of an algorithm in airway management, acoustic imaging of the airway and management of the difficult pediatric airway.

The administrative exhibits remind us of the valuable work of a number of nonprofit organizations and societies. We all are familiar with specialty societies and their contribution to the advancement of science and practice of anesthesia and medicine. We should be equally aware of the humanitarian work that is carried out throughout the world by nonprofit organizations. REMEDY (Recovered Medical Equipment for the Developing World) was created by William H. Rosenblatt, M.D., of Yale University, in 1994. REMEDY has recovered and reprocessed millions of dollars' worth of medical equipment and supplies that would have been discarded by hospitals in the United States. These recovered items were donated to a number of countries around the world that are in desperate need of such supplies and equipment. The REMEDY plan can be applied to any hospital in the United States and has the potential of saving millions, if not billions, of dollars of medical equipment through the donations. REMEDY provides support and shares its experiences with others who are interested in joining this humanitarian mission. Teaching anesthesia in developing countries and providing free surgical care for indigent people of other countries represent other humanitarian outreach efforts that are occurring through U.S. physicians.

The members of the Committee on Scientific and Educational Exhibits will review the exhibits on Sunday afternoon and Monday morning. Three exhibits will be recognized for first-place and merit awards. The criteria include originality, clinical relevance, scientific merit and visual impact.

My sincere thanks to the members of the committee: 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., Ph.D., Erin A. Sullivan, M.D., and Yaser Wafai, M.D., Ph.D., who have devoted considerable time to serve on this committee. We invite and encourage all participants at the Annual Meeting to attend and review the scientific and educational exhibits.

Andranik Ovassapian, M.D., is Professor of Clinical Anesthesia and Director, Airway Study and Training Center, Department of Anesthesia and Critical Care, University of Chicago, Chicago, Illinois.

2002 PBLD Program: Got Issues? We've Got Solutions

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

An opportunity to discuss an enigmatic situation in an interactive format with colleagues from a variety of educational backgrounds and clinical experiences — this is what the Problem-Based Learning Discussion (PBLD) program offers. Moderators assist learners in identifying key issues of a case as the group works toward a resolution while acquiring new knowledge and insight into problem solving.

First available last year, the PBLD program is again paperless! The "casebook" is available *only* in CD-ROM format and offers extended discussion sections, which make the cases useful as educational tools even for those who cannot attend a specific session. The open call for cases was handled online. One hundred ninety-six cases were submitted for consideration, of which 128 were accepted. Fifty-five percent of the cases in 2002 will be first-time offerings, and the entire gamut of anesthesiology subspecialties is represented. PBLDs focusing on critical care, thoracic, transplant, neuro, obstetric, regional and pediatric anesthesia, and acute and chronic pain management are included. Additional sessions will address operating room management, ethical and legal issues, resident education, occupational health and stress management.

We are excited to announce a case writer's forum to complement the open call for cases. Prospective case writers are invited to meet with PBLD committee members to learn firsthand about how to develop cases, the process of evaluation and acceptance of PBLDs and techniques of moderating sessions in the hope of attracting new discussants with diverse areas of expertise. The case writer's forum will be held on Monday, October 14, from 9 a.m. to 10 a.m. at the Orange County Convention Center, Room 315B.

PBLD sessions will take place at the Rosen Centre Hotel from Saturday, October 12, through Tuesday, October 15. Breakfast sessions will be held 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. In addition, 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.

Tickets will be $30 for the breakfast sessions, $40 for the luncheon sessions and $20 for the refreshment sessions; this includes the food service as well as the CD-ROM (also available separately for $15). Sessions are filled on a first-come, first-served basis, so please register early, and list alternative choices in the event that your primary choice is sold out. Several weeks prior to the meeting, you will receive the case, with guiding questions and a brief bibliography that may help you as you ponder the issues that will be addressed during the PBLD session.

Titles of cases may seem straightforward, but as you peruse the PBLD offerings, consider the educational objectives. These are the keys to the essence of each PBLD and will help you to choose a session that meets your academic needs. The PBLD committee and moderators look forward to your participation in this exciting educational format.

Meg A. Rosenblatt, M.D., is Clinical Associate Professor of Anesthesiology, Mount Sinai School of Medicine, New York, New York.

Orlando Location Inspires Art Show Theme 'Fountain of Youths'

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

Orlando, Florida, vacation capital of the world, has inspired the ASA Committee on Art Exhibits to announce that "Fountain of Youths" will be the theme of this year's exhibit. The combination of both a tropical climate and a fantastic entertainment environment for the young (and the young at heart!) was the basis for this decision.

The committee offers a new theme each year to afford artists and writers a chance to produce works that are unique to that theme. "Fountain of Youths" entices the imagination to produce pieces on several levels, incorporating water, children or both. Works can be entered irrespective of the theme category in any one of the many categories we offer: painting (oils, acrylics, watercolor, tempera and gouache); photography (color or black and white); graphic works on paper (drawings, prints and pastels); sculpture and crafts (including needlework, weaving, pottery, stained glass, jewelry, construction, metal work); literature; and junior exhibit (under 18).

This will be the second year we offer a digital photography category. We hope that the digital entries will increase this year and that more artists will take full advantage of the unique characteristics that the medium has to offer.

The literature category has been modified this year to limit the maximum number of pages to 50 for short stories. Though some writers may feel that this limits their creativity, the committee felt that it would make the judging more equitable and enable the literature judge to read the material in greater depth.

Our literature judge this year is again Shelley Mickle, who provided us with wonderful critiques of each piece entered last year. She provided the writers with comments that were both nurturing and educational. For those unfamiliar with Shelley Mickle, she 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. Over the last year, Shelley also has taken on the hat of book reviewer for the *Gainesville Sun* newspaper and has a column appearing every Sunday.

Our Art Exhibit judges are Nancy Jay, Ph.D., a retired art professor from Valencia Community College in Orlando, Florida. She currently teaches drawing and painting at Georgia College and State University in Milledgeville, Georgia, where she maintains her art studio. She received her M.S.A. degree in painting from Florida State University and has judged several regional art shows in Georgia and Florida.

Robert Eginton, Ph.D., is a photojournalist whose work

Continued on page 20

Jerry J. Berger, M.D., is Associate Professor of Anesthesiology and Director of Acute Pain Service, University of Florida, Gainesville, Florida.

has appeared in a number of publications, including both *Time* and *Life* magazines. He attended the University of Chicago and Rollins College in Winter Park, Florida. He has been an adjunct professor of photography at Valencia Community College in Orlando, Florida, for the past 10 years. We are looking forward to seeing Ms. Jay and Mr. Eginton in our exhibit in October.

A logo has been designed (see page 19) and will be featured on T-shirts to be sold during the meeting in the art exhibit for $10 each. A banner depicting the logo will be displayed in the convention hall, which will guide attendees to the art exhibit. Keep an eye out for the logo, and let it lead you to the most beautiful corner of the exhibit hall, a place where you can catch your breath, relax and enjoy the handiwork of your fellow anesthesiologists and their families.

The exhibit will be open from noon on Sunday, October 13, until 4 p.m. on Tuesday, October 15.

Start planning your entries now. You may enter up to six works per person. Visit the ASA Web site for a complete list of rules and regulations <www.asahq.org/AnnMtg/2002/2002artgl.htm>.

This is my second year as chair of the Committee on Art Exhibit, and I look forward to your comments and suggestions on what is good with the exhibit and what can be improved. I await the wonderment of viewing your art exhibit entries at the meeting and seeing you there in Orlando. Come, relax, participate and enjoy!

Book/Multimedia Education Award

The Anesthesia Foundation announces the Book/Multimedia Education Award to be presented at the 2003 ASA Annual Meeting in San Francisco, California.

This prestigious award will be given tri-yearly for excellence and innovation in books or multimedia that have significant impact on the science and practice of anesthesiology, critical care or pain medicine. Multiple authors are eligible, with the stipend being divided between the first and senior authors.

The award is $10,000 plus expenses for winners and guests to attend the Academy of Anesthesiology 2004 Spring Meeting in Victoria Island, Vancouver, British Columbia, Canada.

Deadline for receipt of contributions is **November 15, 2002**. For further information and specific criterion please contact:

Doris K. Cope, M.D.
UPMC St. Margaret Pain Medicine Center
200 Delafield Ave., Suite 2070
Pittsburgh, PA 15215

Plan on Some Panels at the ASA; Make Reservations Without Delay!

Continued from page 12

If you want some hands-on practice in performing TEE,
We have two separate workshops which are just where you should be.
One will deal with patients having surgery of the ticker;
The other with noncardiac surgery patients who are sicker.

There's more on the agenda, but we haven't got the space
To give you information on the hour and the place.

So check your meeting program for the final information
On the timing of each panel and on its precise location.

On behalf of our committee, I hope that you decide
For panels or for workshops, some time to set aside.
We look forward to this program with great anticipation;
You'll learn a lot and have some fun with group participation.

Regulations Governing Assignment of Tickets

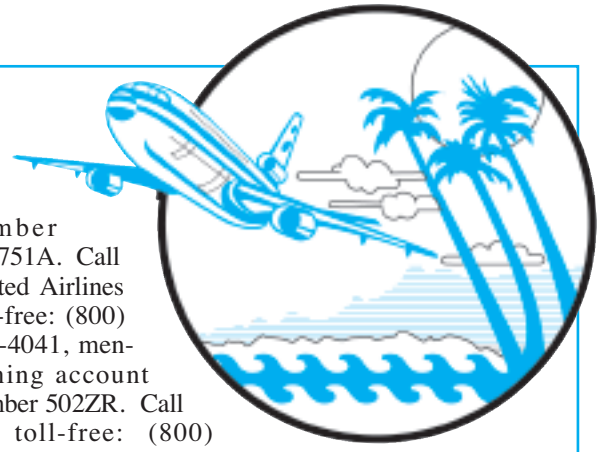
The Refresher Course Lectures, Clinical Updates and Basic Science Review Program will be presented at the 2002 ASA Annual Meeting, Saturday through Wednesday, October 12-16, 2002. The lectures will be held in the Orange County Convention Center.

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 ticket price for each lecture is $10 for all registrants.

The *2002 Annual Meeting Refresher Course Lectures* book containing summaries of the lectures with a CD-ROM that also contains the lecture summaries will be available for $20 per copy. The *2002 Annual Refresher Course Lectures* book with CD-ROM will be available for purchase at the Annual Meeting and is available from the ASA Publications Department <publications@ASAhq.org>. The registration area will be open from 3 p.m. to 9 p.m. on Friday, October 12. This schedule will enable participants to purchase additional tickets and the book prior to the courses beginning on Saturday morning.

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



Delta Air Lines, United Airlines and the ITS group of ExpoExchange, in cooperation with ASA, have made special arrangements to offer Annual Meeting participants discount air fares for the 2002 Annual Meeting in Orlando, Florida.

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 186751A. Call United Airlines toll-free: (800) 521-4041, mentioning account number 502ZR. Call ITS toll-free: (800) 621-1083. When making reservations, mention that you will be attending the ASA Annual Meeting in Orlando.

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 AWD number J096028. For Budget, call toll-free: (800) 772-3773 and mention BCD number U067026. 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 12-16 to receive the special reduced rates.

ASA Placement Service

The ASA Placement Service is a computerized system and will be available in the Registration Area in Halls F1 and F3 at the Orange County Convention Center. Notices of practice opportunities and positions being sought are posted on the Internet through ASA's Web site. Users may search by state, type of position or type of anesthesia. Physicians can browse the employer information, and employers can browse applications submitted by members seeking a position.

Submission forms may be completed online at <http://placement.asahq.org>. You will be able to complete the appropriate application form from this address.

The information may be printed on site on high-speed laser printers.

Users of this system on site at the ASA Annual Meeting will be able to post local contact information. Space is available in Room 225B at the Orange County Convention Center for face-to-face interviewing.

The Placement Service will operate from 3 p.m. Friday, October 11, through 2 p.m. Wednesday, October 16.

Refresher Course, Clinical Update and Basic Science Review Program

Continued from page 11

changes of aging. **Ronald G. Pearl, M.D.**, will examine the matching of ventilation and perfusion in the lung. **Ira J. Rampil, M.D.**, will review the anatomy, biochemistry and circuit connections of the brain. **Isobel Russel, M.D.**, will discuss myocardial function. **Edward R. Sherwood, M.D., Ph.D.**, will provide an overview of current concepts regarding the inflammatory response. **Robert N. Sladen, M.B., Ch.B.**, will examine the physiology of urine formation.

In addition to these topic areas, six lectures will address topics related to airway management; three presentations will focus on allergy and infection; eight will discuss issues related to coagulation, endocrine, metabolic and fluid management; 16 will review technology, monitoring and equipment; three will discuss geriatric anesthesia; eight will discuss medicolegal and ethical issues; 14 will address neurosurgical anesthesia; seven will review current concepts in obstetric anesthesia; 12 will examine operating room management and practice management; 10 will discuss pediatric anesthesia; 10 will review issues related to postoperative management; 14 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 the ASA membership at the 2002 ASA Refresher Course Lecture, Clinical Update Program and Basic Science Review Program.

As Chair of the Committee on Refresher Courses, I would like to extend my deep thanks and gratitude to the members of the committee, and I especially want to thank **Jan Ehrenwerth, M.D.**, Vice-Chair of the committee. The committee has recommended a total of 111 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 Orlando.

MHAUS to Offer Writing Award

The Malignant Hyperthermia Association of the United States (MHAUS) is pleased to announce the inception of an award to the author of a manuscript related to malignant hyperthermia (MH).

MH is an inherited disorder of muscle that is "triggered" by commonly used anesthetic agents and may lead to death or disability. Early diagnosis and prompt treatment is the key to reducing morbidity and mortality related to MH. MH may occur at any time during an anesthetic whether in a hospital, ambulatory surgical center or an office-based setting. A large variety of programs have been developed by the scientific panel at MHAUS in order to increase awareness of the syndrome and its manifestations. These include procedure manuals for recognizing and treating MH applicable to the hospital or to the ambulatory surgical center, a continuing medical education-accredited slide show and a variety of publications.

In order to promote awareness of MH and its various manifestations and to encourage continued study of the syndrome, George Massik, a founding member of MHAUS, has graciously offered to support an annual writer's award. The Daniel Massik Fund at The Foundation for Jewish Philanthropies in Buffalo, New York, was established by Mr. Massik in memory of his son who died from MH. This award will provide a stipend of $2,000 to an anesthesiology resident/fellow or an anesthesiologist who is within five years of ending his/her training to attend the ASA Annual Meeting or, in special circumstances, another meeting of similar merit.

Award Details

The award will be given to the primary author of the best manuscript concerning malignant hyperthermia. The format may be a case report, literature review or original study and should follow these guidelines:

- The document should address a significant issue related to the problem of malignant hyperthermia.
- Those participating must currently be a resident/fellow in anesthesiology or an anesthesiologist who is within five years of ending his/her training.
- The paper must be a minimum of three double-spaced typed pages and a maximum of 10 pages.

Deadline for receipt of the manuscript in the MHAUS office is **August 15, 2002**.

The award will be presented at the annual MHAUS Recognition Reception at the ASA Annual Meeting.

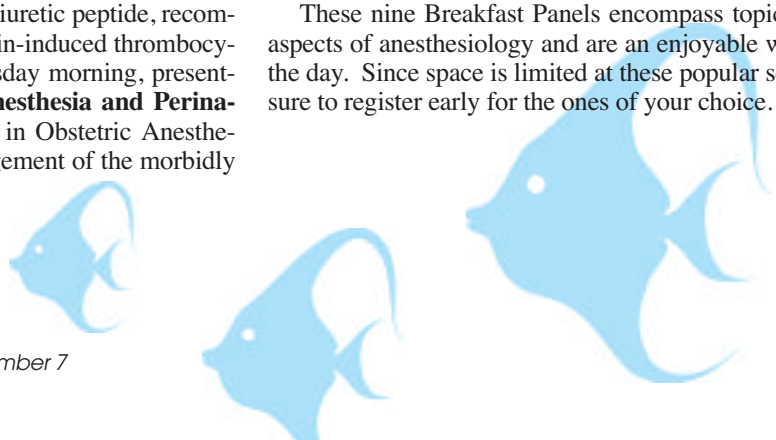
For further information regarding the application process for this award, please contact the Malignant Hyperthermia Association of the United States, Attention: Dianne Daugherty, 39 East State St., P.O. Box 1069, Sherburne, NY 13460, via fax at (607) 674-7910 or e-mail at <mhaus@norwich.net>.

Breakfast Panels: Nourishment for the Mind and Body

Continued from page 13

transfusion and alternative therapies. **The American Society of Critical Care Anesthesiologists** will present "New Therapeutics in the Perioperative Period." Presentations will cover diverse topics such as natriuretic peptide, recombinant-activated protein C and heparin-induced thrombocytopenia. The third panel on Wednesday morning, presented by the **Society for Obstetric Anesthesia and Perinatology**, will be "Clinical Dilemmas in Obstetric Anesthesia." Experts will discuss the management of the morbidly obese parturient, the safety of neuraxial anesthesia in the presence of anticoagulants and the best options for regional analgesia for labor and delivery.

These nine Breakfast Panels encompass topics from all aspects of anesthesiology and are an enjoyable way to start the day. Since space is limited at these popular sessions, be sure to register early for the ones of your choice.



Ventilations: Anesthesiology Aphorisms, 5th Installment

Continued from page 1

What I've learned (Upton's Rules) — Submitted after 35 years of clinical service

- A bad I.V. never gets any better.
- I've never been sorry I've intubated a patient; I've been sorry about some I didn't.
- An axillary brachial block is a crummy block.
- If you have difficulty with tiny needle lumbar punctures, go to a bigger needle.
- Most failures of lumbar puncture are due to inadequate forward flexion.
- Share severe anxieties about a patient with the surgeon.
- If you can't find out, if all else fails, ask the patient.
- If the monitors say you are in trouble, you probably are.
- Outpatients really, really appreciate a postoperative telephone call from you.
- Praise a nurse once in a while.
- Think it over three times before arguing about a surgical decision.
- Oxygen sats of 90 percent sometimes mean right bronchial intubation.
- One of your best friends is the end-tidal pCO_2.
- When a nasal tube or cannula won't pass, use your gloved finger behind the uvula.
- Watch regurgitation in the patient with a hiatal hernia, especially in the head-down position.
- No one else in the O.R. is really interested in your problems, but you had better be interested in theirs.
- In rectal cases, infiltration of local anesthetics around the anus works very well.
- If your old patient isn't doing well postoperatively, especially after a regional procedure, check the pCO_2.
- As my father used to quote: "Be not the first by whom the new is tried nor yet the last to lay the old aside."
- If you can't keep 'em alive when they're alive, you can't keep 'em alive when they're dead.
- A surgeon cannot be delayed until he/she actually arrives in the O.R.
- It's better to have a running 20-gauge I.V. than an 18-gauge hematoma.
- Never lead the charge (adopt new practices) as you will get all the arrows in the chest. Never bring up the rear (fail to abandon old practices) as you will get all the arrows in the back.
- A surgeon's definition of anesthesia is "pancuronium"; an anesthesiologist's definition is "propofol."
- You know you're doing a BIG MAC when your agent alarm keeps sounding.
- Not everything that counts can be counted, and not everything that can be counted, counts.

Finally, here are but a few selections from Dr. Abouleish's book, which is a summation of a career's experiences:

- Being humble unfortunately is misinterpreted by some as weakness in character and position.
- It's not what you say but how you say it.
- Truth is like pregnancy…it can't be hidden for long.
- The respect you get in America depends on your efficiency and knowledge.
- The secret of success:
  Working like a horse
  Eating like a bird
  Thinking like a fox
  And seeing your veterinarian once a year.

R. Dennis Bastron, M.D., wrote: "The Berra-ism "classical music isn't as bad as it sounds" is a misquote of "Wagner's music is better than it sounds," often attributed to Mark Twain. Although Twain said (wrote) it, he was actually quoting Bill Nye.

A resident wrote: "You misattributed the saying "begin at the beginning" to Yogi Berra. This is a quote from Lewis Caroll.

I wish to thank the following people for submitting material for this installment:

Michael J. Louthan, M.D., Robert M. Chuda, M.D., Bryon A. Solberg, M.D., R. Dennis Bastron, M.D., Erik A. Boatman, M.D., David Ferris, M.D., Rodger E. Barnette, M.D., Kenneth J. Simpson, M.D., Thomas E. Upton, M.D., Winthrop P. Wilcox, Jr., M.D., Fergus D. Lane, M.B., Robert Prince, M.D., Richard M. Flowerdew, M.D., L. Kahn, CRNA, MS.

Reference:

1. Abouleish EI. *Moments With The Pen.* <www.momentswiththepen.com>.

Reimbursement Negotiations: A Few Practical Suggestions

Karin Bierstein, J.D.
Assistant Director of Governmental Affairs (Regulatory)

Negotiating payer contracts is an exercise that some anesthesiologists and their practice managers are coming to enjoy. The confidence that permits them to enjoy the process is based on solid preparation and knowledge. In last month's "Practice Management" column, we provided a list of key contract elements other than the anesthesia conversion factor. This month, two practice managers, Michael J. Monea, President, Central Anesthesia Services, Inc. (Kentucky) and W. David Ackley, C.P.A., M.B.A., President, Medical Account Services, Inc. (Ohio) have summarized their well-organized approach to contracting for higher reimbursement.

Approximately two years ago, reimbursement rates in our market appeared to be among the lowest in the region and, in fact, the country. We were losing good recruits to other regions in the country with superior rates. Given stagnating and/or declining income for our services and ever-rising costs, the practices that we represent decided to negotiate higher reimbursement for their services forcefully. We have achieved some significant successes. The following information outlines some of the negotiating strategies used by our team of physicians and practice managers.

Working With Your Hospital Administrator

We recommend communication with your hospital administrator prior to entering into contract negotiations with third-party payers. These discussions can include:

- Review of pertinent details of reimbursement rates from other payers of similar size subject to any confidentiality clauses to which you may have agreed;
- Information from published sources on average reimbursement rates for your region;
- Range of reimbursement levels the group is planning to request;
- Assurance that any reasonable offer will be seriously considered;
- Information regarding escalating costs associated with malpractice, health insurance, the employment of nurse anesthetists or anesthesiologist assistants, etc.;
- Clear understanding that should the payer fail to propose and implement reasonable rates, the group may be forced either to decline participation or to initiate the process that will eventually result in departicipation. (This assumes that your agreement with the hospital does not require participation.)

Whether or not the group has an exclusive contract with the hospital, such communication can have the impact of isolating the payer should it try to convince your hospital facility that the anesthesia group is being unreasonable in its demands for increased reimbursement.

What Information Should Be Shared With the Payer?

The anesthesia group is under no obligation to share details of other contracts during negotiations. Such information might result in an agreement at an unnecessarily low rate. Conversely, there may be occasions where it will be beneficial to share this information. (Always make sure that you are not subject to any confidentiality clauses.) For example, if you have successfully negotiated a rate of $5X.00 with Payer A, you may be able to use that information with Payer B, which is of similar size with the same approximate number of subscribers but has offered you $4X.00. Demonstrating that Payer A has offered $5X.00 is a valuable tool to pressure Payer B to submit a competitive rate.

Success may create a domino effect among other third-party payers in your region. While we were recently negotiating with one of the three largest commercial payers in our area, a smaller network approached us with an offer that represented an increase in unit rates from the previous year's contract. We informed the network that we were concluding negotiations with another larger payer that had agreed to rates much higher than those offered by the network. The network eventually agreed to rates that turned out to be higher than the ones negotiated with the larger payer.

In another instance, after informing the hospital administration of the need for an increase in rates with the assurance that any reasonable offer would be carefully considered, we

sent a 90-day letter terminating our participation to one of the three major payers. Eventually, we signed a one-year agreement with rates significantly higher than previously paid. After further discussions with the hospital, we approached the other two major payers with rate demands that at least equaled their competitor's. New two-year contracts were then negotiated and signed with significantly higher rates than those we had previously received.

Items to Negotiate

In addition to the unit rate and such other fundamentals as the term of the contract, we recommend specifically negotiating the following items:

Time Unit

Some nongovernmental payers are attempting to follow the Medicare model and to pay for fractions of time units. That is, 20 minutes would equal 1 + 5/15 or 1.3 time units instead of two time units. Anesthesia contracts more typically provide that a "unit" consists of "15 minutes or any fraction thereof." Other payers will round up only from six or eight minutes. If you are not able to secure the "any fraction thereof" language — and such a definition of time units is one of the most important items in the contract — recognize that the partial unit can have the effect of lowering the realizable unit rate, which you would want to have adjusted.

To illustrate, if Payer X uses fractional units, a 95-minute hysterectomy (6.33 time units) and a nominal $48 conversion factor would result in a realizable rate of just $45.53 per unit ($591.84 ÷ 13 total units). An 82-minute laparotomy, which has the same number of base units, would yield $45.88. Details are provided in Table 1.

Table 1: Effect of Fractional Time Units

Procedure		Total Units	Conversion Factor	Reimbursement	Realizable Rate
Hysterectomy					
6 base units, 95 minutes	Payor X	12.33	$48.00	$591.84	$45.53
	Payor Y	13	$48.00	$624.00	$48.00
Laparotomy					
6 base units, 82 minutes	Payor X	11.47	$48.00	$550.56	$45.88
	Payor Y	12	$48.00	$576.00	$48.00

Thus Payer X's system of fractionating time units for services has the net impact of lowering reimbursement from $48/unit to less than $46/unit. Similar calculations could be performed for systems that round minutes up and down, assuming reasonably reliable data on average procedure times. This information might be used to negotiate the unit rate upward.

Reimbursement for OB Services

As stated in the ASA Relative Value Guide, "there is no single, widely accepted method of accounting for time for neuraxial labor analgesia." We prefer the single-fee or case rate method by which each delivery is paid a set amount. By using case rates, one bypasses the discussions and arguments relative to face-to-face time, how many time units to reimburse per hour, etc. In the Midwest, the majority of payers now use case rates.

Here is an example of successful case-rate negotiation from our own experience. One major payer's system of obstetric anesthesia reimbursement resulted in the lowest payment rates of *any* payer with the exception of Medicaid. Prior to initiating discussions, we calculated the following:

- Average length of time per delivery broken down by type, i.e., cesarean section and vaginal delivery, for all patients.
- Average reimbursement by type of delivery for all commercial payers.
- Average reimbursement by type of delivery for the payer with whom we were negotiating.

With this information, we developed and proposed case rates for cesarean section and vaginal deliveries that more realistically reflected reimbursement received from other payers, excluding, of course, Medicaid. As a component of our discussions, we informed the payer that this system would have the benefit of helping it predict more accurately the cost of obstetrical services while providing us with a level of reimbursement sufficient for us to continue our participation with them. The net result was a near doubling of income from obstetric anesthesia services from this particular payer.

We then used these rates as our *base* level of reimbursement in

negotiations with other payers. This system, with some minor variations, was adopted by at least two other major third-party payers in this region, resulting in an overall increase in obstetric anesthesia reimbursement.

Use of the ASA Relative Value Guide (RVG)

We attempt to ensure that our payers accept claims with the anesthesia (0XXXX) codes instead of the surgical Current Procedural Terminology (CPT™) codes. There are two reasons for this. First, remember that surgical codes *do not* have anesthesia base values assigned to them. Base values for the surgical codes are determined by utilizing the ASA CROSSWALK™, which will link to the ASA RVG base values. A few surgical codes link to more than one ASA code with differing base values. Here are two examples:

CPT Code	Description	CROSSWALK™ Anesthesia Code #1	CROSSWALK™ Anesthesia Code #2
49420	Insertion of cannula intraperitoneal or catheter for drainage of dialysis temporary	00800 4 base units	00480 6 base units
52320	Cystourethroscopy including ureteral catheter with removal of uretal calculus	00918 5 base units	00910 3 base units

Sometimes the payers will "crosswalk" to the anesthesia code with the lower value and pay for the service at a lower level than anticipated. Contract language will not necessarily prevent errors or the need for appeals.

Note: HIPAA-compliant electronic claims will require the anesthesia code; reporting the surgical code in addition will depend upon payer contracts or practices.

Miscellaneous

- Try to include language related to time for processing clean claims, both electronic and the paper. The payer should be willing to define a time frame in which a claim is declared clean or in which they will inform the practice of any problem. With our electronic clearinghouses, we can often determine that a claim has been rejected one day after submission.
- Sometimes the payer will consider providing separate and additional payment for the use of long-acting narcotics such as Duramorph®. For those that have refused, we have been able to negotiate a higher reimbursement for epidural follow-up service (code 01996).
- It is common for payers to seek to offset amounts that they believe should be refunded to them against payments due to the anesthesia group. Contract language can exclude such offsets.
- In a multiyear contract, it is worth asking for an annual escalator clause that will increase rates automatically.

Given the growing shortage of anesthesia providers as well as skyrocketing expenses for malpractice, health insurance and personnel (especially nurse anesthetist) costs, it is extremely important that full and complete effort be given to contracting for the maximum reimbursement. It is our hope that these few suggestions will help you prepare for your next negotiating session.

New Hampshire Opts Out of Federal Supervision Requirement

S. Diane Turpin, J.D., Assistant Director
Office of Governmental Affairs (State)

On June 11, 2002, **New Hampshire** Governor Jeanne Shaheen bowed to the will of a handful of rural hospitals and opted the state out of the Medicare requirement for physician supervision of nurse anesthetists. Governor Shaheen's decision was based on the view that unless she opted out, rural hospitals would no longer treat emergencies and provide other services that require anesthesia care. Some rural surgeons argued that they did not want to supervise nurse anesthetists because they believed their malpractice premiums would increase if they were required to do so. The reasons given by Governor Shaheen for opting out fly in the face of the reality of the rule, which has been in existence since 1965. Nevertheless, the governor, who is running for U.S. Senate, ignored the advice of the state medical board and the majority of the physicians in the state. The New Hampshire Society of Anesthesiologists and the State Medical Society explained to the governor that the Medicare rule did not place any new restrictions on nurse anesthetists, surgeons or hospitals and explained the ramifications of opting out, to no avail.

New Hampshire is the only state that allows the independent practice of nurse anesthetists. Governor Shaheen's letter to the Centers for Medicare & Medicaid Services recognized that medical staffs and hospital administrators would decide whether any level of physician supervision necessary is needed for nurse anesthetists. It appears that there are only five hospitals in the state that use nurse anesthetists exclusively; all other hospitals have anesthesiologists or utilize the anesthesia care team.

New Hampshire joins **Iowa**, **Nebraska**, **Idaho** and **Minnesota** in opting out since the rule became effective on November 13, 2001.

Numerous states continue to consider the issue of opting out of the Medicare requirement for physician supervision of nurse anesthetists. The issue is under review at some level in **Alaska**, **Kansas**, **Kentucky**, **Montana**, **New Mexico**, **North Dakota**, **Oregon**, **Tennessee**, **Vermont**, **Washington** and **Wisconsin**. **Hawaii's** legislation to establish a task force to consider the issue failed to pass before the end of the legislative session.

FSMB Offers Office-Based Surgery and Anesthesia Guidelines

The Federation of State Medical Boards (FSMB) adopted Model Guidelines for office-based surgery and anesthesia at its annual meeting in April. FSMB has identified three pathways that state medical boards can adopt separately or in combination for oversight of office-based surgery in unregulated settings. The three pathways include adopting FSMB Model Guidelines, requiring accreditation by a recognized national or state accrediting organization and developing individual state standards. The Model Guidelines address administration issues such as governance and patients' rights and quality of care issues like personnel, credentialing, patient evaluation, informed consent, medical records, discharge, emergency and transfer protocols, reporting requirements and peer review. A clinical section addresses anesthesia, monitoring, surgical services, ancillary services and facilities and equipment.

Under the model guidelines, anesthesia must be administered by a licensed, qualified individual within his or her scope of practice. Anesthesia administered by a nonphysician must be supervised by an anesthesiologist or operating physician unless state law permits otherwise. All health care practitioners who administer anesthesia or supervise the administration of anesthesia should maintain current training in advanced cardiac life support or pediatric advanced life support. The anesthesia provider should be physically present during the intraoperative period and be available until the patient is discharged from anesthesia care. The guidelines recognize that not all procedures are appropriate in the office setting and state that "[p]atients who have pre-existing medical or other conditions who may be at particular risk for complications should be referred to a facility appropriate for the procedure and the administration of anesthesia."

The guidelines recognize that monitoring equipment should be appropriate for the type of anesthesia and the nature of the facility. At a minimum, provisions should be made for a reliable source of oxygen, suction, resuscitation equipment and emergency drugs. All anesthesia equipment should be maintained, tested and inspected according to the manufacturer's specification, and sufficient back-up power should be available.

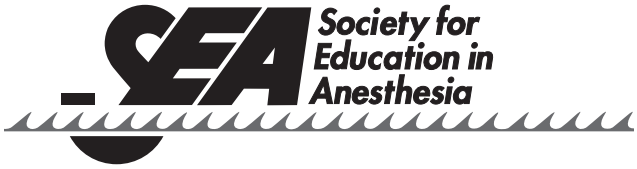
As states continue to grapple with the need to regulate office surgery, the FSMB Model Guidelines may at least provide a starting point for states to use in considering the issues that should be addressed.

The Department of Health and Human Services' Office of Inspector General (OIG) is preparing an analysis of office-based surgery and anesthesia oversight in six states, including **California**, **Florida**, **New Jersey**, **Pennsylvania**, **Rhode Island** and **Texas**. The OIG's report will review the process by which these states developed the requirements for office surgery and the impact of those requirements.

SEA Promotes Excellence in Anesthesia Education Through Grants Partnerships

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

From its inception, the Society for Education in Anesthesia (SEA) has sought to promote excellence in teaching and teaching innovation. One of the vehicles through which SEA and its leadership strives to achieve this goal is through an active grants program [Table 1], partnering with academic medical centers, other nonprofit organizations and industry.



SEA-Duke Prize

Initially presented to SEA by J.G. Reves, M.D., then chair of the department of anesthesiology at Duke University, this prestigious award has recognized the lifetime educational contributions of such notables as Philip Liu, M.D., Robert L. Willenkin, M.D., Charles H. McLeskey, M.D., and Charles W. Otto, M.D. The 2003 SEA-Duke Prize recipient, Robert K. Stoelting M.D., will be recognized at the SEA Annual Fall Meeting in Orlando on Friday, October 11, 2003. For further program information, please visit SEA's Web site at <www.seahq.org>.

SEA-Ronald L. Katz Traveling Fellowship

In partnership with Health Volunteers Overseas (HVO), a private, nonsectarian volunteer organization headquartered in the United States, SEA is offering senior residents and fellows the opportunity to learn from a one-month experience in developing nations. Presently, HVO's Tanzania, Africa, location is the site for the fellowship. Learning opportunities include communication skills, cultural diversity and management of limited resources in a setting of a great variety of pathology and surgical techniques not commonly observed in North America. The recipient has the opportunity to contribute substantially to the local community as a teacher and role model for anesthesiology students overseas. The trainee's department is expected to support the application and request training credit.

SEA and FAER

SEA and the Foundation for Anesthesia Education and Research (FAER) collaborate to promote FAER's education grants, which involve annual contributions by SEA to FAER. In addition, SEA leadership has been participating in an advisory capacity with FAER, including FAER's education grant review process.

SEA-Industry Partnerships

Certain objectives are common to both educators in anesthesiology and education needs in industry. Such common ground can give rise to productive collaboration that is neither product-specific nor sponsor-specific.

New technology diffusion in anesthesiology is largely dependent on appropriate education of potential adopters. Conversely, students of anesthesiology should be taught how to properly evaluate, acquire and utilize new technology. They should be instructed in the underlying scientific principles, and they should be taught to integrate this new knowledge into existing teachings and make applicable comparisons for application in their future practice settings.

SEA firmly believes that partnerships with industry are an important vehicle to help accomplish its mission. SEA, however, equally and firmly ascertains that its collaborative projects with industry cannot in any way be construed as promotion or endorsement of individual products.

SEA-Aspect Medical Education Award

This industry-supported educational award is intended to support initiatives to better educate anesthesiologists on recent advances in anesthetic practice, specifically in the domain of consciousness monitoring. The goal of this award is to foster education to help implement appropriate paradigms of evidence-based perioperative care. The selected project is expected to enhance education and training in the domain of perioperative consciousness monitoring integrated in the setting of current anesthetic practice. Grant proposals should seek to develop educational

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Armin Schubert, M.D., is Professor of Anesthesiology, Cleveland Clinic Health Sciences Campus of the Ohio State University, Cleveland, Ohio.

research or demonstration projects with either a local or national focus.

SEA-Arrow International Education Award

This industry-supported educational award is intended to support initiatives to better educate anesthesiologists on recent advances in anesthetic practice, specifically in the domain of noninvasive hemodynamic monitoring. The goal of this award is to promote excellence in anesthesiology education or special contributions in teaching new technology for noninvasive hemodynamic monitoring by funding proposed education research or demonstration projects in this domain.

Recipients of SEA's education partnership awards are encouraged to publish their work in SEA's peer-reviewed publications. The *Journal of Education in Perioperative Medicine* (JEPM) is the peer-reviewed, online journal of SEA <www.jepm.org>, which publishes original articles, reviews of education techniques and tools, critical analyses and editorials. The *Journal of Clinical Anesthesia*, a peer-reviewed, indexed publication, is the official print journal of SEA, and it publishes selected peer-reviewed JEPM contributions.

Because its educational grant partnerships are growing substantially, SEA expects to make an ever more significant impact on educators dedicated to excellence and innovation in teaching. It is SEA's intent to actively pursue common educational ground with other partner organizations so as to maximize value for its members and anesthesiology educators at large.

Table 1 : SEA's Grants Partnerships at a Glance

Awards	Partner Acknowledgements	Description	Timing and Process
SEA-Duke Prize for Excellence in Anesthesia Education ($5,000)	Made possible by the generosity of the department of anesthesiology at Duke University. Initiated by J.G. Reves, M.D.	Recognizes outstanding life-long contributions in anesthesia education and seeks to identify inspirational role models	Nominations to SEA Headquarters.* Award Presented annually at SEA Fall Meeting. For nomination process, please contact SEA Headquarters*
SEA-Ronald L. Katz Traveling Fellowship (travel and lodging)	Established with a gift from Ronald L. Katz, M.D., in partnership with Health Volunteers Overseas	Supports senior resident or fellow in developing country for one month	Presented at the SEA Annual Spring Meeting
FAER Support by SEA	SEA contributes annually to FAER, co-sponsoring education grants	FAER Education Grant	See FAER Web site <www.FAER.org>
SEA-Arrow Education Awards	Made possible by an educational grant from Arrow International	Intended to promote excellence in teaching innovation relating to noninvasive hemodynamic monitoring	(TBA) Interested educators, please contact SEA Headquarters*
SEA-Aspect Education Awards	Made possible by an educational grant from Aspect Medical	Intended to promote excellence in teaching innovation relating to consciousness monitoring	(TBA) Interested educators, please contact SEA Headquarters*

* Society for Education in Anesthesia, 520 N. Northwest Highway, Park Ridge, IL 60068-2573; (847) 825-5586, <sea@ASAhq.org>

Medical Professionalism: Is It Necessary or Too Arbitrary?

David B. Waisel, M.D.
Committee on Ethics

A resurgence of interest in professionalism in medicine has given rise to a number of papers and statements. I want to take this opportunity not only to introduce a new statement on medical professionalism but also to consider why such statements are written.

The "Charter on Medical Professionalism" is an internationally prepared statement from the Medical Professionalism Project <www.professionalism.org> and can be viewed at <www.annals.org/issues/v136n3/full/200202050-00012.html>. It was organized by the American Board of Internal Medicine, the American College of Physicians-American Society of Internal Medicine Foundation and the European Federation of Internal Medicine. The charter declares: "Professionalism is the basis of medicine's contract with society" and describes three fundamental principles and 10 commitments. These principles and the commitments are outlined in the table on page 32, and readers are encouraged to read the full, brief document.

Statements such as the charter tend to perturb people. Declarations about medical professionalism address us as people and as individuals, which is different and far more personal than addressing anesthetic practices. A reader may easily infer that authors, by advocating for basic ideas, are suggesting that the readers do not honor or value those beliefs. Further, these statements use powerful, unambiguous words such as "must," "should," "require" and "demand." Statements do not seem to consider — or at least do not overtly acknowledge — the real-world pressures physicians must balance constantly. Unfortunately, these distractions may overwhelm the reader to the point that the relevance of the statement is lost. Readers may gain more from these statements by taking a different approach to them.

Approaching Statements on Professionalism: Why Are They Written?

They are written as a reminder. Reminders serve an important purpose. Anesthesiologists are amply pressured to skirt professional behavior. As the charter states: "Changes in the health care delivery systems in virtually all industrialized countries threaten the very nature and values of medical professionalism." In many cases, anesthesiologists may perceive the conditions of daily practice as too onerous to actively consider professionalism. It is rare, however, that we have anything more than ourselves to remind us of the tenets of professionalism. Thus it is useful to have a reminder of those sober obligations in light of aggressively omnipresent, blaring daily pressures.

They are written to direct attention to areas that need work. The proper diagnosis and management of some professional issues are largely settled, such as in confidentiality, while other often more recent issues have not had proper approaches delineated. A purpose of statements such as the charter is to focus attention on those areas in which further theoretical and empirical research is needed to help develop pathways to resolution. Consider this analogy: The statement "manage the airway appropriately" is mostly an impractical goal without an understanding of airway anatomy, risk factors, difficult airways and management options. In the same vein, "commitment to maintaining trust by managing conflicts of interest" is of little benefit without being able to define "trust," identify conflicts of interest, avoid entanglements and resolve conflicts.

They are written to propose new areas of professionalism. A good statement brings forth new areas for consideration. The charter, perhaps reflecting its international nature, offers a new challenge for medical professionalism. The third principle put forth is the primacy of social justice [Table]. This continues to be defined in the commitment to improving access to care:

> "Medical professionalism demands that the objective of all health care systems be the availability of a uniform and adequate standard of care. Physicians must individually and collectively strive to reduce barriers to equitable health care. Within each system, the physician should work to eliminate barriers to access based on education, laws, finances, geography and social discrimination. A commitment to equity entails the promotion of public health and preventive medicine, as well as public advocacy on the part of each physician, without concern for the self-interest of the physician or the profession."

David B. Waisel, M.D., is Assistant Professor of Anesthesia, Harvard Medical School, Boston, Massachusetts.

Summary of Charter on Medical Professionalism

Principle of primacy of patient welfare. This principle is based on a dedication to serving the interest of the patient. Altruism contributes to the trust that is central to the physician–patient relationship. Market forces, societal pressures and administrative exigencies must not compromise this principle.

Principle of patient autonomy. Physicians must have respect for patient autonomy. Physicians must be honest with their patients and empower them to make informed decisions about their treatment. Patients' decisions about their care must be paramount, as long as those decisions are in keeping with ethical practice and do not lead to demands for inappropriate care.

Principle of social justice. The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

- Commitment to professional competence
- Commitment to honesty with patients
- Commitment to patient confidentiality
- Commitment to maintaining appropriate relations with patients
- Commitment to improving quality of care
- Commitment to improving access to care
- Commitment to a just distribution of finite resources
- Commitment to scientific knowledge
- Commitment to maintaining trust by managing conflicts of interest
- Commitment to professional responsibilities

I am unsure what to do with these statements. I agree that physicians should participate in public health to improve access to care and to eliminate barriers to access. The argument for individual physician responsibility for societal health and the practices of health care in part arises from the idea that medical training and practice are largely supported by society to serve the specific purpose of health care. Without this support, most physicians would be unable to become physicians or to practice high-quality medicine. It has been argued that legitimate reciprocity of this investment requires anesthesiologists to not only manage all issues related to anesthesia but also to ensure the further growth and development of the specialty.

However, I do not know whether this "should" rises to the level of an obligation, particularly "without concern for the self-interest of the physician or profession." That seems to be an excessive standard except in the most extreme circumstances. Further, even if it does rise to the level of an obligation, I am not sure if the prescribed path is proper. The mandate for professional participation in matters presumes expertise. Medical training does not prepare physicians for advocacy or for the complex reasoning and understanding necessary to consider public policy. While physicians have every right to participate in democratic decision-making, most physicians do not have the special knowledge that affords them the right to use their unofficial authority to influence policy.

The Next Step

Problems notwithstanding, statements such as the "Charter on Medical Professionalism" help provide necessary balance as we navigate daily practice. Anesthesiologists are encouraged to read them and consider them as reminders of core beliefs, guides to areas that need further work and proposals of new areas to consider.

Reference:

1. ABIM Foundation. American Board of Internal Medicine. ACP-ASIM Foundation. American College of Physicians-American Society of Internal Medicine. European Federation of Internal Medicine. Medical professionalism in the new millennium: A physician charter. *Ann Intern Med.* 2002; 136:243-246.

Involvement! Call for Resident Component Governing Council Candidates

Bracken J. DeWitt, M.D., Ph.D., Chair-Elect
ASA Resident Component Governing Council

I would like to welcome new and returning residents to an exciting time in anesthesiology. I am often reminded of my high school principal saying, "You'll only get out of life what you put into it." With this as a motto, involvement becomes a central theme and involvement in our profession a necessity. There are currently unprecedented opportunities for residents to become active in anesthesiology. I would like to discuss briefly just a few.

There are several forms of communication between the ASA Resident Component and residents across the nation. Perhaps the most visible is this "Residents' Review" column. Each month, articles pertaining to resident interests are highlighted. The co-editors of this column are always seeking resident comments and guest writers in determining what is of greatest interest to anesthesiology residents. If you have a concern, idea or are interested in writing an article, please contact Jill M. Mhyre, M.D., at <jmmhyre@umich.edu> or Carlos O. Viesca, M.D., at <crcviesca@worldnet.att.net>.

Co-editorship of this column is composed of a senior and a junior editor, and the Governing Council will look for a junior editor each year to serve for two years. If you are interested in this position, please contact me at <bjdewitt@hotmail.com>. Another form of communication with residents is the ASA Resident Component Web site <www.ASAhq.org/asarc>.

I encourage all anesthesiology residents to subscribe to the Anesthesiology Resident Mailing List at <www.ASAhq.org/asarc/maillist.html>. This allows residents to stay up to date on events and changes in ASA that pertain to residents. In the near future, the ASA Web site will have a direct link to the Resident Component section. Although there is currently a wealth of information on the site, there are several goals toward which we should work. The summation of these goals is to produce a comprehensive Web site that addresses residents needs and allows for greater communication between ASA and its resident members, including how to write a successful curriculum vitae, how to choose a job in anesthesiology (perhaps with resident recommendations), how to pass the board examinations (perhaps including study materials), how to find a residency program pertaining to medical students and much more. In short, if there is a question regarding anesthesia and residency, the ASA Resident Component Web site should be the first thought in finding the answer. If you have any ideas or suggestions regarding the ASA Resident Component Web site, please contact Christine A. Doyle, M.D., at <christine@montydoyle.com> or any of the Governing Council members.

Political involvement has been an ongoing topic of the "Residents' Review." There are resident opportunities at the local, state and national level. Individually or through your local medical society, local/state public officials are very happy to hear your thoughts on anesthesia-related health care issues that affect patient safety. This personal contact can often greatly influence the decision-making process. Most state anesthesiology societies have a resident component, but if your state component does not, the ASA Resident Component has a booklet on how to organize one <www.ASAhq.org/ProfInfo/ResGuide/01ResidentsGuide.html>. State anesthesiology resident components have officers and delegates to the ASA Resident Component House of Delegates. In addition to these state elected positions, national positions in the Resident Component House of Delegates are available. The Resident Component House of Delegates gathers annually to address issues important to resident training and to elect three new Governing Council members: chair-elect, alternate delegate and secretary. This year the Resident Component House of Delegates will convene on Saturday, October 12, 2002, at the ASA Annual Meeting in Orlando, Florida. A description of each of the position responsibilities is outlined below and is also referenced at <www.ASAhq.org/asarc/elections.html>.

Chair-Elect (two-year position):

Following election as Chair-Elect, this individual becomes familiar with the duties of the Chair. The Chair-Elect often undertakes special projects in conjunction with the Chair. Only individuals with more than 18 months of residency/fellowship remaining are eligible for election. Following the one-year term as Chair-Elect, the individual

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Bracken J. DeWitt, M.D., Ph.D., is a CA-3 resident at Johns Hopkins University, Baltimore, Maryland.

Ten-Hut, Military!

Thomas H. Cromwell, M.D., ASA Secretary

In the March 2002 issue of the *ASA NEWSLETTER*, an article appeared titled "ASA Needs a Military Component Society" by Alvin R. Manalaysay, M.D., Ph.D., Chair, Committee on Uniformed Services. It cited a number of aspects unique to the practice of anesthesiology in the military.

ASA Now Has a Military Component

The Board of Directors approved of a resolution requesting formation of a new military component at the March 2002 meeting. The Committee on Bylaws is currently drafting the necessary bylaws, and pending ratification of that action by the House of Delegates in October, the component will exist. It will have the same rights, privileges and obligations of existing state components.

The practice of anesthesiology in the military is unique for a number of reasons, most glaring of which is the requisite change of duty station on a recurring basis. This has provided little opportunity for military anesthesiologists to become involved in and develop allegiance to a state component. As a result, virtually none of the anesthesiologists so affected have joined state components and are therefore relegated to associate membership statue with no voice or vote in ASA. Trends also were developing within the military that were of increasing concern to ASA. Among them were independent practice for nurse anesthetists and command positions of nurse anesthetists over board-certified anesthesiologists.

Some apprehension was voiced by ASA membership when the original concept of a military component was introduced. These included:

- Effect on existing component membership if large numbers of military anesthesiologists abandon state components for a new military component. In truth, there should be no negative effect. As stated previously, few if any active military belong to an existing state component.
- Who should be included? While the "uniformed services" include groups other than the military (Veterans Affairs and Public Health Administration), it was decided that these other groups are not subject to frequent relocation and many can and do currently belong to state components. Therefore, it was decided to limit the new component to active military.

So, the new component has been created to address the needs of a unique segment of our membership. It is now incumbent upon the anesthesiologists practicing in the military to avail themselves of the new component. It will succeed only to the extent that they join and actively participate in its activities!

Because the ASA membership database does not specifically identify members in military service, please notify the ASA office if you would like to be included in this new component. Contact the ASA Membership Department at <r.wallace@ASAhq.org>.

ABA Announces …

ABA Recertification Examination Dates

All certificates awarded by the American Board of Anesthesiology (ABA) on or after January 1, 2000, expire at the end of the 10th year following the year in which the candidate passes the certifying examination. The ABA recertification program is voluntary for ABA diplomates whose certification is not time-limited. ABA diplomates may take the examination by computer at more than 350 test centers during a two-week period, July 12-26, 2003. ABA will inform applicants of the test sites when the list is available.

Diplomates may obtain an application on or after October 15, 2002, either on the ABA Web site <www.ABANES.org> or by writing the ABA at 4101 Lake Boone Trail, Suite 510, Raleigh, NC 27607-7506. Applicants may submit their application to the ABA directly from the Web site or via mail.

The deadline for the ABA to receive completed recertification applications is **December 15, 2002**. The ABA will consider applications received by January 15, 2003, with payment of an additional fee for late filing. The Board will not consider applications received after January 15, 2003.

In Memoriam

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

Timothy G. Barila, M.D.
Sarasota, Florida
April 18, 2002

Herbert L. Frank, M.D.
Harrisburg, Pennsylvania
March 30, 2002

James J. Gallagher, M.D.
Wellesley, Massachusetts
February 28, 2002

William Grillo, M.D.
Willimantic, Connecticut
May 14, 2002

Samuel C. Hardy, M.D.
Derwood, Maryland
May 1, 2002

Ivey E. Lamberth, Jr., M.D.
Tyler, Texas
March 27, 2002

Ramon A. Lopez, M.D.
Guaynabo, Puerto Rico
November 29, 2001

David M. Nowak, M.D.
New York, New York
March 18, 2002

James C. Russell, M.D.
San Francisco, California
May 16, 2002

Involvement! Call for Resident Component Governing Council Candidates

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holding this office assumes the position of Chair of the Governing Council for the following year.

Alternate Delegate to AMA Residents Physicians Section (two-year position):

During the first year of this term, the Alternate Delegate becomes familiar with the role of the Delegate and attends all AMA meetings with the current Delegate. Again, only individuals with more than 18 months of residency/fellowship remaining are eligible for election. Following the one-year term as Alternate Delegate, the individual holding this office assumes the position of Delegate for the following year.

Secretary (one-year position):

The individual elected to this office is responsible for the transcription and distribution of the minutes of all meetings of the Resident Component Governing Council and the Resident Component House of Delegates as well as the credentialing of Delegates for the House of Delegates meeting.

These descriptions are outlines and are certainly not inclusive of all duties, responsibilities or activities of the Resident Component Governing Council. The newly elected Governing Council members will assume their duties at the conclusion of the ASA 2002 Annual Meeting and will continue their roles through the Annual Meeting at the end of their respective term limit. Current officers with e-mail addresses and additional information may be found at <www.ASAhq.org/asarc/officers>.

Candidates interested in running for office should submit a one-page candidate statement and a maximum three-page curriculum vitae by **September 12, 2002**, to Ronald A. Bruns, ASA Executive Office, 520 N. Northwest Highway, Park Ridge, IL 60068-2573.

In conclusion, there are numerous opportunities for resident involvement, and there are many that space will not allow for here. Whether at the local, state or national level, professional involvement is both satisfying and rewarding.

Anesthesiologists: Quietly Saving Lives

I read with interest and perhaps some amusement the "Residents' Review" column by Bing Shi, M.D., Ph.D., in the March issue of the *NEWSLETTER*, where she writes emphatically that "We, not the surgeons, are the commanders and pilots in the operating room."

The question "What is the anesthesiologist's job in the operating room?" can be answered in many ways: James E. Cottrell, M.D., Chair, Department of Anesthesiology, Downstate Medical Center and President-Elect of ASA, noted in the February 2002 *NEWSLETTER*, "Above all else, anesthesiologists are doctors who keep patients alive while surgeons do things that would otherwise kill them." In my introductory lectures to beginning nurse anesthetist students, I suggest that we should think of our job as "life support of the patient, with a little anesthesia thrown in" (in order to emphasize to them the importance of the former, which is often lost on the novice when looking at the forest of the myriad of anesthetic techniques). Compared to other medical specialists, anesthesiologists also can be said to be the airway specialists.

Perhaps the truest notion of our purpose, however, was suggested to my entering residency class by a very astute and practical professor at Stanford, Frank Sarnquist, M.D., who commented that our job was to facilitate the work of the surgeon, i.e., orchestrate the operating room environment to facilitate expeditious completion of the surgical procedure. (I think it was he who also asked, "What do you see when you watch an expert anesthesiologist?" The answer: nothing.)

The trueness of his comment is more evident to me the longer I practice in our specialty — and the more experience and expertise I gain. Ever since I was exposed to the concept of exceptional customer service during my first shopping experience at Nordstrom (interestingly, the same year that I started my anesthesiology residency), that concern has become my top priority in every aspect of my life and career that involves service to others. The astute expert thinks about how s/he can adapt what s/he does to the needs of others. The novice thinks about how s/he can mold the actions/needs of others to what s/he needs to get done to accomplish "his/her job." The impact of the paradigm shift on what we can do for surgeons and patients can be dramatic, not the least of which is manifest as tremendous timesavings in the operating room.

All this came to mind when I read Dr. Shi's column because recently a friend was telling me of two incidents in her hospital of practitioners deciding against certain well-accepted techniques that have proven benefits to patients because they said they did not feel comfortable doing it those ways.

I would suggest that hopefully they will wise up to the fact that no one gives a hoot what they are comfortable doing, because it is not about them, it is about the patient, the surgeon and customer service and that they had better learn to expand their horizons. If they are not comfortable with it, someone else can be found whose brain can handle that stuff.

(P.S. Let no one misinterpret what I am saying here to imply allowing one to be coerced into undertaking unsafe practices. It is precisely one's demonstrated expertise and commitment to customer service that offers the best prevention against such a suggestion being fostered on oneself by other less informed, less expert and less patient-focused practitioners.)

Leo I. Stemp, M.D.
East Granby, Connecticut

Fatigue's Siren Call Must Not Lull Us to Sleep

I could not agree more with Dr. Lema's comments regarding the necessity for anesthesiologists to take a stand regarding reasonable work hours in "It's Been a Hard Day's Night," from the March 2002 "Ventilations." The patient safety and occupational health ramifications of excessive work hours need to be underlined and highlighted. Fatigue has been implicated in many of the high-profile industrial disasters

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(Exxon-Valdez, Three Mile Island, Space Shuttle Challenger) and medical malpractice occurrences (Libby-Zion) of recent years. Closer to home, sleeplessness and fatigue play a contributing role in a large percentage of anesthetic errors.[1]

The problem is simple and clear. The remedy is a bit more complex. It is difficult to craft universal regulations to which all anesthesiologists must abide. Each individual anesthesiologist and each work environment are unique such that a 28-hour call might be manageable in one situation but unreasonable in another.

It is apparent that we, as a specialty, must develop our own parameters for safe anesthetic practice. It is significant that this clarion call for a rational approach toward acceptable work hours should appear in the widely read *ASA NEWSLETTER*. This promises to be a tedious and contentious undertaking and will require input from all sectors of our diverse specialty. But if we do not take on this project, it will be done "for" or "to" us by legislators and regulators.

In general, it is better to be the windshield than the bug.

Jonathan D. Katz, M.D.
Hamden, Connecticut

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1. Gander PH, Merry A, Millar MM, Weller J. Hours of work and fatigue-related error: A survey of New Zealand anaesthetists. *Anaesth Inten Care*. 2000; 28: 178-183.

An Easy Day's Night for Hospital Administrators

Dr. Lema's March 2002 "Ventilations" article, "It's Been a Hard Day's Night," discussed the probability of longer and longer hours in the operating room for anesthesia personnel. The piece rings true, except at the end, when he talks about leaving the hospital at 8:30 in the evening and running into the C.E.O. In most hospitals, anyone from administration has left before 5 p.m. After all, they have lives outside the hospital!

Robert F. LaPorta, Ph.D., M.D.
Dix Hills, New York

Lema Is Positively Inspirational!

I just wanted to compliment Dr. Lema for his April 2002 "Ventilations" article, "Where Would You Rather Be But Right Here, Right Now?" Being a physician is a great privilege and responsibility. Yes, the distraction of government, HMOs and unappreciating patients can be frustrating. And yet, how rewarding it is to care for the sick and afflicted as they trust us with their lives. Your "Ventilations" are heartfelt, so I thank and encourage you not to be dispirited by a few. I look forward to your next positive glance at life.

Philip S. Koerper, M.D.
Billings, Montana

FDA Division Director: Droperidol Needs More Study

As Peter L. Bailey, M.D., points out in his letter in the June 2002 *ASA NEWSLETTER*, droperidol is a widely used drug that has been available on the market since 1970. Such a long history of use certainly gives support to the safety of this drug. On the other hand, it also weakens our ability to detect new safety signals under the Food and Drug Administration's (FDA's) voluntary system of post-marketing adverse events reporting.

When a serious adverse event occurs, one of the last things that physicians consider is the possibility that a drug they have used for 30 years might have been a contributor. This is particularly true when the adverse event is common in the setting in which it was observed. For example, in the perioperative setting, cardiac dysrhythmias are relatively common, and there are many causes to consider: concomitant medications, patient comorbidities, perisurgical trauma and stress, alterations in sympathetic and parasympathetic tone and fluid and electrolyte shifts. Further diminishing our ability to detect these events is the fact that QT prolongation has only recently begun to receive widespread attention as a potential drug-related adverse event, and anesthesiologists generally do not monitor for QT prolongation.

Dr. Bailey suggests that the FDA is over-reacting to a very small signal. Estimates of under-reporting vary, but most are that fewer than 10 percent of cases of adverse events associated with drugs are ever reported to FDA. Under circumstances such as were mentioned above that are relevant to droperidol, vast under-reporting of events is

expected, and any potential safety signal must be taken very seriously, particularly when the associated events may be life-threatening.

Based on the currently available data, we can only conclude that droperidol can cause dose-related, clinically significant QT prolongation in some individuals. Doses well below the approved starting dose for droperidol (2.5 mg I.V. or I.M.) have been associated with torsades de pointes, and as Dr. Bailey points out, in some cases there may be other contributing factors. That does not mean that droperidol had no role in those cases.

Unfortunately, we do not have enough information to quantify the risk at this time. Torsades de pointes is a preventable complication of QT prolongation but requires attention to the possibility of its occurrence in relation to any potential risk factor, such as use of a drug like droperidol. Ensuring that the practicing community is aware of such a possibility is challenging, especially for drugs with such a long marketing history as this one.

For this reason, and because actual events of torsades occurred at doses well below the labeled dose, a "black box" warning was chosen as the most reasonable way to communicate this risk. Black box warnings require that companies include the warning itself on all promotional materials in order to raise awareness among health care providers. The FDA's intent is not to halt use of the drug but rather to increase awareness of potential complications in order that it be used safely. Unfortunately, the tools available to FDA for communicating such risk are blunt. In foreign markets, both injectable and oral formulations of droperidol were discontinued following an extensive risk-benefit assessment.[1] We chose a visible warning instead.

There will be more information available on this potential risk in the near future. The FDA is conducting a study designed to evaluate the effect of dose on the QTc interval. Upon completion of this study and an evaluation of alternative medications, the FDA plans to convene a meeting of the Anesthetics and Life Support Drugs Advisory Committee to consider whether additional actions are needed.

Cynthia G. McCormick, M.D.
Director, Division of Anesthetic, Critical Care and Addiction Drug Products
Center for Drug Evaluation and Research
U.S. Food and Drug Administration
Rockville, Maryland

Reference:

1. Medicines Control Agency. <www.mca.gov.uk/ourwork/monitorsafequalmed/safetymessages/droleptan.htm>.

FOUNDATION FOR ANESTHESIA
EDUCATION ■ RESEARCH

And the Awards Go to…

The Foundation for Anesthesia Education and Research (FAER) Board of Directors is pleased to announce the award recipients from the February 2002 submissions. The Foundation is grateful to ASA, its individual members, component societies, subspecialty societies and corporations for their generous contributions that allow the funding of these awards. The descriptions of the projects were provided by the investigators.

Research Education Grants ($25,000 for two years)

Amr E. Abouleish, M.D., University of Texas Medical Branch, Houston, Texas: "The Impact of Longer Surgical Durations and Inefficient Staffing Scheduling on the Staffing Costs of Two Academic Anesthesiology Departments." **Mentor: Kevin C. Wooten, Ph.D.**

In the environment of decreasing revenue with increasing costs, academic anesthesiology departments face several challenges in meeting their missions. Complicating these challenges is the fact that most academic anesthesiology departments provide care for surgeries of longer-than-average duration and for patients with payer mixes that pay less than private-practice groups' payer mixes. Further, operating room scheduling of surgical cases may sometimes lead to inefficiencies from the perspective of staffing costs, especially to anesthesiology departments. The purpose of this study is to estimate the academic anesthesiology department staffing costs attributed to longer-than-average surgical duration and inefficient scheduling of surgical cases. Results from this study will provide evidence and support for anesthesiology departments' budgets and the need for the university to provide financial support for staffing costs beyond the revenue generated by the clinical care.

David T. Raphael, M.D., Ph.D., University of Southern California-Los Angeles, Los Angeles, California: "A 3-Dimensional Teaching Atlas of the Brachial Plexus Using MRI Neurography." **Mentor: Patrick Coletti, M.D.** Co-sponsor: AstraZeneca.

Materials currently available for teaching regional anesthesia of the brachial plexus include planar drawings, photos and other images intended to reveal the expected underlying anatomy in a normative patient. It has been proposed to create a digital versatile disc (DVD) library of high-resolution three-dimensional (3-D) magnetic resonance imaging (MRI) brachial plexus images using MRI neurography, a technique that allows the selective imaging of peripheral nerves. Images will be processed by advanced 3-D imaging software such that from the perspective of choice of the viewer relative to the patient, the viewer is able to visualize the corresponding 3-D color-coded reconstruction of the underlying anatomy, including the brachial plexus nerves in relation to the surrounding tissues, through successive transparent 2-D planes. These brachial plexus images, obtained from patients of differing body habitus, would form the basis for a prototype 3-D image set in an instructional DVD relevant to the performance of brachial plexus nerve blocks.

Research Starter Grants ($85,000 for two years)

Martin S. Angst, M.D., Stanford University, Stanford, California: "Differential Rate for the Development of Acute Tolerance to Opioid-induced Analgesia, Respiratory Depression and Sedation." **Mentors: David C. Yeomans, Ph.D.**, and **Steven L. Shafer, M.D.** Co-sponsor: American Society of Regional Anesthesia and Pain Medicine.

A long-term objective of our research is to optimize the use of

FAER Report (continued)

opioids for the treatment of pain. The standardized conditions offered by a human experimental pain research laboratory combined with intravenous drug infusion and plasma sampling algorithms, physiologically meaningful pain models and pharmacokinetic/dynamic modeling techniques are the basis of this research.

Clinical investigations suggest that the perioperative development of tolerance to opioid-mediated analgesia (need to increase the dose to maintain analgesia) may explain why patients receiving a high rather than a low intraoperative opioid dose suffer from increased postoperative pain. This observation implies two hypotheses that are tested in human volunteers receiving a six-hour opioid infusion paradigm, i.e., that the development of acute opioid tolerance is dose-dependent and that tolerance develops faster to the analgesic than to the respiratory depressant and sedative effects, the latter preventing dose escalation. Results of this study may impact current dosing patterns and encourage co-administration of drugs preventing the development of tolerance.

Christopher J. Jankowski, M.D., Mayo Clinic and Foundation, Rochester, Minnesota: "Preoperative Cognitive Dysfunction and Postoperative Delirium in Elderly Orthopedic Surgical Patients." **Mentor: David O. Warner, M.D.**

Our population is aging, and elderly patients frequently require surgical procedures. Unfortunately, up to 50 percent of older patients are confused postoperatively. This confusion, known as postoperative delirium (POD), leads to complications and increased costs and may limit patients' long-term ability to perform daily tasks. Thus, POD is a significant public health issue. Unlike delirium in medical patients, the predictors and functional consequences of POD have not been well-defined. We hypothesize that diminished preoperative mental capability predicts POD and that POD leads to future declines in cognitive capacity and the ability to function independently. Five hundred elderly patients undergoing hip or knee replacement will undergo detailed, preoperative and postoperative neuropsychological and functional testing and be evaluated for POD while in the hospital. Our ultimate goal is to develop a strategy to prevent postoperative delirium so that the elderly can recover smoothly and resume their normal activities quickly after surgery.

Rashmi N. Mueller, M.B.B.S., University of Texas Medical Branch, Galveston, Texas: "The Effect of Zinc on Neurobehavioral Outcome After Transient Global Cerebral Ischemia in Rabbits." **Mentor: Mark H. Zornow, M.D.**

Cerebral ischemia is a major cause of morbidity and mortality in the United States. Zinc ions, which normally function as neuromodulators in the central nervous system, may also act as an important mediator of ischemic injury to neurons. Free synaptic zinc may be released in large amounts following cerebral ischemia. This zinc may translocate into postsynaptic neurons, causing injury. The focus of my proposal is to examine whether zinc chelation can improve neurobehavioral outcome after transient global cerebral ischemia in the rabbit. We will administer zinc chelators into the brain during ischemia, and the neurobehavioral outcome will be assessed by the rate of acquisition of the eyeblink classical conditioned response. Previous work from this laboratory has shown that brain ischemia inhibits conditioned learning. Zinc chelation may provide neuroprotection, which would be evidenced by improved neurobehavioral outcome. These experiments will help clarify the role of zinc in global cerebral ischemia.

[More award recipients will be featured in the next "FAER Report."]