Even if the ultimate goal of every anesthesiologist is to keep the patient safe, there are myriad ways to ensure that goal. Anesthesiologists must be objective and decisive in an increasingly subjective and gray world of what’s right, what’s wrong and what’s practical in medical ethics.

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SUBSTANCE ABUSE HOTLINE:
Contact the ASA Executive Office at (847) 825-5586 to obtain the addresses and telephone numbers for state medical society programs and services that assist impaired physicians.
In what seems like a lifetime ago, I took a survey course on the Civil War during my graduate work in history. It was taught by a distinguished professor of history, a man I had known for many, many years. A very interesting teacher, he challenged his graduate students to evaluate primary source material. At the end of class one day, he handed out two documents. One was a letter to the Secretary of the Navy from someone criticizing Abraham Lincoln’s conduct of the war; the other was a personal letter. The author and the recipient were, at first glance, completely unknown to the students in class. Both were dated in the early months of 1862.

Our assignment was simple. We were to read the documents and write a three- to five-page essay on whether these documents were an accurate reflection of the feelings of the people during the Civil War. The letter to the Secretary of the Navy was thought-provoking. Some work in the library (in those pre-Internet days) proved that the author was a well-known person of rank in society. In the letter, he accused Lincoln of Southern sympathies and not wanting to conduct the war in a manner in which it could be won. In essence, without using the word, the letter’s author called Lincoln a traitor. To the students, this was shocking. It went against all we had learned and believed — but the letter was authentic. Was there more to Lincoln’s direction of the war than had become public knowledge?

The second document was equally perplexing. Library research failed to shed any light on the author or the recipient. Who were these men? The letter spoke of Lincoln in glowing terms — that he was a master politician, conducting the war in a manner that would lead to ultimate victory. Yet something in the letter did not ring true. The content seemed too zealous, too patriotic to be representative of the feelings of a majority of the Union.

A week later, the essays were handed in and class began. The professor wrote on the board the simple phrase, “Rules of Evidence.” A lively 45-minute discussion ensued about how to evaluate documents such as the ones we had been given. It turned out that the author of the letter to the Secretary of the Navy was a staunch abolitionist. He had become disillusioned by the slow progress Lincoln had made on the slavery issue. Clearly his charges were false, although at first glance he certainly seemed to have the proper access and insight to validate his accusations. The second letter was written by two Southern spies. The letter was in code and actually told of a plot to destroy rail connections in Maryland.

Why go through this long discussion talking about the rules of evidence? What can this possibly have to do with anesthesiology?

In the February 2007 issue of the AANA NewsBulletin, the headline over a light purple text box screamed “President Wicks Responds to Charges in the ASA NEWSLETTER.” In essence the purple box was a letter to the editor that American Association of Nurse Anesthetists (AANA) President Terry Wicks had sent to ASA and that was determined not to be appropriate for publication. Quite simply Mr. Wicks took

“I give credit to many of the nurse anesthetists at my institution as they were willing to seek information and not rely upon just one source for their decisions. Without knowing it, they were following the rules of evidence that I had learned in graduate school.”
wanted to hear my side of the story. I was asked repeatedly about the issue during the day and several days thereafter. A copy of the page in the AANA NewsBulletin was posted on a bulletin board reserved for nurse anesthetist news near the locker rooms. I give credit to many of the nurse anesthetists at my institution as they were willing to seek information and not rely upon just one source for their decisions. Without knowing it, they were following the rules of evidence that I had learned in graduate school.

But what about President Wicks? I would never write, “Why was CMS so reluctant to change? Pressure was brought by AANA against this change in the teaching rule” without having strong evidence from multiple sources. Interestingly enough, some of this information comes from the nurse anesthetists themselves. Other sources have included aides to legislators and published material by AANA. After the elections, AANA lobbying became even more intense, and as Mark J. Lema, M.D., Ph.D., pointed out, “At the eleventh hour, outgoing Chairman Bill Thomas (R-CA) of the House Ways and Means Committee dropped ASA’s Medicare Anesthesiology

“For the specialties of anesthesiology and nurse anesthesia to prosper, ASA and AANA need to resolve their differences. There are external threats ready to leech away our respective specialties, and open public disagreement will only accelerate that process.”

Teaching Rule reform bill (H.R. 5246/S. 2990) from the final Medicare SGR and tax-cut package due to intense intervention by the American Association of Nurse Anesthetists (AANA).” While Mr. Wicks has not yet responded in press to this assertion, there is, again, a preponderance of evidence by multiple sources that demonstrates that AANA worked actively against the teaching rule change. Simply put, using good historical methodology, it is clear that AANA worked against passage of the teaching rule legislation.

If I understand the AANA position correctly, nurse anesthesia wants a “mega” bill to fix issues of concern with nurse anesthetist reimbursement of student nurse anesthetists and some additional funding for their teaching programs. Quite honestly I do not believe such a global bill can or will pass. It seems more logical that two bills, addressing the specific needs of each group’s programs, will pass. The problem is that one bill unique to each discipline has to be brought forth first, and there needs to be a level of trust that the second bill will not be opposed by the nonsponsoring group. At the current time, that trust does not exist, although ASA has consistently advocated this way of bridging differences.

In 1938 Neville Chamberlain flew to Munich to try to keep Europe from igniting into a firestorm of war. At the negotiation table, Chamberlain’s primary goal was to ensure that war would not erupt and that peace was maintained. He was willing to give almost any concession to see that outcome prevail. What he failed to understand was that his negotiating partner did not share the same values or have the same goal. Thus, less than two years after declaring “Peace in our time,” Europe was at war and soon the world would be as well. Many in ASA feel that AANA has abrogated the trust slowly being established at the negotiating table by actively opposing the teaching rule.

While Chamberlain was flying to Munich, another British politician, Winston Churchill, was still in the wilderness of politics. Within the year, he would be back in the British cabinet, and he would lead his nation through the dark night that was World War II. Churchill wanted peace as much as Chamberlain, but he understood his negotiating partner. To Churchill, while concessions may be necessary, these compromises cannot threaten the essential policies and positions that have served the nation and given its raison d’être.

In yet another lifetime, or so it seems to me, I was the chief of the anesthesiology service at a Veterans’ Affairs medical center. During my tenure, there were two chief nurse anesthetists. The first was in the position when I arrived. We were never able to reach a détente, and I had to abolish the position for a time. I later found out from several different and reliable sources that this individual had gone about the medical center telling everyone what a terrible person I was and that I was a less-than-competent physician. The second chief nurse anesthetist was a godsend to me. This individual was not afraid to tell me what was wrong, always done with respect, and I listened. In a short time, we had built up mutual trust, based on shared values, and our service thrived. This person told me that “As long as I practice, there will always be anesthesiologists; and as long as you practice, there will always be nurse anesthetists — we need to get along.” It is the need for mutual respect embodied in that statement that has guided my relationship with nurse anesthetists, both inside and out of the operating room, ever since.

In my youth, President Jimmy Carter reinforced the

Continued on page 6
Science in Academe: The Lifeblood of Anesthesiology

Charles W. Otto, M.D.
Vice-President for Scientific Affairs

Our best investment in the future of anesthesiology is our commitment to the science of anesthesiology.

— James E. Cottrell, M.D.,
2003 ASA President

In this space in May 2003, then Vice-President for Scientific Affairs Bruce F. Cullen, M.D., wrote: “Academic anesthesiology is under tremendous pressure and is the victim of ‘The Perfect Storm.’” I would like to report that in the ensuing four years we have weathered the storm and that academic anesthesiology is on its way to cleaning up the damage. Unfortunately this is not the case. Dr. Cullen’s words are as applicable today as they were then:

“The workload in most teaching hospitals is increasing...Teaching hospitals are financially strapped...Academic faculty are required to spend most of their time providing service in the operating room...Residents who may have potential for a career in academia are opting for jobs in the private sector because they have few academic mentors with whom to identify, and they have accumulated excessive educational debts. The number of young American anesthesiologists performing meaningful research is falling. Research and development in anesthesiology has dropped, there are fewer competitive applications for National Institutes of Health (NIH) and Foundation for Anesthesia Education and Research (FAER) grants, and publications by U.S. authors in Anesthesiology are in the minority.”

“The next decades will see dramatic changes in the practice of medicine in general and in our specialty in particular. We must do everything we can to ensure that innovation and inquiry become the hallmarks of our academic anesthesiology departments.”

The good news is that anesthesiology is again competing for the best and brightest medical students to join our profession. The number and quality of students choosing an anesthesiology residency has increased significantly in the past few years within the ACGME limit. This may not continue, however, if students begin to perceive that anesthesiology is not an innovative medical discipline. And the bad news is that few are opting to commit their careers to furthering the advancement of our specialty through research. Recent articles and editorials in Anesthesiology have underscored how badly the storm has battered the anesthesiology scientific community. These articles should be required reading for anyone interested in the future of anesthesiology in the United States.

Debra A. Schwinn, M.D., and Jeffrey S. Balser, M.D.,3 in January 2006 pointed out that NIH funding (as a percent of the NIH budget) to anesthesiology departments has remained flat for the past 30 years, never reaching 1 percent of the total, although anesthesiologists comprise approximately 6 percent of the physician workforce. In his 2006 Emery A. Rovenstine Memorial Lecture, Jerry Reves, M.D., showed that only family medicine ranked lower than anesthesiology in the number of NIH dollars generated per academic faculty member. About half of all anesthesiology NIH funding is found in only 10 departments. NIH funding is not the only source of research support, and many prominent anesthesiologists have built successful careers without such funding. But NIH indirect costs support most of the research infrastructure at American medical schools. Consequently NIH funding is extremely important for local prestige and for allowing a department to successfully compete on the local level for research space, equipment and support.

The relative paucity of research in anesthesiology departments portends even greater concerns for the future. With few established research programs, trainees and junior faculty
have difficulty finding suitable role models and mentors that will allow them to develop successful academic careers. Deborah J. Culley, M.D., and colleagues point out that only 30 percent of anesthesiology department chairs have ever had NIH funding compared to 62 percent of their surgical counterparts; and surgical chairs have 2.5 times as many publications as their anesthesia counterparts. The lack of experience in the research arena among anesthesiology chairs may be an impediment to developing an academic environment that promotes research.

A number of changes to our training programs and academic departments have been proposed to improve anesthesiology research. Some of these changes include medical student research scholarships, more research opportunities during residency, a mandatory research year in subspecialty training, increased availability of research time for junior faculty (obviously dependent on dollars to support such) and changes in academic compensation plans to reward research. All deserve careful consideration for immediate implementation.

ASA, through FAER, has tried to address some of these issues. FAER recently instituted a Medical Student Anesthesiology Research Fellowship patterned after the previous ASA medical student summer externship program but with a primary emphasis on research. The dollars available in FAER grants have increased significantly, and the grants have been restructured to emphasize mentoring by providing financial support to the senior advisors on grant applications. An Academy of Research Mentors has been established to recognize those anesthesiology investigators who have contributed importantly to the development of academic anesthesiologists.

Underlying all of these efforts must be the financial stability of our academic departments. A primary focus of ASA’s advocacy efforts for the past few years has been the abolition of the Medicare teaching rule for anesthesiology. We have not yet been successful. Our efforts continue, however, and will not stop until we see the end of this discriminatory rule. Resolution of this issue will not solve all the financial woes of our academic departments. But for most departments, it would provide the much needed additional dollars necessary to free up faculty time for research.

Some are concerned that these steps will not be enough. Alex S. Evers, M.D., and Ronald D. Miller, M.D., have suggested that this lack of research productivity is a symptom of “intellectual malaise” in our specialty. It is suggested that we are too content with our past contributions to patient safety and not concerned enough with the substantial perioperative morbidity that remains. Certainly further efforts to improve anesthesiology research are needed.

There are many challenges in anesthesiology that require investigation, including perioperative cognitive dysfunction, anesthetic effects on developing brains and perioperative multisystem organ failure, to name just a few. Evolving fields of science provide many opportunities for exciting anesthesiology research in such areas as genomics, receptor-specific drugs, systems management, communications and wireless technology. In fact this is an exciting time to be embarking on a career in academic anesthesiology.

The next decades will see dramatic changes in the practice of medicine in general and in our specialty in particular. We must do everything we can to ensure that innovation and inquiry become the hallmarks of our academic anesthesiology departments.

References:
4. Evers AS, Miller RD: Can we get there if we don’t know where we’re going? Anesthesiology. 2007; 106:651-652.
5. Reves JG. We are what we make: Transforming research in anesthesiology. Anesthesiology. 2007; 106:826-835.
The cherry blossoms have peaked and faded. Congress has come and gone from its Easter/Passover recess. ASA is holding another stellar Legislative Conference in Washington for motivated ASA members from our component societies. What are our anesthesiology activists finding as they come to the nation’s capital?

A return to regular order is the new order of the day in Washington. Democrats, true to their pledge, have re-opened committee proceedings with back-to-back hearings on anything and everything under their jurisdiction — that is, after the first 100 hours, when such “regular order” was conveniently brushed aside.

The nation’s capital also is still reeling from nonstop talk about the actions of the Attorney General and his handling of the firing of a large number of U.S. Attorneys. Predictably the discussion quickly progressed beyond the action in question to what the top law enforcement officer had said about his actions and when. Cover-ups never work, and similar cyclical scandals have occurred no matter which party has occupied the White House.

Congress also is still finding its sea legs with respect to the ongoing war in Iraq, with only a bare majority of the House supporting a troop withdrawal by a certain date, despite wider concern about our progress there. Congressional partisanship? Yes, generally, but without clear unanimity from either side. Democracy in action? Certainly, and given that we are six years into the eight-year term of “Bush 43,” as I am told our President agrees end to the unfair sustainable growth rate (SGR) formula that threatens to destroy physicians’ ready willingness to treat the elderly? Where are health issues on the national agenda? Can we possibly do and say enough to overcome these other larger political “elephants” (and donkeys) in the room?

The simple answer is that we must. ASA, as it has in past years, is working with supporters in Congress to reintroduce major discrete bills and move them along. For example, one such new bill, H.R.1866, would allow Medicare “pass through” payments for anesthesiologists willing to compete for jobs in rural areas. This bill would

“How we can move forward? The answer does not lie in partisan politics or rejecting politics because it requires us to ‘take sides.’ As I have long told physician audiences, I do not care if you are a Democrat or a Republican, but I do care if you are not politically involved.”
address rural surgical access shortage issues by ensuring adequate payment to anesthesiologists just as has been enjoyed by nurses delivering anesthesia in such settings. Imagine how quality and patient safety could be increased in rural areas if this simple measure were enacted.

ASA has also labored hard to move reform for the Medicare anesthesiology teaching rule back to the front burner by working with past and new congressional supporters to advance a needed legislative fix. The very future of the specialty depends upon ensuring that the rigors of medical residency do not collapse in the face of government cost-cutting that would allow less rigorous nurse training to be deemed its equivalent, with Medicare patients being left at risk.

And what, too, of the all-important Medicare anesthesia conversion factor issue, which ASA continues to battle within the Centers for Medicare & Medicaid Services? This key issue is caught up in the underlying debate over how to fix the SGR, and our own battle is hard to reconcile without considering the special drag on Medicare physician payment caused by the need to overcome governmental deficit spending.

How can we move forward? The answer does not lie in partisan politics or rejecting politics because it requires us to “take sides.” As I have long told physician audiences, I do not care if you are a Democrat or a Republican, but I do care if you are not politically involved. Your highly capable Washington Office staff will always do all that it can to advance anesthesiology, but only you can bring the face-to-face reality of practice challenges to our legislators. Your ASA staff loves what it does, and we will never tire in advancing our ASA public policy advocacy agenda; but if your personal response is to brush aside what should be a professional responsibility to get involved politically, you are not doing all you can to advance and secure the profession.

Please visit our ASA Web site today and click the box in the very center called “Washington Alerts.” It will take you immediately to interactions with your members of Congress and your Senators. The time for action is now. Please do not wait.

From the Crow’s Nest: Churchill or Chamberlain?

Continued from page 2

handshake of Anwar Al Sadat and Menachem Begin at Camp David. All three men knew what was at stake. Who was taking the greater risk — the Egyptian or the Israeli? Yet there has been a lasting, if uneasy, peace between the nations ever since this summit.

For the specialties of anesthesiology and nurse anesthesia to prosper, ASA and AANA need to resolve their differences. There are external threats ready to leech away our respective specialties, and open public disagreement will only accelerate that process. But leaders on both sides need to be like Churchill, knowing when to acknowledge differences in education, training and responsibility, when to compromise and when to trust those across the table from them. Neither side can afford Chamberlain’s “peace at any price.” Can Mr. Wicks and Dr. Lema reprise the roles of Begin and Sadat even though their respective societies are fundamentally different? This level of statesmanship is needed, for the specialties of anesthesiology and nurse anesthesia demand it now more than ever. Dr. Lema, a student of history and Churchill, stands ready — is Mr. Wicks up to the challenge?

— D.R.B.

References:
One of the fundamental principles of medical ethics and of American law is that each patient has the right to determine what happens to his/her personhood, mind and body. The ethical principle is respect for the personal autonomy of every patient. The legal precedent is that patients are entitled to enough information for them to develop an informed consent to medical procedures. The legal precedent was established by Judge Benjamin N. Cardoza (Schloendorff v. Society of New York Hospital, 1914) in a case in which a patient consented to an abdominal examination under anesthesia but specifically refused any surgery; the surgeon performed a hysterectomy, which he felt was indicated. The legal right to refuse medical treatment and interventions has been repeatedly upheld since that time in many U.S. legal proceedings (e.g., Natanson v. Kline, 1960).

Membership in ASA carries with it the obligation to respect patients’ autonomy and obligates physicians to engage patients in an informed consent process before providing elective anesthetic care. These obligations are described in the ASA Guidelines for the Ethical Practice of Anesthesiology (Section I, 1 and 2) and in Ethical Guidelines for the Anesthesia Care of Patients with Do-Not-Resuscitate Orders. Both House of Delegates-approved documents are available for free on the ASA Web site at www.ASAhq.org under “Clinical Information.”

“Do not attempt resuscitation” (DNAR or DNR) is an informed refusal of resuscitation from the sudden, often unexpected, arrest of breathing and/or circulation. It expresses the patient’s wish to forego cardiopulmonary resuscitation measures that include securing an unobstructed airway, positive pressure...
ventilation, sternal compression, electrical defibrillation and the administration of drugs, often in large doses, to restore normal breathing and circulation.

Note that DNR requests do not preclude any ongoing treatments supportive of vital organ function. In fact, such measures can be increased and added to as necessary to maintain homeostasis as close to normal as possible. Withholding and withdrawing such supportive therapies when they have proved to be nonbeneficial are the subjects of advance directives. Typically patients with specific directives for their care will execute a living will and/or appoint a surrogate with durable power of attorney for health care decision-making. (Note that in this article, “surrogate” is implied whenever “patient” is mentioned for situations in which the patient cannot speak for him/herself.)

Many of the measures used in cardiopulmonary resuscitation (CPR) are the same ones that anesthesiologists employ in the setting of anesthesia care when a patient exhibits cardiopulmonary insufficiency resulting from the administration of anesthetic drugs and interventional manipulations superimposed on the patient’s comorbidities. Hence the presentation of a patient with DNR status creates both a dilemma and discomfort for the anesthesiologist and others involved in the patient’s care. All physicians and nurses have a duty to treat each patient with respect, abide by the patient’s wishes (autonomy), avoid harming the patient (nonmaleficence) and do their best to preserve life and well-being (beneficence). The dilemma for health care workers usually comes down to a perceived conflict between the principles of respecting autonomy versus providing beneficent care. Not all patients value prolongation of life in all circumstances. A mark of true health care professionals is that they respect the vulnerable patient’s decisions above their own discomfort.

So what is to be done when a “DNR patient” is to undergo anesthesia care? For electively scheduled interventions, there are three basic options:

1) **Maintain DNR**, which is appropriate for a strictly palliative intervention even when an iatrogenic injury occurs.

2) **Suspend DNR** and allow a full attempt at resuscitation during the intervention and for a period of time typically sufficient to allow recovery from the effects of the intervention and the residual effects of anesthetic drugs.
Certain interventions (e.g., cardiac surgery) require suspension because they can only be accomplished with the routine use of resuscitation methodologies.

3) **Modify the DNR conditions to allow a limited attempt at resuscitation according to**
   a) specific procedures that the patient will/will not allow or
   b) the patient’s goals and values. In this case, the patient places his/her trust in the physicians to use their clinical judgment to treat easily reversible adverse events that most likely have no long-term adverse consequences, and physicians are trusted to refrain from treatment of conditions that are likely to result in permanent sequelae such as neurological impairment or long-term dependence on technologic support of vital functions.

Anesthesiologists can inform patients that CPR has a higher success rate and lower permanent injury incidence when it occurs during anesthesia care.

Obviously these options and the related decisions may become the determinants of the timing of death. The patient should clearly understand and be able to relate in his/her own words an understanding of terms (e.g., DNR, CPR) and what the terms imply for the potential timing and immediate causes of his/her death. Anesthesiologists should encourage and expect surgeons to address a patient’s DNR status well before he/she is scheduled to arrive at the operating room door. Discussions of the options and making decisions take time and are best accomplished well in advance of an elective scheduled intervention (e.g., preanaesthesia clinic, advance request for anesthesiology consultation).

Ideally there would already be a note on the patient’s chart by the surgeon or the patient’s primary physician that describes the perioperative plan for maintaining or for temporarily suspending and reinstating DNR requests. Whether or not such a note has been written, the anesthesiologist should write a note in the chart acknowledging his/her understanding of the patient’s wishes. For example it could state: “This patient seems to understand that adequate anesthesia care could be impaired by continuation of her/his DNR status. Ms. Anna Smith would like to suspend her DNR status during the tracheostomy and postoperatively until the effects of the anesthesia have dissipated, but no later than 24 hours postoperatively, at which time the patient requests that her DNR status be fully reinstated.”

The ideal is to respect the patient’s informed and long-standing wishes. “Importantly, being autonomous does not merely involve being competent and making a choice — it involves constructing a concept of how one’s life should go according to a coherent set of values.” A patient’s primary physician would be best situated to understand a patient’s coherent values. Because fewer and fewer patients have their own primary care physician as their attending during a hospitalization, however, the responsibility for understanding and adhering to patients’ requests for limitations on treatment falls to the anesthesiologists and surgeons who are asked to care for them.

Automatic suspension of DNR status as a matter of institutional policy or personal preference of a surgeon or anesthesiologist does not sufficiently address the patient’s rights to self-determination in a responsible, ethical and legal manner. When there is real doubt about a patient’s understanding of his/her DNR status at the time immediately before the scheduled start of the elective intervention, there are only two options:
   a) to delay the intervention until the patient has a clear understanding of the options and their implications and can make his/her decision consistent with his/her own values; or
   b) to inform the patient that it is the opinion of the anesthesiologist and the other physicians involved that the only alternative to postponing the intervention is to suspend the DNR status in order to avoid an irreversible decision to omit CPR measures.

Although this choice seems coercive, it is the only way to meet the professional oaths of the physicians to avoid potentially irreversible harm to the patient (e.g., death, neurological impairment).

All medical and surgical practices today are “team sports.” All those involved contribute to the well-being of the patient by following best practices for their area of responsibility, which interacts with and affects the responsibilities of other members of the team. The two responsible physicians in the operating room are the surgeon and the anesthesiologist. They share responsibility for the patient’s care and its outcome. (Just ask any trial lawyer!) Both should be well informed about the patient’s goals and expectations for the intervention (e.g., curative, restorative, palliative); and they both should have a clear understanding of the patient’s wishes in regard to what is/is not acceptable treatment. How else can the team function? How else can the patient’s best interests be served?

References:
Practical Ethical Concerns Regarding Intimate Relationships in the Operating Room

Gail A. Van Norman, M.D.
Committee on Ethics

“The rights of adults to make autonomous decisions are a dominant ethical principle, and policies entirely prohibiting intimate faculty-student relationships are therefore problematic and undesirable.”

Our culture values individual freedoms, strongly supporting the rights of mature individuals to develop relationships without undue regulatory interference. Sexual relationships are intensely private, and it is abhorrent to consider them being scrutinized by governments and institutional regulators. Nevertheless, in limited circumstances, regulatory oversight of private relationships is accepted, including relationships in which behavior is perceived to have overwhelmingly negative impact on a community or when especially vulnerable persons might be exploited. Inappropriate touching of patients by physicians, domestic abuse, marital rape and incest are examples of behavior that our society proscribes. The American Medical Association (AMA) Council on Ethical and Judicial Affairs has consistently ruled that some intimate relationships, such as those between trainees and teachers, patients and doctors, and physicians and co-workers, should be discouraged.6
The following discussion centers on teacher-student relationships, which could occur in the academic setting. Similar concerns apply, however, if the physician has the power to influence evaluation of a coworker of unequal status or power within a health care institution. A physician who has or will in the future provide medical care for a patient should avoid a personal relationship because the power differential between physician and patient is too vast for such a personal relationship to be truly consensual. Physicians must monitor themselves to avoid inappropriate speech to or touching of patients or coworkers that could be interpreted as flirting, coercing or suggesting a personal relationship. Differences in power and influence in the medical workplace create the potential for coercive and disruptive interactions between physicians and staff and even between physicians themselves. Intimate relationships in the work setting can thus set the stage for claims of harassment, a hostile work environment and coercion.

Are faculty-student relationships truly consensual?

Many professionals question whether such relationships can ever be truly consensual when the teacher is in a position to affect a student’s evaluations and future career prospects. Even when a teacher may not actually intend to coerce a student, the student may harbor the belief or fear that his/her evaluations will suffer if he/she does not engage in the relationship or that he/she will be elevated if they do. Several studies show that trainees who develop sexual relationships with their teachers commonly feel, at least to some degree, coerced to enter or remain in the relationship and that these feelings increase over time. For example a student who is dependent on financial aid for his/her education, but whose aid is contingent on good grades, may not feel he/she can reasonably refuse to enter into an intimate relationship if approached by a key evaluator. A large number of students also reported that the relationship had a significantly negative impact on career plans and relationships with other teachers. Even when such relationships begin consensually, studies indicate that they frequently result in fear, regret and disproportionate guilt on the part of the student as time goes on.

Do such relationships cause harm to anyone else?

There is disturbing and strong evidence that students who engage in a sexual relationship with a faculty member are at increased risk of future sexual misconduct or abuse involving their own students or patients. An inappropriate faculty-student relationship can impair the faculty member’s ability to recognize and deliver appropriate feedback when the student commits errors in clinical decision-making or has other performance issues. When faculty members consciously or subconsciously “gloss over” training issues because of their relationship with the student, it results in negative effects not just on the patient under their immediate care but on that student’s future patients as well.
Policies to address faculty-student relationships

One way to mitigate conflicts of interest generated by an intimate relationship between a student and faculty member is for the teacher to withdraw from any role that might involve either supervising or evaluating the student, both now or in the future. This may be more difficult than it appears. In the case of medical students and residents, it can affect daytime clinical schedules, call obligations and cross-coverage issues and may therefore be nearly impossible to implement. Moreover “supervision and evaluation” extend beyond clinical situations: Faculty meetings, reports and comments that directly or indirectly affect performance evaluations submitted by others should be avoided as well.

How should interactions between the student and faculty member be handled when the relationship has ended? The emotional aftermath of the relationship may inappropriately influence future evaluations of the student by the faculty member or of the faculty member by the student. For just such reasons, the University of California implemented a policy at all nine campuses in 2003 that prohibits teachers from dating either students who are in their classes or students for whom they might reasonably expect in the future to have academic responsibility.11

AMA’s position is that “consensual relationships” between a teacher and student are particularly wrong if a current supervisory relationship exists between the two, but they also should be avoided if it is possible that the trainee might unexpectedly come under the supervision of the teacher in question at some future time.6 The fact that such future circumstances may be impossible to anticipate argues for avoiding intimate faculty-student relationships altogether.

Special cases

The rights of adults to make autonomous decisions are a dominant ethical principle, and policies entirely prohibiting intimate faculty-student relationships are therefore problematic and undesirable. It is clearly unethical, however, for a faculty member to engage in repeated relationships with students such that, in the words of Pope, the teacher “seems to regard the trainee pool as a ‘private game reserve’ or well stocked lake, replenished every year.” Such behavior amounts to a form of sexual predation and is specifically exploitative of students. It also harms the teacher and his/her work by discrediting him/her within the trainee pool.12

In summary

Intimate relationships between medical trainees and their teachers present unique and troubling ethical questions and are at best imprudent. Blanket policies prohibiting all such relationships are overly broad, though, and interfere too much with the rights of adults to have private relationships. Institutional policies regarding such relationships should require at a minimum that the teacher end any current or future supervisory role over the student when such a relationship develops. Teachers need to be aware that such relationships carry the risk of harming their credibility as teachers and the credibility of the faculty group to which they belong.

Finally, sexually predatory behavior in the academic or private practice setting is entirely unethical and should be subject to disciplinary action when it occurs. Anesthesiologists should realize that speech and behavior within the workplace that once was tolerated may no longer be permitted. The creation of an uncomfortable workplace by the use of “flirting,” suggesting that an intimate relationship exists and telling of sexually explicit “jokes” are no longer permissible because they are unethical and may be illegal under federal regulations intended to protect workers.

References:
6. For a complete list and files of AMA CEJA rulings, refer to www.ama-assn.org/ama/pub/category/3840.html.
In a recent study, approximately 95 percent of anesthesiologists thought community participation, political involvement and collective advocacy by physicians were important. Nonetheless only between 20 percent to 33 percent of anesthesiologists reported participating in these activities. Anesthesiologists were less active in community participation than family practice doctors, internists, pediatricians, cardiologists and general surgeons (on the order of 60 to 100 percent less); but anesthesiologists were similarly active in collective advocacy and were more active politically.

Do these numbers mean anesthesiologists are laggards? I do not think so. Anesthesiologists, as compared to the other specialties in this study, have had to fight for their patients and themselves through political activity. Perhaps it is appropriate, then, that more anesthesiologists than cardiologists and pediatricians rated political involvement as very important. While for a number of reasons it would be nice to have anesthesiologists more active in community participation and collective advocacy, the work of anesthesiologists in the political arena is not only appropriate but fulfills the primary obligations of the specialty of anesthesiology.

Obligations arise from relationships. In medicine’s case, obligations of physicians arise from an implicit social contract. Society has supported us in becoming physicians and specialists through providing opportunities to train, to perform research and, perhaps most importantly, to learn from and with patients. In return, society expects anesthesiologists to provide patient care, research, training and advocacy related to anesthesiology.

Gruen has suggested that an additional implicit obligation for physicians is to manage those issues that “directly influence individuals’ health” in the practitioner’s community. Note two aspects of this statement. The first is the recognition of community and the idea

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“We as anesthesiologists should continue or increase our participation in community health issues that may improve the health of our future patients.”

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that there are some specific individuals other than direct patients for whom physicians have obligations. Gruen uses “community” to mean those people who live in physical proximity to where the physician practices, and he argues that this proximity brings forth special obligations. The second is the term “directly influence,” which is used to mean that the obligation to be involved is more relevant when the harm clearly and straightforwardly affects health (such as smoking). Indeed physicians considered “involvement in issues closely connected to individual patients’ health to be very important” as compared to issues less clearly linked. It would be natural, then, for physicians to seek to effect those social, economic and environmental characteristics that shape the health of individuals in the community.

In that regard, Gruen suggested that the single most important factor affecting health — access to health care — is the shared responsibility of all physicians. Past that point, however, physicians should be involved with activities that improve community health that are consistent with each physician’s “expertise, interests and situations.” For example cardiologists as a whole may have a special obligation to address heart health. Pediatricians may have a special obligation to address child safety. I would suggest that as fiduciaries of the skills, knowledge and practice of anesthesiology, preserving and improving anesthesiology care is a primary and specialty-specific obligation.

I would argue that the profession of anesthesiology has two main obligations and that we do a good job of addressing them. I imagine our community as the community of present and future patients. One factor that has been shown to directly affect health is patient safety. Clearly anesthesiologists have been leaders in this domain. The Anesthesia Patient Safety Foundation is unequaled in improving operating room patient health. The second obligation is the preservation and development of the profession of anesthesiology. In this case, I laud the political action of anesthesiologists in working to preserve a very successful standard of care and training that dramatically sustains public health.

These behaviors are wholly consistent with the view that our fiduciary obligation is to manage “all things anesthesia.” Unlike other specialties such as cardiology, however, anesthesiology does not have a narrow spectrum of diseases for which we are responsible. In terms of diseases, for example, the anesthesiology community has taken ownership of only the rare conditions of malignant hyperthermia and pseudocholinesterase deficiency. We could, however, take our obligations further, particularly if we widen our view to include ownership of matters that include the fitness of our patients as they come to surgery.

Anesthesiologists should be involved in issues that directly affect the health of the community and are relevant to providing anesthesia care. Anesthesiologists interested in participating may want to consider the following areas:

- Participate in antismoking activities.
- Participate in obesity prevention activities.
- Participate in pain management activities, including intervening politically and improving the lay community’s understanding of pain and pain-related diseases.
- Participate in improving preventative health practices and access to care.

Naturally, participation in almost any altruistic activity fulfills our community obligations as physicians. I

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Discussions of informed consent always begin by pointing out the sea change that has occurred over the past 40 years in medical decision-making. Previous generations of physicians often made decisions for patients based upon their own perception of the patient’s best interests, often with little involvement from the patients themselves. Physicians did not regard this behavior as unethical; indeed, they felt that it would be unethical to place too much of the burden of decision-making upon the patient and family. Consistent with this approach, patients and families also were often “protected” from the harsh realities of unfavorable diagnoses and prognoses.

In the 1960s came a rebellion against authority and a renewed emphasis upon the rights and freedoms of the individual. From the civil rights movement to student protests to consumer activism, citizens demanded greater involvement and control in decisions that affected them. The patient-physician relationship was not immune from this revolution. Respect for patients’ autonomy became a defining issue for the bioethics movement and the most dominant principle in the landmark work on bioethics by Beauchamp and Childress.1

It is beyond the scope of this essay to review the case law associated with informed consent; it suffices to say that from the late 1950s forward, courts in the United States have steadily moved toward the view that the locus of decision-making authority must reside with the patient.2 There are a number of conditions that must be satisfied in order to ensure that informed consent has taken place. Essential elements of informed consent include:3

1. The nature and purpose of the diagnostic test or procedure.
2. The most significant risks of the diagnostic test or procedure.
3. The benefits of the intervention, including the chances for success, if pertinent.
4. The probable outcome of the intervention or refusal of the proposed plan.
5. Any possible alternatives to the diagnostic test or procedure.
6. The patient must be free from coercion.

To properly satisfy these conditions, it is required that the patient have the appropriate decision-making capacity. This

* This element was not included in Miller and Marin’s list but is a basic part of any discussion of informed consent.
capacity is not of an all-or-none quality. Patients often have the capacity to consent to some things and not to others. The best example of this may be a child whom we would allow to decide whether to have an I.V. or mask induction but not whether to have a tumor resected.

When there are questions about capacity, who can decide whether the patient can give his or her own consent? Actually anesthesiologists make decisions about patients’ decisional capacities daily, though they are not always aware that they are doing it. Even though there are experts such as psychologists and neurologists who can help us, they are not usually necessary, and it is important to note that they do not necessarily possess any magical ability to determine health care decisional capacity.

There are many tools and templates that have been published to help us determine capacity — but to be helpful, a tool should allow us to assess several abilities. These abilities include:

1. The ability to understand the proposed treatment and options.
2. The ability to appreciate how that information applies to the patient’s own situation.
3. The ability to reason in a manner that is supported by the facts and the patient’s own values.
4. The ability to communicate and express a choice clearly.

The easiest tool to use comes from a paper published by Annas and Densberger in 1984. They suggest asking the patient the following or similar questions:

1. What is your present condition?
2. What is the treatment that is being recommended to you?
3. What do you and your surgeon think might happen to you if you decide to accept the treatment?
4. What do you and your surgeon think might happen to you if you decide not to accept the treatment?
5. What are the alternatives available (including no treatment)?

If a patient can answer these or similar questions appropriately, then he/she likely has the capacity to make his/her own decisions about surgery and anesthesia. Also of considerable value may be a discussion with the patient’s primary physician. A primary physician will probably know the patient better than you or the surgeon and can often add much to the discussion, including information about the patient’s value system.

In 2004, Ganzini, Derse, et al. reported on “Ten Myths About Decision-Making Capacity.” I refer the reader to this paper for an excellent discussion of mis-conceptions surrounding a patient’s capacity to decide. I would like to propose an 11th myth that is rarely, if ever, discussed in the literature: “Any patient who has just received pain medication cannot give informed consent.”

Certainly any type of medication that can affect the sensorium has the potential to adversely affect one of the essential elements of informed consent. There are, however, inconsistencies in our behavior surrounding this myth. We may allow a patient who is on a patient-controlled anesthesia pump to give consent but not allow a patient who has received a single shot of narcotics in the emergency room to give similar consent. In addition, sometimes we or the nursing staff seem to think that withholding pain medications from patients until they give consent or sign the permit will result in a more valid consent than relieving the pain first so that the risks, benefits and alternatives may be more calmly considered.

If a patient 1) can answer each of the aforementioned questions appropriately, 2) does not slur his or her speech, 3) appears to be making a decision consistent with his or her value system as best as you are able to determine and 4) agrees that the treatment is in his or her best interests, then that patient has a better capacity to consent than any surrogate who may be available. It may be unethical and coercive to withhold needed pain medication until a patient agrees to surgery rather than administer the medication first. When pain medication does not impair patients’ ability to consider their options and express their choices, it does not impair their medical decisional capacity.

What if the patient is too stuporous from medication to give appropriate consent? Who can and should be the surrogate decision maker? Incapacitation by narcotics is a very temporary situation; therefore, if the surgery is not emergent or too urgent, it is appropriate to wait until the patient is awake enough to make his or her own decision. If the surgery should not wait, then absent a durable power of attorney for health care or prior designation of a surrogate, the next of kin is usually the most appropriate person to give consent. Most states now have laws that spell out who the proper surrogate can be. In most cases, it will be a spouse, adult child or significant other. What if the surrogate is not present or it is a late-night case? Often the surgery has already been explained to the patient/surrogate and consent has been given for the surgery. General consent for anesthesia care has already been given, but still lacking is specific informed consent for the anesthetic care. In these cases, proper documentation that the surgeon has obtained general consent for anesthesia care can be referenced in a chart note written...
ASA members frequently contact the Committee on Occupational Health with questions related to disability. The concerns can be grouped into one of three general categories: 1) an anesthesiologist who has suffered an injury or illness and wants to return to practice; 2) an anesthesiologist with an established impairment who is seeking support in his/her attempt to receive disability insurance benefits; or 3) colleagues who are questioning whether an anesthesiologist with particular limitations should be permitted to continue practicing. These issues are invariably complex, and resolution frequently involves subjective determinations with profound personal, professional and societal ramifications.

What makes these issues even more challenging is that a condition that is disabling to an individual in one circumstance might be a mere inconvenience to another or even the same individual under different conditions. For example, to many in the general public, confinement to a wheelchair is the epitome of disability. Wheelchair users, however, do not frequently consider themselves disabled. Indeed several of the leaders in our own specialty have required wheelchairs for ambulation. Identification of an individual as disabled can be so contentious that final resolution requires a decision by the U.S. Supreme Court.

Definitions

Impairment is any loss, loss of use or derangement of any body part, organ system or organ function. An impairment is considered permanent once it has become stabilized with little chance of substantial change in the next year, with or without medical treatment.

Disability as defined by the Americans With Disabilities Act (ADA) (42 U.S.C. § 12101) is “a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such impairment; or being regarded as having such a condition.” Disabling conditions can be subdivided into those that arise from physical, mental, emotional, sensory or developmental etiologies. Some disabilities are congenital in origin, others acquired. Disabilities can have an acute onset, as occurs with injury or acute illness, or a more gradual, progressive onset, as occurs with many chronic diseases. Some are ultimately fatal while others do not affect life expectancy. Some disabling diseases elicit feelings of blame and stigmatization while others evoke compassion and sympathy.

Work disability is a specific subgroup in which employment problems resulting from health conditions impair the individual’s ability to perform a work role in a manner that is considered normal. The etiologic basis of work disability is a complex interaction between the characteristics of the individual and the work environment. A disabled physician (commonly referred to as an impaired physician) is one who is unable to practice medicine with reasonable skill and safety because of mental illness, a physical illness or condition, or the habitual or excessive use or abuse of alcohol or other substances that impair ability.

“IT is predictable that all individuals, if they work long enough, will suffer a disability for some period during their lives.”

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**Legal Considerations:** Disability is one of the protected classes under federal nondiscrimination law. The pertinent federal laws that directly bear on disability discrimination for anesthesiologists are the Rehabilitation Act of 1973 (29 U.S.C. § 794 et seq.) and the ADA.

The Rehabilitation Act prohibits covered employers from discriminating against employees and applicants solely because of disability. The act applies to three categories of employers: 1) federal executive branch employers, 2) federal contractors and 3) employers accepting federal funds (e.g., Medicare).

The ADA extends these same protections to other classes of employees. All aspects of employment are encompassed, including hiring and firing, training, advancement, compensation and benefits. The law goes further by requiring that employers proactively offer equal opportunity to disabled employees by providing reasonable accommodations that do not cause them “undue hardship.” The definition of “employer” under the ADA is broad-based and includes a hospital’s powers in granting professional privileges.

Title II of the ADA prohibits state and local governments and their agencies from excluding a disabled individual from any government program such as medical licensure or renewal. Title III further extends the law to protect applicants to both public and private institutions, e.g., medical schools.

There are certain notable exceptions to protection by the ADA. An individual who poses a direct threat to the health and safety of others is not considered a qualified person with a disability. For example more than one court decision has ruled that a surgeon who is seropositive for HIV poses a significant health risk to his/ her patients, is not “qualified” for his/ her job and is not covered by the ADA. Neither is current illegal use of drugs a protected category. On the other hand, the status of being addicted to an illegal drug may be protected as long as the individual is in recovery and not a current user.

**Professional Competence:** Medical schools, postgraduate training programs, and licensing and specialty certification bodies each set standards to ensure the competence of current and/or future practitioners of medicine. Each is focused upon a different stage in a physician’s career, has unique goals and establishes its own cognitive, physical, emotional and technical standards to prove competence.

Historically most medical schools sought to produce an “undifferentiated graduate” with the knowledge and skills necessary to enter any residency. More recently the ideal that each medical graduate should possess all the technical skills to succeed in any specialty has been questioned. Nevertheless the Association of American Medical Colleges (AAMC) still requires of a graduating medical student that he or she have “somatic sensation and the functional uses of senses of vision and hearing” and “of equilibrium, smell and taste” (see www.aamc.org/medicalschools.htm). The graduate must have sufficient exteroceptive and proprioceptive sense and motor function to carry out activities “necessary for the education of the physician.” They also must be able to consistently, quickly and accurately integrate all information received by whatever sense(s) employed, and they must have the intellectual ability to learn, integrate, analyze and synthesize these data.

The physical and cognitive capabilities required of a graduate of a residency program are similar to those of a medical school graduate. The American Board of Anesthesiology (ABA) requires that each resident “must possess knowledge, judgment, adaptability, clinical skills, technical facility and personal characteristics sufficient to carry out the entire scope of anesthesiology practice …. They must be able to manage emergent life-threatening situations in an independent and timely fashion …. Adequate physical and sensory faculties, such as eyesight, hearing, speech and coordinated function of the extremities are essential …. Freedom from the influence of or dependency on chemical substances that impair cognitive, physical, sensory, or motor function also is an essential characteristic …” (see www.theaba.org).

The Accreditation Council for Graduate Medical Education (ACGME) similarly requires that residents must demonstrate the following competencies: “gather essential and accurate information about their patients … develop and carry out patient management plans… and perform competently all medical and invasive procedures considered essential for the area of practice” (see www.acgme.org).

It is less clear what skills and competencies must be maintained in the years of practice subsequent to residency. As a generalization, the health care industry has not kept pace with many other industries in ensuring the continuing competence of its personnel. Unlike many other professionals whose conduct impacts public safety, physicians are not required to undergo annual physical
and performance examinations or random drug screening. Few health care organizations utilize programs to monitor clinical performance of individual physicians. Many recredentialing and relicensing organizations rely only on self-selected continuing education attendance as proof of clinical competence. The problem with this approach is that physicians are inaccurate in self-evaluation of their performance and learning needs. Continuing medical education (CME) attendance, in particular, is a poor surrogate for professional proficiency.

Thorough and fair testing for competency has proven to be difficult among attending anesthesiologists. Experts in the field continue in the attempt to distinguish a “good” anesthesiologist (one who meets the demands of the job) from one who is incompetent. Part of the difficulty arises from the fact that there are no universally accepted core competencies or a “job description” for an attending anesthesiologist. Each practice, and each anesthetizing location, imposes unique demands that render elements of any universal catalog incomplete or irrelevant.

Many specialty boards, including ABA, are in the process of improving their recertification procedures by adding a mechanism to test clinical skills in addition to the traditional demonstrations of medical knowledge. The goal is to identify specialty-specific competencies and means to measure these competencies among practicing physicians as part of maintenance of certification.

Common Scenarios

It is predictable that all individuals, if they work long enough, will suffer a disability for some period during their lives. Below are some common situations in which anesthesiologists’ ability to practice have been questioned.

Loss of Vision: Adequate visual acuity is necessary for most of the professional activities of an anesthesiologist. Severely impaired central vision, markedly restricted visual fields, color blindness or failed stereopsis (three-dimensional vision) could make it difficult to perform many of the tasks that are integral to the safe practice of anesthesiology. Several research reports have shown that the impaired vision created by wearing ophthalmologic goggles rendered anesthesiologists vulnerable to frequent medication sorting errors and deterioration in intubating skills. It is important to point out that these studies artificially created acute visual loss and do not necessarily apply to anesthesiologists with chronic visual impairment.

Hearing Loss: Hearing loss, especially in high-frequency ranges, is common among older physicians. These losses often go undetected until they have reached an extreme degree.

Hearing deficits appear to be especially prevalent among anesthesiologists. In one study, 66 percent of anesthesiologists had abnormal audiograms measurable over all audible frequencies. High-frequency hearing loss can be especially problematic for anesthesiologists because of several characteristics specific to the operating room. Masks worn in operating rooms can muffle voices and hide facial cues that are helpful in interpreting language. Also, the operating room has a high level of background noise, with intermittent bursts from sources such as music, suction apparatus, beepers, alarms, surgical saws and drills, and the clanging of instruments. The combination of high-frequency hearing loss and elevated levels of ambient noise can interfere with an anesthesiologist’s ability to discern conversational speech and to hear equipment alarms that are commonly set to the higher range of audible frequencies.

Anesthesiologists Infected With Blood-borne Pathogens: In 1991 the Centers for Disease Control and Prevention (CDC) published recommendations to prevent transmission of blood-borne pathogens from health care workers (HCWs) to patients (see www.cdc.gov). These recommendations included an admonition that HCWs with hepatitis B virus (HBV) or HIV should not perform exposure-prone procedures unless they have sought counsel from experts to determine if they may continue to perform those procedures. Also included was the requirement that these HCWs disclose their serologic status to their patients before engaging in exposure-prone procedures.

Shortly afterward the American Medical Association issued an amendment to its Code of Medical Ethics (E 9.131 HIV-Infected Patients and Physicians): “A physician who knows that he or she is seropositive should not engage in any activity that creates a significant risk of transmission of the disease to others. A physician who has HIV disease or who is seropositive should consult colleagues as to which activities the physician can pursue without creating a risk to patients” (see www.ama-assn.org).

It is unlikely that many anesthesiologists are at risk of transmitting a blood-borne disease to their patients. Except in unusual circumstances, anesthesiologists do not perform “exposure-prone” procedures. That being the case, neither the CDC guideline nor the AMA Code
of Ethics should require an HIV- or HBV-positive anesthesiologist to restrict his or her routine practice or disclose his/her serologic status.

In addition to ethical considerations, however, there also are significant medico-legal concerns. The doctrine of medical malpractice imposes a strict duty to avoid patient injury and to protect the welfare of the community. It would be difficult to avoid the conclusion that the transmission of an infectious agent from physician to patient violates the standard of care. This would be especially true if adequate infection control guidelines were not followed. All anesthesiologists, regardless of serologic status, should adhere to universal precautions and recommendations for sterilization/disinfection.

Neurologic and Psychiatric Illness: A number of chronic neurologic diseases that impair motor function (such as multiple sclerosis and Parkinson’s disease) can adversely affect the ability to practice anesthesiology. In most cases, the patient (anesthesiologist in this case) and his/her physician can monitor the progression of these diseases and ensure that safe practice is not imperiled.

The situation is more complicated with conditions such as Alzheimer’s disease that primarily affect cognitive and executive functioning and can impair medical reasoning. Frequently this kind of mental impairment is unappreciated by the patient and is first identified by a colleague or spouse. Physicians suffering from this type of disease also are unlikely to benefit from efforts at remediation.

A seizure disorder can be a particularly vexing situation for an anesthesiologist. Many variables associated with the seizure disorder — for example, etiology, frequency and severity of seizures and adequacy of medical control — will determine the advisability of continued and/or restricted practice. In general those rules that apply to driving restrictions (six months seizure-free in many states) represent a reasonable requirement before resuming unrestricted practice. Where sleep deprivation or disturbances in circadian rhythm exacerbate the seizures, it is advisable to eliminate night work.

Psychiatric disease, including anxiety, depression, personality disorders and disruptive behavior, is at least as common among physicians as in the general population. The overall prevalence of psychiatric disease among anesthesiologists is unreported. The relatively high prevalence of chemical dependence and suicide, however, suggests that underlying psychiatric disease is at least as common as that seen among other physicians. Severe unmanaged neurosis or psychosis is incompatible with safe anesthetic practice. On the other hand, well-monitored and controlled illness should not be a contraindication to safe practice. The potential cognitive or motor effects of potent psychotropic medications also require close monitoring.

Fatigue can act independently or contribute toward exacerbation of any of the conditions discussed above. There is increasing awareness of the patient safety issues resulting from sleep deprivation and fatigue among anesthesiologists.

Substance-Related Disorders: Substance-related disorders are those diseases that result from taking a substance of abuse, the side effects of a legally prescribed and administered medication, and toxin exposure. Included in this category are substance use and substance-dependence disorders.

It is debatable whether or not substance-related disorders are more prevalent among physicians than the general population. The National Institute on Drug Abuse reported that health care professionals suffer from substance-related disorders (including alcohol abuse) at a rate roughly equivalent to that of the general population (8 percent to 12 percent).

The rate of substance-related disorders varies among specialties, with the highest rates commonly reported among anesthesiologists, psychiatrists and emergency physicians and the lowest rates among surgeons and pediatricians. Other authors have questioned whether there is an excessive prevalence of substance-related disorders among anesthesiologists, with the notable exception of illicit use by anesthesiologists of major opiates.

Considerable controversy exists surrounding the question of re-entry into practice for a resident or attending anesthesiologist in recovery. A number of reports have documented encouraging rates of rehabilitation and successful return to practice. On the other hand, a recent report by Collins et al. reveals a failure rate approaching 50 percent for residents attempting successful re-entry into anesthesiology residency. Relapse in this setting can be lethal, with an alarmingly high incidence of suicide or lethal overdoses.

The Aging Anesthesiologist: The population of anesthesiologists is aging. In 1994, 22.8 percent of ASA members were age 55 years or older (ASA personal communication). As of 2006, 27.7 percent were age 55 or older (ASA, personal communication). Although each individual ages differently, there are certain common, general processes that will ultimately impact an anesthesiologist’s ability to practice: a broad spectrum of progressive and irreversible deteriorative changes, a
reduced ability to respond adaptively to environmental changes, increased vulnerability to many diseases and increased mortality.

Cognitive changes associated with aging can significantly impact an anesthesiologist’s performance. The overall decrease in the complex processes involved in cognition result in a consistent age-dependent decline in physicians’ current knowledge base and in performance on recertification examinations.

One’s ability to perform effectively in a stressful environment, to adapt to new and quickly changing conditions and to process incoming information and rapidly make complex decisions all deteriorate with age. Also impacted is the ability of an anesthesiologist to perform a number of attention-related tasks and to sustain the vigilance and monitoring tasks that are so integral to safe anesthetic practice.

On the other hand, performance in the operating room relies on additional skills, including technical agility, experience and judgment that can compensate for mild cognitive deterioration and in some situations provide an advantage to older professionals. In one study that examined operative mortality, surgeon age over 60 years was not an important predictor of operative risk in five of the eight procedures studied. Even in those procedures where older surgeons did have a higher mortality rate, the effect of age was largely restricted to surgeons with low procedure volumes.

Psychosocial changes also challenge the aging anesthesiologist’s ability to practice. Physicians in high-intensity specialties such as anesthesiology who are in the middle and late stages of their careers are particularly vulnerable to psychological morbidity such as increased anxiety, depression, stress and burnout.

A number of physical changes that accompany normal aging can interfere with the safe practice of anesthesia. Age-related deterioration in vision and hearing has been discussed above. Also important are decrements in manual dexterity, strength and stamina. Older anesthesiologists are particularly vulnerable to the detrimental effects of fatigue. Increasing age is associated with a decreased tolerance of shift-work cycles and a greater tendency to late-night errors. Extended work hours and night call are among the most stressful aspects of anesthetic practice and the most important reasons for retirement among older anesthesiologists.

Disability Insurance: Private disability insurance policies for health care providers and disability clauses in life insurance policies became readily available during the early part of the 20th century. By the mid-1980s, marketing of disability insurance for health care professionals was extremely competitive with a resultant liberalization of underwriting and pricing structures.

As a result of a number of cultural and socioeconomic changes in the 1990s (including the impact of managed care on physician work pressure and job satisfaction), the economics of disability insurance reversed dramatically. From 1980 to 1992, the number of claims almost doubled. The increase was greatest among five specialties — anesthesiology being among those five.

As a result of these changes, many companies have abandoned the disability marketplace, while the remaining few have tightened the terms of policies. In most cases, underwriters have eliminated “own-occupation” coverage, eliminated lifetime and reduced maximum benefits, and imposed more stringent documentation for the claimed disability. It is not unusual for the claim of a physician seeking disability payments to be ultimately resolved in a court of law.

Conclusion

Questions about disability frequently arise from individual anesthesiologists or their colleagues. Decisions about the advisability of suspending anesthetic practice are complicated and frequently require third-party input.

Disclaimer: The opinions expressed are those of Jonathan D. Katz, M.D. They do not necessarily represent the views of ASA.

References:
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t is estimated that evidence-based care is provided to
patients less than 50 percent of the time in this country. In an attempt to improve this, performance measures with comparative outcomes are increasingly used by: the national government (Centers for Medicare & Medicaid Services [CMS]) via core measures with publication of results on “Hospital Compare” www.hospitalcompare.hhs.gov; the Joint Commission; the many comparative databases (Maryland Indicators, University Health System Consortium, Premier); state governments (i.e., Massachusetts, New York and Pennsylvania); and the Leapfrog Group (which is sponsored by employers that provide costly health insurance to their employees whose goal is to initiate breakthrough improvements in health care).

Why do they do this, and how does the use of comparison measures help health care?

Competing for Customers
The thought is that by collecting and publicizing comparative quality data (and relative costs in some cases), competition among hospitals will lead to improved care, decreased costs and avoidance of preventable complications. Where government and the Joint Commission are involved, the public reporting of process and outcome data are thought to drive improvement by giving consumers information to make informed choices and fostering competition among hospitals to attract “customers.” “Pay for Performance” (increased payments for higher quality, scaled copayments and deductibles) has been used by the Leapfrog Group as well as Premier with its three-year demonstration project with CMS known as the Hospital Quality Incentive Demonstration. In December 2006, Congress enacted law that, for the first time, directly linked Medicare physician payment to quality data reporting. What had been the Physician Voluntary Reporting Program in 2006 became the Physician Quality Reporting Initiative (PQRI) in 2007, and an incremental 1.5-percent payment (beginning July 1, 2007) for Medicare services was linked to reporting data on a group of 66 quality measures covering most medical specialties (details of which can be found at www.cms.hhs.gov/PVRI). Incentive programs are proliferating among private health plans, and
Medicare has linked hospital payments to quality measurement for several years, but this is the first federal program-wide physician pay-for-reporting action.

Even ASA has recently considered performance measures, as have many other specialty societies. One of ASA’s performance measures concerns the administration of perioperative prophylactic antibiotics, namely, on-time administration of prophylactic antibiotics within 60 minutes prior to incision (see www.ASAhq.org/Washington/P4P%20Antibiotics%20for%20Healthplans.pdf). This topic has appeared with increasing frequency in the anesthesia literature.3,4,5,6 and was derived from a set of performance measures put forth by the Surgical Infection Prevention Project (SIPP) in 2002.7 Many specialties, including anesthesiology, have additional quality measures awaiting adoption by CMS in 2008 and future years. It is possible that, over time, more substantial monetary linkages will occur and that data reported in the first phases of the PQRI will lead to performance thresholds subsequently.

Surgical infection is a leading cause of patient injury, mortality, excess length of stay and increased costs.8 It has been estimated that up to 50 percent of these infections are preventable with appropriate interventions.9 In 2002, SIPP — which evolved into the Surgical Care Improvement Project (SCIP) in 2005 — started a nationwide quality improvement initiative with the goal of optimizing the outcomes of patients undergoing surgery by improving the use of evidence-based practices shown to reduce the incidence of surgical infections.7 Three of these measures involved antibiotic prophylaxis: appropriate selection, appropriate timing (within 60 minutes prior to incision) and discontinuation within 24 hours of surgery end time.7 It has become evident that administration of the drugs in a timely fashion is critical to their efficacy and that anesthesiologists are well positioned to accomplish this task. The measure is designed to focus on timeliness as distinct from drug choice or indications for prophylaxis, the latter forming the basis for a companion set of measures for surgeons.

Room for Improvement

This article presents a how-to guide to improve on-time administration of prophylactic antibiotics, which has evidence-based support9 but poor compliance as only 56 percent of Medicare patients undergoing major surgery receive antibiotics within the one-hour time interval.5

For any quality improvement project, a number of elements must be in place before undertaking the actual change. Initially an area for improvement must be identified. It can range from a simple problem with an easy fix to a complex systemwide redesign. In this case, administration of prophylactic antibiotics within 60 minutes before incision was chosen. Appropriate leadership support is essential to the success of larger projects because of the ability of leadership to dedicate resources and provide the authority to effectively implement any needed changes.

The most important part of successful implementation is that a group is formed that can share ideas and data and foster teamwork. This team is responsible for the actual work and should be composed of the various stakeholders touched by the process needing change, which could include nurses, pharmacists, support staff, physicians and the physician champion. A physician champion is essential to any quality improvement project that involves changes in clinical care as he or she can lead the educational discussion that can achieve “buy-in” from other physicians (lead with the evidence), especially when they are of the same specialty. The physician champion must be credible, respected and have good communication skills. Use of ad hoc experts, when necessary, can provide content or operational guidance. The team needs to set a meeting tempo with more frequent meetings in the beginning. For our team, this was twice a month. Initially the team will set goals, adopt a formal improvement methodology, do a gap analysis by mapping the existing process compared to the ideal process, and establish baseline measurements. One final advantage of the team approach is that once established, it acts as a template to tackle future projects.

Several quality improvement methodologies can be adopted for health care improvement, including the Six Sigma approach, the...
Always a Work in Progress

At our institution, we have adopted the PDSA cycle for rapid improvement. The advantages of using the PDSA model is that small tests of change can be implemented rapidly, studied to see if they work and changed as needed. Testing in this way allows a process to be worked out in a small pilot population prior to its spread to other populations. Often an impediment to the initial implementation is the idea that one needs to design a perfect system before implementation can take place. One of the mantras we stress is “implementation before perfection.” We do this for two reasons: there are too many circumstances to plan for, and new barriers not thought of during planning will only become apparent after implementation. By using the PDSA cycle, one can rapidly identify the problems and fix them. Other rationale for adopting this methodology is the intuitive simplicity and low costs (compared to Six Sigma) because expert consultants are not needed, although Six Sigma has been used by others to improve adherence for antibiotic prophylaxis administration.5

As mentioned before, the team should map the current process and the ideal process as envisioned by the team. The difference between the two is known as gap analysis. We had multiple “gaps” in our process. One example of this involved our preoperative holding area process. We were often too early in our administration of prophylactic antibiotics because the preoperative nurse in our holding area was responsible for administration based on the printed operating room schedule instead of taking into consideration case overruns and emergency add-ons that delayed scheduled cases.

After working through several PDSA cycles, including considering the circulating nurse administering the antibiotic, we moved to a system in which the anesthesiologist took the responsibility for administering all antibiotics (except vancomycin and levofloxacin due to their longer infusion time). In fact, initially, an anesthesiologist was not on the original team, but it was soon realized that an anesthesiologist physician champion was integral to successful improvement. Gap analysis can drive change by showing unnecessary steps mapped out in the baseline process, knowing that simplifying a process will decrease the potential for error. Defining the current process also allows one to predict where most errors will occur and mitigate against them by building redundant systems — this is called “failure mode effects analysis” (FMEA). An example of this can be found in the pre-incision “time out,” where potential omissions in care can be remedied.

After the initial implementation is introduced, continual measurement of success (or failure) of process interventions and outcomes is done. One needs to know what worked and did not work. This is the study phase of the PDSA cycle.

“One of the more difficult challenges is sustaining the improvement after the initial ‘honeymoon’ period is over. This erosion occurs in most process changes as attention turns away to new problems.”

Studying the results, continuing with successful interventions while acting to change the unsuccessful ones will drive improvement. During this phase, the team will continue to do several tests of change for various processes and system modifications in order to find the ones that work before spreading them across the entire facility.

It Takes a Team

Communication and education via grand rounds, staff meetings, dashboards, e-mails, etc., should be used to publicize the project and create a sense of purpose and togetherness. It is important to celebrate successes when they occur and give credit to the people doing the work on the “front line.” Expect failures as a part of system change; not all interventions will have the desired result. Early on we attempted to have the anesthesiologist mix the antibiotic but realized that compliance would be better achieved if the antibiotic accompanied the patient to the operating premixed, hanging on the patient’s I.V. pole.

The system that has evolved at our institution is as follows. The surgeon is responsible for ordering the prophylactic antibiotic while the anesthesiologist is responsible for administration. The acceptance by the anesthesiologist for the administration component was one of the changes that gave us our most dramatic improvement. Other institutions have reported similar improvements with the anesthesiologists administering the antibiotics.11 The pharmacy sends these premixed medications to the preoperative holding area.
where they are stored in a refrigerator. The preoperative nurse prepares the antibiotic for administration (attaches tubing and primes the line) and hangs it on the patient’s I.V. pole.

The anesthesiologist administers the antibiotic in the operating room within one hour prior to incision. During the intraoperative “time-out,” the circulating nurse asks the name of the antibiotic and the time it was administered. If none was ordered, the surgeon has a chance of ordering at that point. If the anesthesiologist has not administered it before the time-out, the antibiotic can then be administered before incision. The time out is an example of a redundant step to prevent a miss or “mitigate a failure.” In addition a visual prompt on the anesthesia record was added, which acts as an additional reminder to administer antibiotics (as well as simplifying the process of checking compliance). An electronic medical record can be leveraged using built-in prompts to remind practitioners to give antibiotics. By following the above process, we are currently at 99.5-percent adherence and have sustained rates of greater than 98 percent for the last 12 months for this measure. This is considerably higher than our baseline measure of 28 percent in 2003.

Making the Grade

One of the more difficult challenges is sustaining the improvement after the initial “honeymoon” period is over. This erosion occurs in most process changes as attention turns away to new problems. Erosion will not occur if the changes become part of the culture of the institution. Other ways to sustain compliance is through auditing and feedback. There are numerous methods for auditing and providing feedback of results. We do real-time chart reviews in order to capture errors in a timely manner (usually within 24 hours of procedure). A letter is sent to the anesthesiologist when an omission has occurred. The letter includes the patient’s name and date of surgery and describes the administration error (similar letters are sent to the surgeon if an incorrect antibiotic is prescribed or if the duration of prophylaxis is greater then 24 hours). An electronic medical record can link the lack of an antibiotic administered (i.e., over-riding the antibiotic prompt) to an automatic e-mail.

Because of the competitive nature of physicians, a physician report card can be a powerful tool to influence behavior. We display physician report cards in the operating room suite and present individual physician results at departmental grand rounds. We do this in a blinded fashion, assigning each physician a number so that he/she sees how he or she compares with his or her colleagues. We also show how we compare as a group to national benchmarks. In contrast, unblinded data are sent to individual anesthesiologists with his/her compliance rate versus some benchmark (the group mean, the top 10 percent, national numbers, etc.). Finally, unblinded data can be used by the chairperson to help “outliers” come into compliance.

We have described a “how to” guide of process improvement using a national measure from SCIP, which anesthesiologists increasingly are being pressured to perform. The hallmarks of process improvement involve education, process development, implementation, monitoring results and feedback. As pay-for-performance and quality measures become increasingly popular in all aspects of medicine, it behooves us as a specialty to be proactive in determining which ones make the most sense for us to adopt while never forgetting that we are attempting to improve care for our patients.

References:

Board of Directors Interim Meeting Summary

The ASA Board of Directors held its interim meeting in Chicago, Illinois, on Saturday and Sunday, March 3-4, 2007. The Board committees on Administrative Affairs, Finance, Professional Affairs and Scientific Affairs met as Review Committees on Saturday to review reports for consideration by the Board of Directors on Sunday.

Among the actions taken by the Board of Directors were the following (unless otherwise noted, Board action is subject to action by the ASA House of Delegates in October):

**WCA and Board Meeting in 2008**
Due to conflicting dates with the 14th World Congress of Anaesthesiologists (WCA), the dates of the 2008 Interim Meeting of the Board will be moved to February 23-24.

**Mentoring Program for Diversity**
The Committee on Professional Diversity has been charged with developing a formal ASA Mentoring Program for Diversity, with appropriate support from the ASA Executive Committee, in an effort to recognize and enhance gender, racial, ethnic and multicultural diversity at all levels of involvement in ASA.

**New and Updated Practice Parameters**
1. An update of the Practice Guidelines for Obstetric Anesthesia, originally approved in 1998, was approved by the House in October 2006 and published in the April 2007 issue of *Anesthesiology*.
2. New Practice Guidelines for Neuraxial Opioids Associated with Respiratory Depression are being drafted with member input through open forums and are scheduled for completion by October 2007. A second practice parameter addressing the prevention, diagnosis and management of infections and bleeding complications associated with neuraxial blockade will follow completion of the respiratory depression document.
3. The Task Force for Practice Guidelines on the Prevention and Management of Operating Room Fires also held an open forum in May, and the practice parameter is scheduled for completion in 2007.
4. A task force for a practice parameter on magnetic resonance imaging related to anesthetic practice is being formed and is planned to begin its work in fall 2007.
5. Also being updated with anticipated completion in 2008 are the Practice Guidelines for Perioperative Transesophageal Echocardiography, first approved in 1996, and Practice Guidelines for Chronic Pain Management, first approved in 1997.

**Partnering for Master’s of Business Administration (MBA) Program**
In light of the success of the ASA Certificate in Business Administration (CBA) program, now in its seventh year, formal discussions will begin to explore a partnership between ASA and the physician executive MBA program at Auburn University. An ASA-sponsored MBA program would likely require three years of coursework, could be entered using CBA credits and would be designed for working physicians and those with families.

**2007 Budget**
The Board approved an amended 2007 budget to provide for income of $25,100,625 and expenses of $25,398,740.

**Performance and Outcomes Measurement**
The work of the Committee on Performance and Outcomes Measurement was acknowledged, and ASA will continue...
to participate actively in the ongoing development of such measurements in an expedited fashion, which should include having measures available for consideration and working proactively with other organizations and agencies.

**Smoking Cessation Initiative**

The Task Force on Smoking Cessation Initiative requested support for a pilot project and related resources to support strategies for increasing the involvement of ASA members in smoking cessation efforts, with the ultimate goal of increasing the abstinence rates for their patients who smoke. The Smoking Cessation Leadership Center, funded by the Robert Wood Johnson Foundation, is providing technical assistance and funding.

**Anesthesia Advanced Cardiac Life Support**

The Committee on Critical Care Medicine, in conjunction with the American Society of Critical Care Anesthesiologists (ASCCA), has drafted a document that outlines the development of a supplemental educational module/chapter, which focuses on the unique problems of perioperative cardiac arrest as an adjunct to the American Heart Association’s advanced cardiac life support guidelines or as an ASA monograph. The committee and ASCCA plan to jointly submit the final product to the House of Delegates in October.

**Model Policy for Organ Donation After Cardiac Death**

A draft Model Policy for Organ Donation After Cardiac Death (DCD) was developed by the Committee on Transplant Anesthesia and reviewed by the Committee on Critical Care Medicine, the Committee on Ethics and ASCCA to serve as an educational guide and template for departments of anesthesiology to use when developing their individual DCD policies. The document was referred back to the Committee on Transplant Anesthesia.

**Medical Student Component**

The Board approved a recommendation from the ASA Resident Component that the Medical Student Delegation be recognized as the Medical Student Component and function as a component society within ASA, separate from the Resident Component.

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**Practical Ethics for the Informed Consent Process for Anesthetic Care**

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by the anesthesiologist who states that he or she is now proceeding with anesthesia care in the patient’s best interest. Of course in a true life-or-death emergency, consent to anesthesia care can always be presumed.

We all have the potential to fall prey to time constraints and production pressure on the day of surgery. Except in emergencies, taking the time necessary to help your patients develop an informed consent to their anesthetic procedures is an ethical duty of all anesthesiologists. This may motivate anesthesiologists to initiate the informed consent process with information about anesthesia care, which can be distributed at the hospital, surgeon’s office, included with a preadmission information packet that is sent to patients, or on a Web site or during a patient visit on a day before the actual surgery is scheduled. ASA materials are available to support anesthesiologists for these purposes.

Patients will appreciate your efforts to respectfully inform them of appropriate anesthetic choices and prepare them for their anesthetic care. Patients will recognize that their anesthesiologist is an ethical physician who cares about them personally and is not just a hospital-based technician who performs procedures.

**References:**

2007 Plenary Session Speaker: Sten G.E. Lindahl, M.D., Ph.D.

Sten G.E. Lindahl, M.D., Ph.D., Professor at Karolinska Institutet and Chief of Research and Education at Karolinska University Hospital in Stockholm, Sweden, will deliver the plenary lecture at the 2007 Annual Meeting in San Francisco. The plenary session is scheduled for Tuesday, October 16, from 11:30 a.m. to 12:20 p.m. The topic is “Oxygen.”

In his lecture, Dr. Lindahl will discuss aspects on the appearance of atmospheric oxygen and the time prior to the invention of oxygenic photosynthesis — still the only known source of oxygen. There also will be thoughts on oxygen sensing and interactions with anesthetic agents as well as on hypoxia and hypoxic-inducible factors. In addition, evolutionary views on pulmonary oxygen uptake with important clinical relevance will be presented. Furthermore, results from work on brown adipose tissue, present in neonates, concerning oxygen consumption, i.e., heat production, and uncoupling of the respiratory chain will lead not only to temperature balance during anesthesia but also to a disclosure of mechanisms — known from before oxygenic photosynthesis — that may be of possible value in modern medicine.

Born in Malmö, Sweden, Dr. Lindahl trained at the University of Lund, Lund, Sweden, and interned at Helsingborg General Hospital and Malmö General Hospital, both in Sweden. He is certified as a pediatrician and an anesthesiologist. Among his many appointments, Dr. Lindahl has served as Professor, Mayo Medical School, Mayo Clinic, Rochester, Minnesota (1988), Academic Chair of the Department of Surgical Sciences, Karolinska Institutet, and Chief of Research, Education and Development at Karolinska Hospital. He has served in his current position since 1990. He has served as an adjunct member of the Nobel Committee for Physiology or Medicine and is an ordinary member of the Board of Trustees of the Nobel Foundation. Dr. Lindahl also is on the International Advisory Board, Journal of Anesthesia, Japan. He holds memberships in many medical and scientific organizations.

Dr. Lindahl’s research interests include ventilation/perfusion matching, prone position, oxygen sensing and regulation of breathing. He has received funding from the Swedish Medical Research Council, the Swedish Heart-Lung Foundation and the medical faculty, Karolinska Institutet.

He has published in 119 original scientific publications and has had more than 200 abstracts published. Publications also include editorials and review articles, book chapters and various other publications. He has been invited to present many national and international lectures.

To unwind, Dr. Lindahl enjoys opera and literature. “Outside” interests include backpacking north of the Arctic Circle in the Swedish or Norwegian mountains, jogging and following his soccer team.

Anesthesiologists’ Ethical Responsibilities for Community Service

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offer only some suggestions here. Whenever anesthesiologists have worked as patient advocates outside of the operating room, it has increased respect for the specialty. We as anesthesiologists should continue or increase our participation in community health issues that may improve the health of our future patients.

References:
Imagine that you work at one of the nation’s most prestigious hospitals, with intimate access to the most advanced anesthetic equipment available. Faced with the challenge of performing a general anesthetic for an elective surgery on a healthy patient, you decide to induce anesthesia with inhalational ether, stimulate the respiratory drive by administering CO$_2$ and assess oxygenation by closely watching the patient’s skin color.

In the modern practice of anesthesiology, we take pulse oximetry, automated blood pressure cuffs and short-acting, predictable agents for granted. But less than a half-century ago, these everyday implements were experimental at best or even unheard of. Anesthesiology, the first medical specialty born in the United States, has developed from the humble beginnings of the first ether anesthetic to a well-respected and multifaceted field in just over a century and a half, and since the early 1930s, the valuable history of our art has been carefully preserved by the Wood Library-Museum of Anesthesiology (WLM), located at the ASA headquarters building in Park Ridge, Illinois.

The WLM, the largest museum in the world dedicated to the history of anesthesiology, features such

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EMIT: We’re ‘IT’ for the Latest in Information Technology

Keith J. Ruskin, M.D., Chair
Committee on Electronic Media and Information Technology

The Committee on Electronic Media and Information Technology (EMIT) continues to develop innovative programs that help ASA and its members. EMIT members were on hand at the ASA Resource Center at the 2006 Annual Meeting in Chicago last October. The theme of our exhibit was emergency communication, and we fielded many interesting questions about the best ways to talk when the power goes out. Using communication technology to improve clinical care is an ongoing theme for EMIT. Two years ago, EMIT published a landmark study showing that using cellular telephones may improve patient care, and several hospitals have used that study to decrease the restrictions on telephone use in critical care areas. Several committee members recently published the results of a study on how well information from preanesthesia testing clinics is sent to the operating room on the day of surgery. The results of this study can be used to develop communication strategies that make the preanesthesia visit more productive.

At its winter meeting in January 2007, EMIT discussed the archive of electronic ASA documents. For example the Wood Library-Museum of Anesthesiology (WLM) stores books and letters, photographs, videotapes and 16 mm films that document the history of our specialty. All of these media are subject to degradation, and it is rapidly becoming impossible to find film projectors or certain kinds of videotape players. While books and letters on paper can always be read, paper eventually fades and disintegrates over time, and motion and skin oils accelerate decomposition even with careful handling. As a result, the WLM has asked EMIT to suggest ways to preserve ASA’s important collection of documents while making them available to members on the Web.

EMIT also has been working to speed payment of health insurance claims. EMIT represents ASA at meetings of Accredited Standards Committee X12, the group that the Health Insurance Portability and Accountability Act charged with creating standards for electronic submission of health insurance claims. X12 sponsored a conference on real-time claims adjudication in Washington, D.C., last February. The goal of this meeting was to jump-start a process whereby health care insurance claims can be processed immediately, ideally before the patient leaves the hospital. This will have several clear benefits for all physicians: An all-electronic workflow may mean that fewer office staff are required to call patients or insurers. It also will be possible to submit a claim and get payment information immediately after the surgery has been completed.

Perhaps most importantly, EMIT members are developing innovative educational programs. EMIT presents an annual series of computing workshops at the Annual Meeting that are sold out nearly every year. The topics of the workshops reflect the interests of ASA members, and last year we added new presentations on digital photography and Photoshop, among others. EMIT has been working with the Committee on Outreach Education to develop electronic continuing medical education, including an Annual Meeting Highlights series in which selected lectures presented at ASA meetings are made available for viewing on the Web.

As always our most important source of new ideas is ASA’s membership. We look forward to helping you with your information technology needs.

Bibliography:
Irving M. Pallin, M.D. — February 1910 – October 2006

Erwin Lear, M.D.

Irving M. Pallin, M.D., ASA President in 1957, died this past October 8. Notice was received by way of a returned ASA membership letter.

Dr. Pallin was born and raised in Boston, Massachusetts, and received his undergraduate training and medical degree from Tufts Medical School. He completed a two-year internship at the W.W. Backus Hospital in Norwich, Connecticut, in 1939. He elected to enter the specialty of anesthesiology and was accepted at the New York Postgraduate Hospital program under the direction of Milton C. Peterson, M.D., an E.A. Rovenstine graduate.

During his residency, he dated a nursing supervisor from a nearby hospital whom he eventually married; her name was Anne Gertrude Lear.

Upon completion of his residency training, Dr. Pallin entered into a solo clinical practice, traveling from case to case with a miniature anesthesia apparatus and a cylinder of cyclopropane in his car trunk. In 1942 he was invited to establish an anesthesia department at the Jewish Hospital of Brooklyn. On arrival at his new post, he found anesthesia services provided by nurse anesthetists at the beck and call of the surgeons. Coincidently one of the nurse anesthetists was his niece, Ruth Lear.

Dr. Pallin was often requested by the chief surgeon for difficult cases. The quality of the medical anesthesia provided led to requests from other surgeons, and soon a medically based anesthesia service became a reality. Over time Dr. Pallin collected a talented staff of attendings such as Drs. Samuel I. Josephs and Eli Brown. Dr. Josephs was an M.D., Ph.D. (a cardio-physiologist) who later became a governor of the American College of Anesthesiologists. Dr. Brown went on to create the department of anesthesiology at the newly constructed Sinai Hospital of Detroit and was soon appointed Chair of Anesthesiology at Wayne State Medical School. He later became the 1981 ASA President.

Under Dr. Pallin’s leadership, the anesthesia service at the Jewish Hospital flourished. The hospital was a primary teaching facility of the Long Island College of Medicine, and medical students were rotated through all major services, including anesthesia. Dr. Pallin was instrumental in attracting Merel Harmel, M.D., to the medical school when it was taken over by the New York State University system in 1950. He was appointed clinical professor at the medical school.

Within Dr. Pallin’s department, teaching and research were emphasized. Senior residents were required to complete a research project under faculty supervision. One of the research projects led indirectly to the introduction of nallyl oxymorphone. A small family-owned company (Endo) produced Numorphan, which was said to have analgesic potency equivalent to morphine without the respiratory depression. DuPont later bought out the firm. Within Dr. Pallin’s department, studies found the claims to be untrue, and the company’s biochemist synthesized a compound to offset the respiratory depression; it acquired the brand name of “Narcan.” Indeed it offset respiratory depression. Numerous studies were subsequently published by Dr. Pallin’s staff dealing with tranquilizers, analgesics and cyclohexylamines.

From April to June, anatomy and nerve blocks were taught by the anesthesia staff by utilizing cadavers at the anatomy laboratory of the medical school. This staff also ran the pain clinic. On the clinical side, obstetrical anesthesia was provided by full-time attending staff supplemented by “moonlighters,” B.R. Fink, M.D., among others. Epidurals

Erwin Lear, M.D., is Professor Emeritus, Anesthesiology, Albert Einstein College of Medicine, New York, New York. He is former editor of the ASA NEWSLETTER (1984-97). He is the nephew of Dr. Pallin.
for labor and delivery were provided as well as music piped into the labor and delivery rooms. Cardiac anesthesia for mitral and aortic valve surgery was provided before the days of the bypass machine. Hypothermia for neurosurgery was also utilized.

Over the course of time, international residents arrived at Dr. Pallin’s department. In the early 1950s, the Japanese government sent several physicians to be retrained as anesthesiologists in order to bring the specialty up to date. Among these physicians were chest surgeons, internists and an infectious disease specialist. One of these residents, O. Aochi, M.D., became the first chair at the medical school in Kyoto. Residents from other countries included the Philippines, Thailand and Italy, to mention a few.

While Dr. Pallin may be remembered primarily for this ASA activities, his earlier efforts were directed at the New York State Society of Anesthesiologists (NYSSA) and its PostGraduate Assembly (PGA). In this environment, he functioned at many levels, culminating in the NYSSA presidency.

In the mid-1960s, Dr. Pallin was consulted by a firm that was building a hospital in Sun City, Arizona. Since he was nearing mandatory retirement at the Jewish Hospital, Dr. Pallin not only served as consultant to the hospital builders but agreed to establish an anesthesia service; hence he retired and moved to Sun City, Arizona.

Three of his children also moved west: Samuel Pallin, Mary Jane Sandler and Jonathan Pallin. A fourth child, Carol Sue Sandler, remained in New York. Sadly, her husband perished in the 9/11 World Trade Center disaster.

Dr. Pallin will be cherished by his children, many grandchildren and colleagues.

WLM: A Treasure Trove of Anesthesiology History

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rare items as William Harvey’s “An Anatomical Study of the Motion of the Heart and of the Blood in Animals,” Morton’s ether inhalers, a vintage 1860s nitrous oxide machine and personal correspondence from giants in our field, including Wood, Waters and Lundy. In addition to its exhaustive compilation of modern books and journals, the WLM houses a priceless rare book collection and artifacts critical to explaining our past. A collection of videos titled “The Living History of Anesthesiology” features one-on-one interviews with anesthesiologists whose contributions to our specialty define who we are today. The annual Lewis H. Wright Memorial Lecture at the ASA Annual Meeting also is sponsored by the WLM.

For scholars interested in historically based academic pursuits, the WLM offers four fully funded three-week fellowships annually, allowing intensive primary-source experience with its in-house resources. It is indeed a once-in-a-lifetime opportunity to visit the museum, meet the dedicated and knowledgeable staff and satisfy one’s intellectual curiosity.

As anesthesiologists and residents, we cannot address many of the challenges facing our specialty today without the benefit of knowing our past. To protect our training programs, understand the roles of other providers or effect changes in legislations, techniques or equipment, we must be armed with the knowledge behind these issues.

As the three resident representatives to the WLM Board of Trustees, we have had the incomparable opportunity of visiting and learning about the WLM’s great offerings and importance in maintaining the heritage of our specialty. We’ve had the good fortune of meeting some of the giants of today while helping in the preservation of the memory of giants past. We’ve been surprised by just how much we’ve learned and have enjoyed the experience, and we encourage any provider, staff or resident to get involved with this important organization. Serve on a committee. Contribute your personal archives and artifacts. Take advantage of an opportunity not offered by many other medical specialties. Visit the museum and its Web site at www.woodlibrarymuseum.org. Find out why the oxygen cylinder is green, why we use a pulse oximeter and why a pencil-point spinal needle even exists. You may be pleasantly surprised.
Anesthesiologists who participate in Medicare’s Physician Quality Reporting Initiative (PQRI) will be eligible for a 1.5-percent bonus based on the total dollar amount of their claims submitted to Medicare during the second half of 2007. This is tantamount to a 1.5-percent increase in the conversion factors for both anesthesia and for all other services for the period July 1 through December 31. To place the potential bonus in context, consider that the average annual change in the anesthesia conversion factor since 1992, the first year in which the Physician Fee Schedule was implemented, is a 1.5-percent increase.

This column will discuss the PQRI conditions for earning the bonus and the origins and significance of the program. The most important points are:

1. To participate, physicians must begin reporting the PQRI measures, using specific codes on their Medicare claim forms, on July 1.
2. Feedback reports are confidential.
3. The program is strictly voluntary. The only penalty for not reporting is the loss of the opportunity to earn the bonus.
4. Centers for Medicare & Medicaid Services (CMS) only published specifications for the measures in April. ASA members should make sure that they check www.ASAhq.org, www.cms.hhs.gov/pqri and their own carriers’ Web sites frequently as more PQRI information comes out.

Eligibility for the Bonus
All physicians and certain allied health professionals will be eligible to participate in the PQRI, whether they participate with Medicare or not. No preregistration is necessary. Submitting one’s first claim containing PQRI codes will trigger participation. To earn the bonus, anesthesiologists will report each measure by submitting the specified quality-data codes on all Medicare claims to which the measure applies. As long as the anesthesiologist reports each applicable measure on at least 80 percent of the claims for the cases in which that measure could have been performed and reported, he or she will qualify for the bonus.

What Are the Applicable Measures?
For the 2007 reporting period, there is only one measure that is clearly intended for anesthesiologists (and which would probably not have been included but for the considerable efforts of Alexander A. Hannenberg, M.D., Vice-President for Professional Affairs, and other ASA representatives): the timely administration of antibiotic prophylaxis to surgical patients. In order to be part of the initial set of 74 measures that CMS had adopted for the PQRI as of January, the antibiotic prophylaxis measure had to pass muster with the American Medical Association Physician Consortium for Performance Improvement and also with the Ambulatory Quality Alliance (see the December 2006 issue of the ASA NEWSLETTER for explanations of the role of these organizations). Although the third major entity whose endorsement is theoretically necessary, the National Quality Forum, has not yet approved a physician-level antibiotic measure, it seems certain that the PQRI will be receiving data on the measure described on its official list thus:

30. Perioperative Care: Timing of Prophylactic Antibiotic — Administering Physician Description
Percentage of surgical patients aged 18 years and older who have an order for a parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) for whom administration of prophylactic antibiotic has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)
Many anesthesiologists are assuming the responsibility for the preoperative administration of beta-blockers to coronary artery bypass graft (CABG) patients, and there is also a PQRI measure for this service. The PQRI list contains a number of other measures that are so general as to be potentially applicable to all physicians; for example, screening patients over age 65 for fall risks.

The whole panoply of measures is important because physicians must report on at least three measures 80 percent of the time in order to obtain the bonus, unless fewer than three are applicable. CMS does not yet have an answer to the question whether the beta blockade, fall screening or any other measures are “applicable” to anesthesiologists. Among the answers to the frequently asked questions on the PQRI Web site is the following: The December 2006 Medicare legislation that created the PQRI, the Tax Relief and Health Care Act of 2006 (TRHCA, pronounced “Trisha”) “requires CMS to validate, using sampling or other means, whether quality measures applicable to covered services of a participating eligible professional have been reported. We plan to focus on situations where eligible professionals have successfully reported fewer than three quality measures.” A lot will depend on the methods of sampling and validation.

**Mechanics of Reporting**

CMS deserves credit for having made reporting performance of the PQRI measures as simple as possible. The PQRI grew out of the 2006 Physician Voluntary Reporting Program under which a small number of physicians opted to report on a set of 16 initial measures without a financial incentive. Both are based on including performance codes on the claim submitted to Medicare.

Like other performance reporting systems, the PQRI measures consist of a numerator and a denominator that permit the calculation of the proportion of a given patient population that receives a particular intervention or experiences a particular outcome over a stated period of time. The PQRI numerator consists of a new quality process code adopted by the Current Procedural Terminology (CPT™) Editorial Panel (“Category II” codes) or, if there is no CPT- II code, by CMS (“HCPCS” codes). These codes all have five digits, consistent with the CPT™ and CMS models.

If the particular intervention is not performed, anesthesiologists and others should nevertheless report the appropriate CPT-II and HCPCS codes on the claim. Remember that the PQRI is about reporting not about achieving clinical perfection. Two-digit modifiers appended to the numerator code allow the physician to report that the intervention was not performed, i.e., documented, for either a specific or a “not otherwise specified” (NOS) reason. Table 1 below displays the structure of PQRI measures.

The PQRI codes are to be entered on the claim like any other CPT procedure code, except that the submitted charge must be “$0.00.”

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Modifier excluding this case from the denominator (as appropriate)</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All</strong></td>
<td>CPT-II or HCPCS code</td>
<td>1-P: exclude for medical reason 2-P: exclude for patient reason 3-P: exclude for systems reason 8-P: exclude for reason NOS</td>
<td>ICD-9 and/or CPT code(s)</td>
</tr>
<tr>
<td>#30: Perioperative Care: Timing of Prophylactic Antibiotic — Administering Physician</td>
<td>CPT-II 4048F Documentation that prophylactic antibiotic was given within 1 hour (if fluoroquinolone or vancomycin, 2 hours) prior to surgical incision (or start of procedure when no incision is required)</td>
<td>8-P: Antibiotic was not given within 1-2 hours..., reason not otherwise specified (There are no recognized exclusions based on medical, patient or systems reasons)</td>
<td>CPT-II 4047F Documentation of order for prophylactic antibiotics to be given within 1-2 hours....</td>
</tr>
<tr>
<td>#44: Pre-Operative Beta-blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery</td>
<td>CPT-II 4115F Beta-blocker administered within 24 hours prior to surgery</td>
<td>1-P: Documentation of medical reason(s) for not administering beta-blocker within 24 hours... — or — 8-P: Beta blocker not administered within 24 hours prior to surgical incision, reason not otherwise specified</td>
<td>CPT procedure codes for CABG surgery 33510-33514, 33516, 33533-33536</td>
</tr>
</tbody>
</table>
Attribution — Who Reports and Who Gets Paid?

The individual anesthesiologist who performs the intervention, i.e., who ensures the timely administration of prophylactic antibiotics, reports the PQRI codes (4048F and 4047F) on the claim submitted under his or her name and National Provider Number (NPI). CMS will analyze whether the 80-percent threshold has been met at the individual clinician level.

Consistent with the primary objective of the PQRI program, which is to accustom health professionals to reporting quality and performance measures, if two clinicians participate in the case and both report the PQRI measure on their claim, it will count toward the 80-percent threshold for each of them. Nurse anesthetists who submit their claims independently will thus be able to report applicable measures even if the anesthesiologist does so, too.

The bonus payment will go to the anesthesiology group, or to the individual, or even to the hospital if the hospital employs the anesthesiologist or nurse anesthetist — whoever holds the Taxpayer Identification Number (TIN) that is also entered on the claim. If only one anesthesiologist in a group using a single TIN qualifies for the bonus, the group will still receive the payment. It can then pay the bonus, of course, to the member who earned it or distribute it in any other manner.

There is a statutory cap on the bonus for physicians who report low volumes of cases with a PQRI measure. This cap is unlikely to affect anesthesiologists because, if they choose to participate, the antibiotic prophylaxis measure will be reportable in every surgical procedure for which antibiotics have been ordered. The purpose of the cap is to prevent a physician or other health professional from earning, for example, $3,000 based on total Medicare allowed charges of $200,000 (1.5 percent) for reporting a measure on claims filed for as few as four out of a total of five eligible cases performed between July 1, 2007, and January 1, 2008.

Confidential Feedback

CMS will give confidential feedback reports to participating physicians at about the time that the lump sum bonus payments go out in mid-2008. There will be no interim feedback and no public disclosure.

What Happens in 2008?

Congress created a quality reporting program for 2007 when it enacted TRHCA. Without additional legislation — and funding — it is not clear whether the PQRI will continue into 2008. CMS expects to be administering the PQRI or a similar program next year, however, and TRHCA does give CMS the discretion to expand measures to include structural measures such as the use of electronic health records and electronic prescribing technology. Proposed measures for 2008 will be published by August 15, 2007, and finalized by November 15, 2007. The law directs CMS to consider the use of medical registry-based reporting.

ASA, in addition to beginning to explore potential registries for reporting by its members, has brought four draft measures for anesthesiologists to the AMA Physician Consortium for Performance Improvement and is working to ensure the adoption of as many as possible. See Figure 1 — and watch the ASA Web site for information on when the Consortium Web site will be ready to receive your comments.

Conclusion: Is the PQRI Going to Be Important to Us?

Yes. CMS sees the PQRI as a first step toward the agency’s transformation “from a passive payer of claims to an active purchaser of health care services.” As we already know, the objective of CMS and other payers is now “Value-Based Purchasing,” and “value” depends on ensuring quality,
Objective performance measures and transparency. Performance reporting will be the foundation of incentives and rewards for the improvement and maintenance of quality.

Finally, is the bonus going to be worth it? Take a hypothetical 10-anesthesiologist group providing 1,800 Medicare anesthetics from July through December. Assuming the average number of cases per unit is 14, because Medicare cases take longer, and that the 80-percent threshold is met, the group will receive a $6,119.82 bonus payment next summer:

<table>
<thead>
<tr>
<th>Medicare cases</th>
<th>1,800</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average units per case</td>
<td>14</td>
</tr>
<tr>
<td>Total allowed units</td>
<td>25,200</td>
</tr>
<tr>
<td>National average anesthesia conversion factor</td>
<td>$16.19</td>
</tr>
<tr>
<td>Total allowed charges</td>
<td>$407,988.00</td>
</tr>
<tr>
<td>PQRI Bonus</td>
<td>1.50%</td>
</tr>
<tr>
<td>Payment</td>
<td>$6,119.82</td>
</tr>
</tbody>
</table>

The more significant incentive is undoubtedly going to be the professional satisfaction of moving the group’s performance up into the highest decile. With a national average rate of 77 percent of surgical patients receiving prophylactic antibiotics within one hour before incision, according to hospital data reported to CMS and published at www.hospitalcompare.hhs.gov, and the top decile performing at the 95-percent level, there is room for improvement in many anesthesiology departments. A study published in the December issue of Anesthesia & Analgesia (see Source Material below) shows one hospital’s successful strategy.

Source Material:

- PQRI Web site: www.cms.hhs.gov/pqri
- To receive e-mail updates on physician issues, including PQRI, individuals can sign up for the Physician Open Door listserv at: www.cms.hhs.gov/apps/mailinglists/default.asp?audience=4
Legislation has been introduced into the Texas Legislature that would require a person to obtain a license in order to practice as an anesthesiologist assistant (AA). Although AAs in Texas currently practice pursuant to the delegatory authority of anesthesiologists as set forth in the medical board’s guidelines, licensure more clearly defines and anchors the practice of AAs in a state than delegatory authority. AAs are currently licensed in 10 states* and practice pursuant to a physician’s delegatory authority in six.†

Under H.B. 3313, an AA would be authorized to assist the supervising anesthesiologist in developing and implementing an anesthesia care plan for a patient. AAs would practice only under the direct supervision of a board-certified anesthesiologist who is physically present or immediately available. The supervising anesthesiologist may supervise no more than four AAs; an AA may have more than one supervising anesthesiologist.

In providing assistance, an AA’s scope of practice could include:

- obtaining a comprehensive patient history, performing relevant elements of the physical examination and presenting the information to the anesthesiologist;
- pretesting and calibrating anesthesia delivery systems and interpreting such information from the monitors in consultation with the anesthesiologist;
- initiating multiparameter monitoring before anesthesia or in other acute care settings under anesthesiologist supervision;
- establishing basic and advanced airway interventions, including intubation and the performance of ventilatory support;
- administering intermittent vasoactive drugs and starting and adjusting vasoactive infusions;
- administering anesthetic, adjuvant and accessory drugs;
- assisting and initiating with the supervising anesthesiologist the performance of epidural anesthetic procedures, spinal anesthetic procedures and other regional anesthetic techniques;
- providing initial CPR in response to a life-threatening situation as directed by a physician or protocol until the supervising anesthesiologist arrives;
- participating in research and clinical teaching activities as authorized by the supervising anesthesiologist; or
- performing other tasks delegated by an anesthesiologist and that the AA has been trained and proficient to perform.

Conversely AAs would be prohibited from prescribing medication or controlled substances. AAs would practice only under the supervision of an anesthesiologist or in any location where the supervising anesthesiologist is immediately available for consultation, assistance and intervention.

H.B. 3313 creates the Texas Anesthesiologist Assistant Board, which would be an advisory board to the medical board. The AA board would consist of six members, including a physician, AA, two anesthesiologists and two members from the public who are not licensed or trained in a health care profession. The board also would adopt rules that establish continuing education requirements for AAs, licensure fees, procedures for disciplinary actions and procedures to review licensure applications. The medical board would adopt rules to regulate AAs and the supervising anesthesiologists.

Lastly H.B. 3313 protects patients from misrepresentation. AAs would be prohibited from referring to a license as “board-certified” or any other terminology that implies that the AA is a physician. Student AAs would not be permitted to use the terms “intern,” “resident” or “fellow.”

Office-Based Surgery

In February 2007, the Washington Medical Quality Assurance Commission (MQAC) announced that it was considering proposed office-based surgery rules and that it
Committee on Respiratory Care

Thomas M. Fuhrman, M.D., M.M.Sc., F.C.C.M., F.C.C.P., Chair
Committee on Respiratory Care

“Only after all of those important steps will a credential in critical care be offered by NBRC. This may take several years, but the field of respiratory care will be enhanced by this project and the efforts of the members of the Committee on Respiratory Care.”

The ASA Committee on Respiratory Care is the official avenue through which ASA maintains its influence within the domain of the respiratory care practitioner (RCP). ASA and its members have always been involved as RCPs have progressed from being oxygen cylinder delivery technicians right through the heyday of intermittent positive pressure breathing to the present and future of critical care and with the growing importance of home health care.

A principal charge of the Committee on Respiratory Care is the appointment of representatives to organizations that rely on ASA for guidance as they further the field of respiratory care. These organizations include the National Board for Respiratory Care (NBRC), the Board of Medical Advisors (BOMA) to the American Association for Respiratory Care (AARC) and the Committee on Accreditation for Respiratory Care (CoARC). ASA representatives in turn are active and vital members of these organizations.

Those formal organizations with ASA representation work in consultation with AARC, the parent organization. Meetings between the organizations are undoubtedly assisted by the ASA Committee on Respiratory Care members who use their advisory capacities to facilitate the promotion and education of respiratory care.

Five members of ASA represent our Society on NBRC. This organization is responsible for developing, writing, editing and administering examinations for credentialing RCPs as registered respiratory therapists (RRTs), certified respiratory therapists (CRTs), certified and registered pulmonary function technologists and neonatal/pediatric RC specialists. The CRT examination is recognized as the basis for licensing in 48 states. NBRC administered 25,298 examinations to RCP candidates in 2006 through its secure computer-based testing system.

Two members represent ASA on the Committee on Accreditation for Respiratory Care (CoARC). CoARC is responsible for ensuring that respiratory therapy education programs comply with the standards adopted by the Commission on Accreditation of Allied Health Education Programs (CAAHEP). All respiratory therapy educational programs are accredited through CoARC reviews and site visits. (Several former and present Committee on Respiratory Care members also serve as volunteer site visitors for CoARC.)

ASA has four representatives to the AARC Board of Medical Advisors. (Other societies with representatives on BOMA include the American Thoracic Society, the
American College Chest Physicians, the American Academy of Pediatrics, the American College of Allergy and Immunology and the Society of Critical Care Medicine.)

The Committee on Respiratory Care also is responsible for providing annual reports of activities of NBRC, CoARC and BOMA to the ASA membership. These reports are presented to and reviewed by the House of Delegates at the ASA Annual Meeting.

The ASA Committee on Respiratory Care is chaired by Thomas M. Fuhrman, M.D., Professor of Anesthesiology and Perioperative Medicine at the Medical College of Georgia. Dr. Fuhrman, C. Alvin Head, M.D., the former chair of the Committee, and past committee member Robert A. May, M.D., were all respiratory therapists prior to medical school.

What’s new in the field of respiratory care? Currently NBRC is undertaking a very thorough study that may result in a credential for RCPs working in the specialized area of sleep disorder testing and therapeutic intervention. Also, of special interest to ASA members involved in critical care, NBRC has had a request to consider an adult critical care specialty examination by AARC. When such requests are received from NBRC sponsors such as AARC, the Board of Trustees follows a five-step process in considering the matter. The first step with respect to a possible adult critical care specialty examination, a viability study, was conducted on September 16-17, 2006, by a committee of experts representing organizations interested in respiratory care and, more specifically, adult critical care (including several ASA members).

If it is decided to move to the next step, a personnel survey will seek to determine an accurate estimate of the number of respiratory therapists performing adult critical care, their typical job titles and other significant information. The results of the personnel survey would then be used by NBRC to further evaluate whether or not a sufficient population exists to support the development of a specialty credentialing examination in adult critical care.

Next a job analysis/test specification (role delineation) is performed. This concerns research that determines the tasks performed by practitioners in a particular job and identifies the more important tasks for testing on national examinations. Then NBRC will undertake examination development from test specifications — that is, construction of questions that are directly linked to job analysis tasks.

Finally the validation study is performed, which will determine the correlations between an individual’s job performance as rated by an immediate supervisor and that individual’s examination score (criterion-related or predictive validity). Also, content validity is documented by the linking of test questions to important job tasks.

Only after all of those important steps will a credential in critical care be offered by NBRC. This may take several years, but the field of respiratory care will be enhanced by this project and the efforts of the members of the Committee on Respiratory Care.
The Society for the Advancement of Geriatric Anesthesia (SAGA) continues to grow while maintaining its devotion to promoting age-appropriate care to elders through education, research and training. While advanced age was historically considered to be a contraindication to surgery, advances in anesthesia now allow elders, many of whom have significant coexisting disease processes, to undergo increasingly complex surgical procedures with relatively low mortality. According to the Centers for Disease Control and Prevention, approximately 15 million patients over the age of 65 undergo surgical procedures each year in the United States. These numbers are expected to increase over the next few decades as baby boomers enter their “golden years.” As anesthesiologists we aim to prepare ourselves and our specialty for this demographic shift by increasing awareness and understanding of the unique traits of elders.

SAGA exists to improve the care of the older person having surgery through education and research. Our educational initiatives have included several important efforts. The members of SAGA have worked together with the ASA Committee on Geriatric Anesthesia and the American Geriatrics Society to develop a Geriatric Anesthesia Curriculum. This comprehensive curriculum includes both major topics and current references. It is to be posted on the ASA Web site and will be freely available to both residents and practitioners caring for vulnerable elders.

Additional efforts involve educational programs provided to other anesthesiology societies. In particular there will be several panels devoted to geriatric issues at the ASA Annual Meeting. SAGA also is collaborating with our European colleagues in the Age Anaesthesia Association www.aaa-online.org.uk (the equivalent of SAGA in the United Kingdom) to promote education in elderly perioperative care.

The research initiatives of SAGA have included several projects. Our Annual Meeting will include a poster discussion of current geriatric research from a broad range of investigators. The members of SAGA have worked together with the ASA Committee on Geriatric Anesthesia to encourage more sessions in topics pertinent to geriatric anesthesiology. In addition SAGA has been actively involved with the Foundation for Anesthesia Education and Research Geriatric Research Council in formulating a proposal for a geriatric anesthesiology fellowship that will train anesthesiologists committed to pursuing careers as teachers and physician investigators in the field of geriatric anesthesiology. Some of these efforts are coming to fruition. For instance, as “aging” anesthesiologists, we were particularly impressed with the March issue of Anesthesiology wherein a number of original articles and reviews addressed questions pertaining to cognitive and functional performance of elders in the postoperative period.

Our 8th Annual Meeting will be held in San Francisco on Sunday, October 14, 2007, from 4:30 p.m. to 6 p.m. All ASA members interested in the care of elders are invited to attend. For additional information concerning membership or Society activities, please visit the SAGA Web site at www.sagahq.org.

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Frederick E. Sieber, M.D., is Associate Professor, Director of Anesthesiology, Johns Hopkins Bayview Medical Center, Department of Anesthesiology and Critical Care Medicine, Johns Hopkins Medical Institutions, Baltimore, Maryland.
Regional Anesthesia Experience in Ho Chi Minh City

Anthony R. Plunkett, M.D.

Resident anesthesiologists at Walter Reed Army Medical Center are fortunate to have the opportunity to participate in medical humanitarian missions as part of their training. Attending anesthesiologists have taken residents to a wide variety of countries, including Ecuador, Peru, Honduras, Eritrea and El Salvador. These missions are intended to train military residents “austere environment” anesthetic techniques in medically underserved areas of the world. Furthermore these missions expose our trainees to the realities of field medicine and educate the resident on how to provide safe anesthetic care regardless of the surroundings. These environments are not dissimilar to those encountered on the modern battlefield or in times of national disaster, where the luxuries of state-of-the-art technology and ample supplies are not always available.

This year I had the pleasure of participating in a mission to Ho Chi Minh City (formerly Saigon), Vietnam. The purpose of the mission was to educate Vietnamese anesthetists in the use of neurostimulation and ultrasound for peripheral nerve blocks and continuous peripheral nerve blocks.

The funding for this mission was provided through our department and the John P. Murtha Neuroscience and Pain Institute. The project was coordinated through the private nonprofit organization Health Volunteers Overseas (HVO). HVO promotes health care through training and education in 11 specialty areas: anesthesiology, burn management, dentistry, dermatology, hand surgery, internal medicine, nursing, oral and maxillo-facial surgery, orthopedics, pediatrics and physical therapy. HVO specifically supports anesthesia missions in Eritrea, India, Peru, South Africa, St. Lucia, Tanzania and Vietnam.

Ho Chi Minh City is located in the southern part of Vietnam near the Mekong Delta. It is the largest city in Vietnam with an estimated 9 million people in 809 square miles. There are approximately 80 publicly owned hospitals/medical centers and dozens of privately owned clinics. We worked in the Center for Traumatology and Orthopaedics (CTO).

CTO is the main referral center for all orthopedic injuries in Saigon and its outlying areas. It is a 440-bed hospital with seven operating rooms. The operating rooms are divided into upper-extremity, lower-extremity, spine, pediatrics and trauma. There are approximately 1,000 clinic visits daily. Ten nurse anesthetists and an equal number of attending anesthesiologists support an average case load ranging from 100-140 cases per week.

The anesthesia providers are very skilled at the paresthesia technique for administering regional anesthesia. They most commonly perform interscalene, axillary and femoral blocks. They use little to no sedation during block procedures. All patients are placed on standard monitors for...
American Society of Anesthesiologists NEWSLETTER
Volume 71 ■ Number 5 ■ May 2007

block procedures. One of the main reasons for the continued use of the paresthesia technique is the cost and unavailability of nerve stimulators and insulated needles. This is rapidly changing as major regional anesthesia supply companies are taking interest in Vietnam’s emerging economy.

Our educational mission was divided into two one-week training sessions. During the first week, we provided group discussions centered on a cadaver workshop in a local medical school anatomy laboratory. The cadaver workshop consisted of five cadaver stations/dissections: brachial plexus, femoral nerve, sciatic nerve, paravertebral and ultrasound (live models served as the models for the ultrasound laboratory). We spent the second week in the postanesthesia care unit supervising regional anesthetics on various orthopedic patients using a nerve stimulator (B Braun Stimuplex® HNS 12 Nerve Stimulator) and ultrasound (Micromaxx™, Sonosite). We did not emphasize the ultrasound component, however, as it was unlikely the hospital would be able to afford its own machine. We did use the ultrasound to confirm anatomical relationships and to build confidence in trainees in the use of external anatomy for stimulation blocks. There were, on average, 10-12 trainees and staff observing each block performed (and sometimes as many as 20 surrounding one patient).

By the week’s end, we performed 60 nerve blocks, including four lumbar plexus continuous peripheral nerve blocks (which they had never experienced previously). We demonstrated each of the following blocks: interscalene, supraclavicular, infraclavicular, femoral, lumbar plexus, sciatic and lateral sciatic. The staff and trainees were extremely enthusiastic, quick learners and eager to perform the blocks themselves. By the third to fourth day, they were preparing the patients themselves and performing the blocks with our minimal guidance.

I would highly recommend that my resident colleagues pursue and participate in these opportunities. The Society for Education in Anesthesia (SEA) offers the SEA-HVO Traveling Fellowship, which allows senior residents and fellows to participate in a three- to four-week anesthesia mission in a developing country. Although we were invited to the hospital to teach, by the end of my experience, I felt that I was the one who gained a tremendous amount of knowledge. Before the end of the mission, our hosts had acquired two B Braun Stimuplex® HNS 12 nerve stimulators along with 50 nerve block needles. We had no doubt they would be put to good use. Presently we are planning a second visit in 2008.

planned to hold four public workshops titled “Safe and Effective Analgesia and Anesthesia Administration in Office-Based Surgical Settings.” The first three meetings were held in February and March.

This subject has been a topic of discussion for the past four years. In fact MQAC has previously held public workshops, issued obstetric anesthesia (OBA) guidelines and drafted rules. The Washington State Society of Anesthesiologists (WSSA) has been an active participant throughout this process. WSSA has attended the public workshops and communicated its position to MQAC, Department of Health, the Washington State Medical Association and state legislators.

One of the primary hurdles in developing OBA regulations is to establish that MQAC is authorized to regulate the office setting. Legislation has been introduced that would be a significant step toward the development of these rules. H.B. 1414 would provide MQAC, the Board of Osteopathic Medicine and Surgery and the Podiatric Medical Board with the authority to adopt office-based surgery regulations. Washington would join the 22 states that regulate the office setting via statute, regulation or guidelines.

**Scope of Practice**

The **Louisiana** Supreme Court denied the Louisiana State Board of Nursing’s petition to review the lower court’s decision. The lower court ruled that the board’s statement was a rule, subject to the Louisiana Administrative Procedures Act, and issued a preliminary injunction against the nursing board and nurse anesthetist who sought the statement. The “statement” authorized nurse anesthetists to perform interventional pain management procedures (for background, see [www.ASAhq.org/Newsletters/2007/02-07/stateBeat02_07.html](http://www.ASAhq.org/Newsletters/2007/02-07/stateBeat02_07.html)). The Louisiana Society of Anesthesiologists (LSA) and ASA continue to monitor this lawsuit as there are several unresolved issues at the trial court level. Congratulations to LSA for its hard work!
AMA Meeting to Include Issues for Section Council

Officials from the Society’s Section Council on Anesthesiology of the American Medical Association (AMA) would like to know the names of ASA members planning to attend the AMA Annual Meeting on June 23-27, 2007, in Chicago.

The Section Council is open to all anesthesiologists who attend the AMA House of Delegates meeting. The Section Council meets to discuss resolutions and other issues of importance to anesthesiologists. Meetings usually take place on Saturday and/or Monday of the AMA House of Delegates meeting. If you are attending the House of Delegates meeting, the Society would welcome your participation.

To be placed on the mailing list to receive information on the Society’s AMA Section Council meetings, please send your name, address, telephone number, fax number, e-mail address and reason for attendance to Denise M. Jones at the ASA Executive Office, 520 N. Northwest Highway, Park Ridge, IL 60068; or fax (847) 825-2085.

Book/Multimedia Education Award

The Anesthesia Foundation announces the Book/Multimedia Education Award to be presented at the ASA 2008 Annual Meeting.

This prestigious award will be given for excellence and innovation in books or multimedia with significant impact on the science and practice of anesthesiology, critical care or pain medicine. No more than two author submissions are eligible.

The award is $10,000 (to be divided if there are two authors) plus expenses for the first author and guest to attend the Academy of Anesthesiology 2009 Spring Meeting in St. Petersburg, Florida.

Deadline for receipt of contributions is November 15, 2007.

For further information and specific criterion, please contact www.anesthesiafoundation.org/index.html.

ABA Announces …

To All Who Became Board-Certified in or After 2000

To those anesthesiologists who were board-certified in or after 2000, the American Board of Anesthesiology (ABA) has automatically enrolled you into its Maintenance of Certification in Anesthesiology (MOCA®) program. You should go to the ABA Web site www.theABA.org, log into your personal portal account and view your MOCA Progress Report to determine what you need to do in order to complete the MOCA program before your 10-year certification expires. Failure to complete all MOCA requirements before certification expires will result in your LOSS OF ABA CERTIFICATION.

All MOCA requirements must be met in order to retain certification after its initial 10-year period. The answers to frequently asked questions related to the MOCA program and instructions on how to report your continuing medical education (CME) to ABA can be found on the ABA Web site.

You should know that you may not be able to retain your certification if you have not reported CME and other lifelong learning activities to the ABA via your portal account. If you have not done so already, you should start to report your CME and other lifelong learning activities this year.

ABA strongly encourages anesthesiologists who became ABA-certified in 2000 or later to begin reporting their CME and lifelong learning activities as soon as possible.

In Memoriam

Notice has been received of the deaths of the following ASA members.

Paul B. Comer, M.D. Keay Hachiya, M.D.
Great Falls, Montana Lincoln, Nebraska
December 17, 2006 November 4, 2006

Jay S. DeVore, M.D. Patricia M. O’Neil, M.D.
Kill Devil Hills, North Carolina South Jordan, Utah
February 28, 2007 September 7, 2006

George F. Eden, M.D. John T. Roper, M.D.
Bellaire, Texas Concord, North Carolina
January 2, 2007 March 16, 2007

Charles E. Flanders, Jr., M.D. Paul E. Shutts, M.D.
Darien, Georgia Houston, Texas
April 13, 2006 September 2, 2006
Twin Billing
Robert T. Wilder, M.D., Ph.D., was quoted in a January 4 Post-Bulletin (Rochester, Minnesota) article on the successful separation of conjoined twins Abby and Maddy Fitter. Dr. Wilder was the anesthesiologist during the separation surgery.

Topflight Training for Docs
Richard I. Cook, M.D., was quoted in a January 9 Chicago Tribune article on the use of aviation-based safety techniques and training at Evanston Northwestern Healthcare. Dr. Cook discussed the need for conclusive data on the differences and safety improvements that result from this type of training.

Weeding Out Patients for Surgery
Bevelyn K. Philip, M.D., provided insight on factors that help to determine appropriate patients for outpatient surgery in an article in the January issue of Same Day Surgery.

Anesthesiologist Gives Prez Premium Info
James B. Kelly, Jr., M.D., participated in a Health Care Initiatives roundtable with President Bush on January 25. Dr. Kelly provided information on malpractice insurance premiums in Missouri and highlighted the efforts of ASA to reduce liabilities and premiums for anesthesiologists through first improving the safety of the patient.

Advancing Pain Medicine With the Ear
In an article in the January 31 The Washingtonian, Zena N. Quezado, M.D., commented on advances in pain management and the importance of listening.

New Hospital President Announced
The February 11 The Capital (Annapolis, Maryland) announced that Paul T. Elder, M.D., was named the new president of Anne Arundel Medical Center's medical staff. Dr. Elder has been with the hospital for 22 years.

Philippines Mission
The February 19 The Patriot News (Harrisburg, Pennsylvania) reported that William C. Motter, M.D., was among 30 physicians who traveled to the Philippines as part of the World Surgical Foundation team. The team performed 430 surgeries at Romblon District Hospital during a two-week mission.

Fine Work in Hospice Care
The March 5 The Daily Utah Chronicle announced that Perry G. Fine, M.D., received the Josefina B. Mango Distinguished Hospice Physician Award from the American Academy of Hospice and Palliative Care Medicine for his work in pain management and end-of-life care.

The ASA Communications Department is interested in hearing from members who have been quoted in the media. To let us know that you have been interviewed, or for assistance with media relations, contact Donna Habich d.habich@ASAhq.org or Brittny Dziadula b.dziadula@ASAhq.org in the ASA Communications Department or call (847) 825-5586.
Offended Anesthesiologist on the Defensive

I read Dr. Bacon’s February 2007 “From the Crow’s Nest” in regard to the decision of anesthesiologists not to anesthetize Michael E. DeBakey, M.D. I am in agreement with Dr. Bacon.

All of us anesthesiologists have been in similar situations. In each case, the ethics of the situation and the patient’s wishes should have been paramount. Nevertheless, overly aggressive surgeons wish to proceed by finding some family who is willing to sign the consent.

For reasons that are beyond comprehension, the surgeon wishes to proceed at all costs in such cases without any regard for the patient’s rights, wishes or the medical consequences. These episodes are widespread in American hospitals.

The anesthesiologists, when lacking the surgeon’s support, then have to resort to itemizing the multiple medical reasons as additional justification for why such surgical undertakings are foolhardy. Why are the ethics of the situation not enough?

Texts on surgical ethics never discuss such situations and ignore their existence. Dr. Bacon should be encouraged to open a dialog about this matter with the American College of Surgeons. Our surgical colleagues should be at least as well versed in the ethics of these situations as we are.

Why is it that we are always placed on the defensive for holding the high moral ground? Why are we forced to provide additional medical justification for our position?

Lee A. Balaklaw, M.D.
Louisa, Kentucky

Editorial Underscores Anesthesiologists’ Real Roles

I found your “Shadow Warriors” (February 2007) fascinating and thought-provoking but must disagree with your conclusions.

Once Dr. DeBakey was unconscious, his wife was legally authorized to decide on his treatment. Assured by a competent surgeon that there was a chance (even though slim) to save her husband, any loving wife would accept surgery. The do-not-resuscitate orders signed by a patient often impose a great emotional burden on the next of kin. The decision to operate rested with the wife, not with some ethics committee. The hospital director’s opposition to another anesthetist was both petty and illegal.

Your analogy to the Jehovah’s Witnesses is misleading: “Witnesses” not only refuse transfusions but their families almost always oppose blood administration.

Once the next of kin and the surgeon agree to proceed with the surgery, an anesthesiologist is not qualified to interfere with the decision. Many dissecting thoracic aneurysms have been successfully operated. The first anesthetist may have felt incompetent to provide this challenging anesthesia or may have been more honest to say so to the surgeon and his colleague during the procedure.

It is not the anesthetist’s role to decide on the surgery. His duty is to offer his (not unconsiderable) skills to help the surgeon perform the procedure and keep the patient alive. John Snow, to my knowledge, never refused to administer an anesthetic to a sick patient. In fact, he mentioned several times that no patient was too sick to undergo a skillful anesthesia. And that skill won him the esteem of his surgical colleagues and the London public.

Sorry to disagree, Doug. Again, I immensely enjoyed reading your editorial.

Ray J. Defalque, M.D., M.S.
Birmingham, Alabama

Victimizing the Victim

The “From the Crow’s Nest” editorial published in February 2007 explores in a perceptive manner the clinical and ethical issues surrounding the perioperative decisions concerning the aortic aneurysm surgery of Michael DeBakey, M.D., albeit based on a solitary news report by Lawrence Altman, M.D.1-2 However, this sensitivity abruptly disappears in the last paragraph when Dr. Bacon accuses the anesthesiologists of doing a “disservice to both the profession and themselves” by not speaking publicly about this patient care episode. To me this is victimizing the “victim.” Not only did the anesthesiologists not have an obligation to speak to the media, but such an interaction may have been counterproductive. Although Dr. DeBakey reportedly “permitted his doctors to talk,” there are HIPAA-related issues of patient confidentiality. Second, the Methodist Hospital anesthesiology group may have
been appropriately concerned about its ability to get its side of the story to the public in an unbiased fashion.

Many who deal with the press, both print and media, have witnessed on a personal basis that a long interview is often reduced to a 15-second sound bite or a one-sentence quote taken out of context. The veracity and ethics of the press have come under such scrutiny that even the New York Times itself, Dr. Altman’s own newspaper, regularly publishes a column titled the “Public Editor” by Bryon Calame (Public Editor) to discuss issues of biased, incorrect or incomplete reporting of events in the Times. As a matter of fact, in a November 5, 2006, column (unrelated to the DeBakey story) he states:

Seeking comment from those written about, especially when they are put in an unfavorable light, is a particularly important aspect of fair coverage. It helps ensure that readers get the most complete and accurate view possible of a newsworthy development. Unfortunately, The Times has had too many cases recently where subjects weren’t given a chance to comment, or the attempt to reach them was insufficient.3

To continue the use of the military metaphor employed by Dr. Bacon in the editorial piece: Not all battles are won by a frontal attack!

Paul G. Barash, M.D.
Orange, Connecticut

References:

‘Shadow Warriors’ Editorial Highlights Ethical Dilemma

Dr. Bacon, in your “DeBakey” editorial (February 2007), you handled a very difficult and sensitive subject with great skill, balance, compassion and consummate tact, while pointing out the professional rights and privileges of all members of the team and the patient. These ethical and moral dilemmas with which we are called upon to grapple often defy a clear resolution.

I just wanted you to know how much I admire your astute and thoughtful analysis.

Best personal regards.

Clyde W. Jones, M.D.
San Diego, California

Shield Your Eyes: February NEWSLETTER Cover Potential Health Hazard

I am confused.

Why are protective eyewear and gowns recommended/required for central line insertion and operative procedures, whereas the cover photo of the February 2007 ASA NEWSLETTER clearly shows an obstetric anesthesiologist performing an epidural without eyewear protection or utilizing a sterile gown? Likewise, the photo on page 13 of that same issue reveals the lack of protective eyewear by all of the members of the obstetric operative team.

Is protective eyewear for providers appropriate, or is it not? In our state, the State Board of Health requires eyewear

‘World Awaits Neuraxial Blockade Infection Recommendations

Reading of the article about complications related to infections after neuraxial blockade in obstetrics, written by Samuel C. Hughes, M.D., was an intellectual pleasure.1 It was really reassuring to have this subject being debated after many decades of generalized neglect. Regarding this important adverse event, the recommendations that will be discussed by the task force1 are really very important worldwide, because many other countries look up to ASA for help in guiding improvements in their own standards.

As it has been pointed out by Auroy et al., the control of rare events requires analysis of both outcomes and process of care.2 We definitively need to improve the care we have with the many steps related to neuraxial anesthesia, especially in countries where equipment for regional anesthesia is unfortunately still being reprocessed. These ASA recommendations or practice guidelines are eagerly awaited by many of us outside the United States.

Rogerio L.R. Videira, M.D.
São Paulo, Brazil

References:
protection, including side shields, or similar protection, for all persons in the operating rooms. Is there any reason to believe that potential fluid or blood splatter to a physician’s eyes from an HIV or hepatitis-positive patient is any less serious for a physician in the obstetric area as it is in the operating room area?

Epidural infections are indeed devastating complications. If gowns and gloves are effective in decreasing central line infections (same issue, page 8), why are those protective elements not effective in dimishing infections during placement of epidurals? Similar to central line-related sepsis, neuraxial infection can be easily missed and/or under-reported.

What is appropriate? Is there really a difference between the operating room, the intensive care unit and an operative obstetric suite concerning appropriate sterile technique?

I would recommend that the appropriate ASA committee(s) address this issue.

Steven R. Young, M.D.
Indianapolis, Indiana

‘A New Responsibility’ Meets Age-Old Wisdom

I expect this letter to the editor to be trashed under one of the following categories: Dr. Angiulo doesn’t know about which he writes, and/or Dr. Angiulo is not making a politically correct statement, and/or Dr. Angiulo doesn’t know the facts and/or law of the case about which our past president is writing (March 2007 “Administrative Update: A New Responsibility”).

I have been a practicing physician for 34 years, an attorney and member of the Arizona Bar for 21 years, a pro tem or full-time judge for 11 years and a grandchild for 59 years, though my grandparents have been deceased.

My heritage has taught me that unless I could say something good about a person, say nothing at all. How is this different from a request for information about a colleague in practice? Tell the truth or, absent a legal requirement to respond, say nothing at all.

Treat a request for information as if it will be used to give you the truth about a physician who is about to perform his/her services on you or a close family member. Do we really need courts to tell us these basic, common sense principles? These are the principles that my grandparents passed on to me long before they passed away.

Thank you for consideration of my letter to the editor.

James P. Angiulo, M.D., J.D.
Tucson, Arizona

A Wife’s Response to Dr. Bacon’s ‘Blue and Gold Stars’

I was moved to tears as I read the March “From the Crow’s Nest” in the ASA NEWSLETTER. In response, after collecting my composure, I say a passionate “thank you” to Dr. Bacon.

I am a Blue Star wife! My husband, Col. William W. Pond, M.D., anesthesiologist, is currently deployed to Baghdad in support of Iraqi Freedom for the fourth time. In this deployment, he serves as Commander to the 447th EMEDS Hospital in which he is ranking physician. In past deployments, he served as a member of the Critical Care Air Transport (CCAT) team, an airborne rescue team. I am proud of my husband’s service to our country. I miss him greatly.

I pass the time keeping busy as a diversion. I just returned from Cambodia serving as a member of Operation Smile, a humanitarian medical team serving children in third-world countries that provide free surgical repair of cleft lips and palates. This was my 12th mission overseas, and I can truly state that nowhere in the world does better health care exist than in our great nation. I deeply appreciate members in our medical field who sacrifice long hours to those in need of treatment both here and abroad.

Our troops deserve the same respect and medical care. And they need good doctors. I commend you for your support of their endeavors, faced with danger and adversity, as they provide care to our wounded husbands, sons and daughters. I can assure you that no one knows what it is like to stay back home without their loved one unless they live it, because despite the many diversions that I place in my path in the course of the day, I come home to an empty, still house with the cold reality that my husband is in harm’s way. He is away from his practice and our family protecting others, defending the freedoms that you and I enjoy.

Many in our country at present do not support our troops in service, citing various political reasons. And hence, sadly, where once was patriotism now lies contempt.

Yes, save a place for them, and remember to thank them for their service to our country when they return home! They, indeed, have honored the “flags of our fathers.”

Thank you for defending their honor.

Camille M. Pond
Fort Wayne, Indiana
The scope and safety of anesthesiology would not exist as it does today without the commitment of researchers and educators in anesthesiology, past and present. Because of their tenacity and dedication, we practice in an environment that is a wealth of knowledge, technology and clinical expertise. Every anesthesiologist practicing today has gained from recent discoveries in science and technology based on the education and innovative research that has taken place in our country’s medical institutions. Whether in private practice or academia, anesthesiologists, their patients and their practices benefit from these efforts.

We live in an age of sophisticated technology and rapidly advancing science. We must embrace change or the world of medicine will move to eclipse us. Complacency is unacceptable in a flat world. For a decade or longer, the editors of Anesthesiology and Anesthesia & Analgesia have observed the shift of scientific work and authorship to international departments. To compete more effectively, anesthesiology departments must maintain a strong work ethic and achieve academic excellence. Ultimately only pre-eminence in the clinical sciences will ensure the success of our private practices. To guarantee this outcome, we must sustain a growing investment in research and education.

Mark A. Gerhardt, M.D., Ph.D., a recent Foundation for Anesthesia Education and Research (FAER) award recipient from Ohio State University, makes the case succinctly. His report to FAER states, “The FAER/SCA Award has been critically important with respect to my career development. It has allowed me to establish a publication record and acquire data to support a hypothesis-driven NIH RO1 application. Despite the current trend in NIH funding, as a first-time RO1 award applicant I feel that the data and research program that I was able to build under FAER support allows me to be competitive. The grant provided a measure of credibility as an independent investigator and protected research time within my department/institution, a benefit that cannot be overstated given the workforce shortage clinically. Novel research pathways have been generated from the FAER-funding observations. Continued support of FAER research grants for young independent investigators is imperative for the success of academic anesthesiology.”

At the February 2007 deadline, we received 31 grant applications looking to FAER for the professional development of young scientists who demonstrate a keen interest in a research career in anesthesiology. Research funding in anesthesiology and perioperative medicine offers great opportunities to build a dynamic, state-of-the-art specialty. The number of grants funded each year depends, however, in large measure upon your personal advocacy and financial support. By giving back, individuals, departments, private practices and subspecialty groups join in a united effort that ultimately benefits their colleagues, practices and patients.