Impending factors such as an aging baby boomer population and increased competition for research grants are forcing regional anesthesiology to look at new and proactive ways to keep the subspecialty at the forefront of a changing health care environment.

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

The opinions expressed here are solely that of the editor.

One of the classic episodes of “Star Trek,” the original series, is titled The Enemy Within. On a mission to survey a class “M” planet, Captain James T. Kirk beams down to the planet’s surface with various crew members to study flora and fauna and the environment in an effort to determine if the planet could support colonization. On return to the ship, there is a transporter malfunction, one which splits Kirk into two beings — one good, the other bad. The “evil” Kirk indulges his vices, essentially wine, women and song. The good Kirk is increasingly unable to make decisions and vacillates unlike the strong leader the captain has always been. Spock, the cerebral science officer, glimmers the reason — the “evil” Kirk is integral to making decisive decisions, but only under the discipline and the motivations of the “good” Kirk. In the end, the brilliant engineer Scotty fixes the transporter and beams the two beings into one whole Kirk. In a classic line, Kirk tells Spock that he has seen a part of himself that no man ought to see.

Perhaps the creators of “Star Trek” were on to something. The ethics with which we practice on a daily basis are in many respects a balance of our “good” and “bad” selves. Our internal moral compass gives us an intuitive sense of what is permissible and what is not. When conflict develops between our internal moral compass and the external societal expectations of correct ethical behavior, the practice of medicine becomes morally difficult; for example, the Jehovah’s Witness patient who for whatever reason begins to experience life-threatening hemorrhage during an operation and quite literally is dying before the anesthesiologist’s eyes. A simple blood transfusion will save the patient’s life, and in patients who are not Jehovah’s Witnesses, red cell and blood product transfusion is routine care. Yet, morally, we know that the Jehovah’s Witness patient has refused this treatment. We are obligated as physicians to respect this religious tenet and work hard to save the patient by all means short of transfusion. For some physicians, though, letting anyone die who can be saved is unethical, and balancing the wishes of patient autonomy with paternalistically appropriate medical care remains extremely difficult.

One of the more contentious ethical issues that has come before the anesthesiology community in the last 18 months is the participation of anesthesiologists in capital punishment. The American Medical Association (AMA) has a clear policy on physician participation in this act of the state, and ASA has endorsed AMA’s position. In essence, the AMA policy is that any participation by a physician in any aspect of capital punishment is unethical, including determining if the condemned is dead and witnessing the execution as a professional witness. As a policy, it is well written and clear, with little room for interpretation. Thus it is easy to understand and follow and makes obvious the behavior deemed by AMA to be unethical.

In the September issue of the Mayo Clinic Proceedings, an anesthesiologist and ethicist, David Waisel, M.D., argues against the AMA policy in an article titled “Physician Participation in Capital Punishment.” Additionally, his article outlines reasons why it may be permissible for physicians to be involved with executions, though his writing does not address the larger issues surrounding the ongoing debate about the appropriateness of capital punishment in general. Dr. Waisel’s essay is accompanied by two editorial comments — one by two respected anesthesiologists (William Lanier, M.D., and Keith Berge, M.D.) and another by a well-known ethicist (Arthur Caplan, Ph.D.). Taken as a whole, these three documents make fascinating reading, leaving the reader wondering which of the persuasive arguments should be internalized and become part of a personal ethical code and which are less valuable to the reader.

Dr. Waisel bases his argument on compassion for the
condemned criminal in that the improper administration of execution drugs constitutes cruel and unusual punishment. For physicians who care for patients on a daily basis — and for anesthesiologists specifically, who rarely deal with the complications of drugs inadvertently administered subcutaneously — this argument almost engenders a reaction on the subconscious level. We, as anesthesiologists, do not like to see people hurt. Perhaps that is why the dismissive editorial of the nonphysician, Dr. Caplan, bothers me the most. His editorial consists of the usual ethical principle and moral arguments, ones that could easily be used to teach undergraduate courses in ethics. The answer is clear, concise and sterile. Yet for physicians, who have to apply these principles and opinions to the clinical situation before them, the answer never seems to be so transparent. Dr. Waisel’s unique perspective, that viewing the condemned as a patient will allow for physician participation in capital punishment, is something that Dr. Caplan cannot understand.

Drs. Lanier and Berge, both practicing anesthesiologists, acknowledge in their editorial this uncouth treatment of patient care, despite all reluctance on their part to call the condemned a patient. The opposition to Dr. Waisel’s arguments from Drs. Lanier and Berge are well reasoned, and they point out the underlying assumption that the issue of participation cannot be pulled out of the greater discussion surrounding capital punishment. As they point out, however, there are concerns with the current process and the means by which execution is carried out. Training executioners to monitor depth of anesthesia and intravenous access, the two areas where many of the problems with lethal injection have occurred, violates AMA and, by extension, ASA policy. The convenient argument that veterinarian drugs and hence veterinarians should be substituted for physicians is passing the buck to another group that may be as reluctant to address or participate in the execution. The condemned is treated by an “animal doctor,” further dehumanizing the prisoner.

Throughout the three essays, the specter of the Nazi doctors, the purely evil side of medicine, haunts the debate. But almost always, there is little discussion of why Nazi physicians acted as they did. Dr. Waisel, an accomplished historian of anesthesiology in World War II, offers some insight. What is often forgotten is that while the crimes were horrific and the atrocities still scream out for retribution some 60 years later, the medical personnel were products of their time. The eugenics movement, taken to extremes in Nazi Germany, was, however, openly discussed in America. Anti-semitism, the cornerstone of Nazi political thought, had its dark underside in the United States as well. During medical school in the early 1980s, one of the professors, a semi-retired pathologist who taught me, spoke about the quota for acceptance of Jewish medical students in the 1930s. In point of fact, many of the leading medical schools and universities in this country in the 1920s and 1930s limited Jewish enrollment. The Nazi physicians had followed one branch of teaching to what they perceived as a logical conclusion — one that only the “evil” Kirk could imagine. To prove their hypothesis, they often massaged data to fit their hypothesis and ignored other observations that were contrary to what they wished to prove. As 21st-century physicians, it would be nice to say that we do not have these faults and that clearly they are not prevalent to the extent present in Nazi Germany. There are instances, though, whereby zealots have falsified data and published what amounted to fiction to further their goal. Only vigilant work by other doubting scientists in a society that encourages debate has demonstrated these grievous errors.

In the final analysis, what keeps us from descending into the abyss of Nazi Germany, as Dr. Waisel argues, is our open and free society. The importance of Dr. Waisel’s article, Drs. Berge and Lanier’s editorial and the thoughts of Dr. Caplan are not that any one particular individual is right but that there is respectful debate on all aspects of these questions. The first sentence of the AMA’s position on capital punishment states, “An individual’s opinion on capital punishment is the personal moral decision of the individual.” Why then is participation condemned by AMA? If an individual favors capital punishment, why is it unethical for that person to participate? The AMA position is extremely restrictive, for an overt act such as starting an intravenous line is prohibited as well as the more covert rendering of technical advice about the amount of drug to be used.

In 2001, Faber et al. did an interesting study. In an anonymous questionnaire, they asked physicians if they would be willing to participate in capital punishment. The striking finding is that 19 percent of the respondents were willing to administer the lethal drugs, while 36 percent were willing to declare the patient dead — both actions specifically prohibited by AMA. If this study is accurate, there are a significant number of physicians who do not feel the AMA policy, and by extension the ASA policy, fully covers the situation. Has the time come for ASA to study this question? As this issue continues to smolder, anesthesiologists and other members of the anesthesia care team will most likely be asked to help develop skills for the executioner in intravenous line insertion and monitoring of anesthetic depth. If we choose to enter into this debate, we must ensure that voices that represent a minority, such as David Waisel’s, are heard and allowed to participate in the discussion. We must learn to allow our intellect to help discipline our emotions — yet we cannot

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What’s in a Strategic Plan?

Arthur M. Boudreaux, M.D.
Assistant Secretary

In his book *The Richest Man Who Ever Lived,* Steven K. Scott discusses King Solomon’s secrets to success, wealth and happiness. Solomon, purportedly one of the wisest men who ever lived, stressed the importance of vision and diligence in achieving success at any endeavor. Mr. Scott defines vision as “a precise, clearly defined goal with a detailed plan and timetable for achieving that goal.” Of equal importance is diligence, “a learnable skill that combines creative persistence, a smart-working effort rightly planned and rightly performed in a timely, efficient, and effective manner…”

Strategic planning is an important part of most large organizations. Some groups, however, spend much time and effort on the planning process, generate a thoughtful document, congratulate themselves on a job well done, and never implement any of the strategies proposed. The vision may be too broad, the goals not realistic or perhaps external circumstances arise to derail the process.

“We have heard much in the past few months about our strengths in patient safety, membership, education, support for research and advocacy. Our leadership has discussed the need for organizational improvement to make us more efficient and effective in order to position our Society and our specialty for the myriad changes in medical practice expected in the future. Strategic planning with vision and performed with diligence will assist us in achieving our goals.

At the August Board of Directors meeting, the Administrative Council approved a strategic plan for 2007-09 and distributed it to the Board of Directors for comment and feedback. Some highlights of the plan follow:

**A. New Vision and Mission Statements:**

**Vision**
ASA is the world’s premier medical specialty organization, leading through innovation in patient safety, clinical care, advocacy, education and research.

**Mission**
ASA is an organization of physicians and other professionals, dedicated to serving the best interests of its members and their patients. ASA supports patient safety by promoting improved quality, ethical behavior, discovery of new knowledge and involvement of an anesthesiologist with every patient receiving anesthesia services, including perioperative care, pain management and critical care.

**B. Values**
This section describes the values of our Society and its members. It includes the paramount importance of safe patient care, integrity, ethical behavior, respect for the rights of patients, promotion and dissemination of educational information, active promotion of new knowledge, advocacy for the specialty as the practice of medicine and for fair compensation for our services and encouragement for leadership and participation in professional, community service and charitable organizations.

**C. Strategic Priorities**
This section includes 10 specific, detailed goals and objectives for fulfilling our mission. These goals involve education and training, advocacy for the specialty, increasing member value, support of the subspecialty societies and for the work and goals of ASA’s foundations, support for research, and development of an effective organizational infrastructure.

We will utilize the new strategic plan as a guide for officers, staff, division chiefs, section chairs and committee chairs to direct committee and staff work products for future years. With this focus, we will be able to more effectively

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GAO Confirms Huge Medicare Conversion Factor Disparity for Anesthesiology

Ronald Szabat, J.D., LL.M.
Executive Vice-President – External Affairs and General Counsel

In a long-expected study, recently completed and released, the federal government’s General Accountability Office (GAO) has independently verified what ASA members have long known. Payments under Medicare for anesthesiology services are disproportionately lower than private payer “reimbursement” for comparable services. All told, and based on its methodology as discussed below, GAO says that Medicare anesthesia payments are 67 percent lower than average commercial payments.

Since the inception of Medicare’s resource-based relative value payment system, ASA has made the case that anesthesiology has been significantly undervalued and underpaid. ASA’s own biennial surveys have shown that Medicare payment for anesthesiologists is a mere fraction of what private insurance companies pay. And ASA advocacy efforts, both on the regulatory and legislative sides, have consistently made the case that the Medicare anesthesia conversion factor dramatically lags that of the private sector.

In support of gaining independent data to help Congress and the Administration, several years ago Rep. Fortney “Pete” Stark (D-CA), now chair of the House Ways and Means Health Subcommittee, and former Representative and Chairwoman Nancy Johnson (R-CT) asked GAO to take a hard look at government payments for Medicare anesthesia services. In asking GAO for a comprehensive study, Reps. Stark and Johnson expressed concern that the difference between Medicare and private anesthesia payments could create regional discrepancies in the supply of anesthesiologists, and they asked GAO to explore the issue in depth.

Specifically, GAO was asked to study the extent to which Medicare payments for anesthesia services were lower than private payments across Medicare payment localities in 2004 and whether or not the supply of anesthesia practitioners across Medicare payment localities at that time was related to the differences between Medicare and private payments for anesthesia services, or to the concentration of Medicare beneficiaries in these localities.

In a far-ranging report that admittedly used claims data from only two large anesthesia service billing companies for seven principal anesthesia services in 41 Medicare payment localities, GAO nonetheless reached conclusions verifying a huge payment disparity. As included in the report, “[for] 2004, average Medicare payments for the seven anesthesia services ranged from $177 to $303 across the 41 payment localities, a range of 71 percent.” At the same time, GAO concludes that “average private payments for the same set of seven anesthesia services … ranged from $472 to over $1,300 across these localities, a range of 177 percent (emphasis added).”

... GAO says that Medicare anesthesia payments are 67 percent lower than average commercial payments.”

Ronald Szabat, J.D., LL.M., is ASA Executive Vice-President – External Affairs and General Counsel, managing its Washington, D.C., office.
Not surprisingly, GAO also found that the number of anesthesiologists decreased as the concentration of Medicare beneficiaries increased in 87 payment localities. This fact alone gives new teeth to arguments long made by ASA and other national medical specialty organizations that the comparatively lower rates of Medicare payment, now coupled with annual threats of sustainable growth rate payment cuts, are a severe disincentive for physicians to practice in areas with a high concentration of Medicare beneficiaries.

Despite repeated attempts by ASA to supply data and assist GAO in its efforts, the report specifically did not review hospital stipend levels, thus failing to study any correlation between anesthesiologist supply and Medicare beneficiary numbers — a possible marker of cost-shifting to cover Medicare physician payment shortfalls. ASA believes this was a major missed opportunity by GAO to highlight another indicator of Medicare payment problems.

All told and despite its methodological limitations, the GAO report is useful in making the case for legislative and regulatory reform for anesthesiology payments. Along these lines, ASA’s own landmark work through the American Medical Association’s (AMA’s) Relative Value Update Committee should produce significant relief as Medicare considers thousands of comments from ASA members in support of an increase in the Medicare anesthesia conversion factor for 2008. Stay tuned for more on that in the coming months.


Administrative Update: What’s in a Strategic Plan?

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meet our fiduciary responsibilities to our members and fulfill our vision and mission as stated above. The strategic plan will be revised as needed on a timely basis. The goals are reasonable and achievable. ASA is fortunate to have hundreds of volunteer physicians and other members and staff who will most certainly provide the “creative persistence and smart-working effort” necessary to fulfill each goal. We should all look forward to a bright future for our Society and for the medical specialty of anesthesiology.

Reference:
A discussion is unfolding within anesthesiology circles regarding the apparent demise of anesthesiology physician scientists in academic medicine. Although not addressing regional anesthesia specifically, an article in the journal Anesthesiology by Debra A. Schwinn, M.D., and Jeffrey S. Balser, M.D., presented persuasive evidence that our specialty — as a whole — is failing to adequately train future physician scientists and has an abysmally small percentage of “NIH [National Institutes of Health] grants relative to other specialties.”

As a consequence, anesthesiology is “at risk of losing its status as a respected academic discipline within the broader biomedical community.” Subsequent editorials and multiple letters to the editor unanimously agreed that “academic anesthesiology is indeed in a crisis, and that bold steps are needed to avert the demise of our specialty as a legitimate academic discipline.”

Drs. Schwinn’s and Balser’s “main solution is to establish an increase in subspecialty fellowships that incorporate at least 1 year of research [emphasis added].” They note that “exposure to a rigorous research environment whets the appetite for research in many individuals who would otherwise not have been exposed” and that none of our fellowships “have a research requirement (although some have such a recommendation), in contrast to those of our peer specialties.”

While we agree that the crisis in anesthesiology is not only severe but growing, we propose that mandating at least one year of fellowship training devoted exclusively to research may actually be counterproductive for regional anesthesia fellowships at this time. As with any policy change, the cost-benefit ratio must be examined when considering an intervention of this magnitude.
Potential Benefits: The premise of a mandated year of fellowship-level research is to encourage more fellows to choose a research-oriented career, but a full year of research is not required to make such a decision. Currently, guidelines for single-year regional anesthesia fellowships recommend participation in clinical and/or laboratory research activities. Although limited exposure to research does not prepare fellows for an academic career compared with a mandated fellowship year of research, it also does not serve as a disincentive to continuing their postgraduate education. Therefore, the critical question is how many additional fellows would choose a physician scientist career by mandating a full year of research compared with the current more-limited exposure during their single year of training?

If we are to persuade fellows to choose a research-based career path by exposing them to “a rigorous research environment,” such environments must first exist. As Drs. Schwinn and Balser noted, only 40 percent of the current academic anesthesiology departments in the United States have “even one NIH grant credited to a faculty member or trainee in their department,” with few of these individuals specializing in regional anesthesia; and only 10 anesthesiology departments hold NIH department-sponsored research training grants. As others have opined, “not only are we not training an adequate number of new physician scientists in anesthesiology, but we also do not have a sufficient number of academic faculty that can serve as role models. The latter exponentially compounds the problem of the former.” Without role models committed to a physician scientist career path, it is doubtful that mandating a year of research will convince fellows to choose a research-based career path. So, the number of additional fellows who would choose a physician scientist career by mandating a full year of research compared with the current more-limited exposure during their single year of training may be negligibly small — the “benefit” of the intervention would be minimal, at best.

Potential Costs: Without adequate mentors, mandating a research year will either further decrease the already small number of available fellowships or require many fellows to spend a year of training without adequate mentorship. In addition, there are significant costs associated with adding a year of fellowship — both to the programs and to the fellows themselves. Regarding the former, unless funding were secured from other sources, many departments would be unable to sustain their current fellowships, further decreasing the available programs. In regard to the possibility of increased training duration deterring residents from seeking fellowship training, Drs. Balser and Schwinn suggest that the historical examples of cardiology and gastroenterology are evidence to the contrary. However, each of these subspecialties provides interns (whose median base salary in the United States is far below that of anesthesiologists) the opportunity to dramatically increase their postgraduate earnings, undoubtedly aiding fellowships in continuing to draw applicants. In contrast, the same is not true for regional anesthesia fellowships.

Would fellowship training increase the reimbursement for regional techniques and therefore the salaries of future fellowship graduates? Drs. Balser and Schwinn propose that “… by including extensive research and clinical educational requirements, these subspecialties were able to establish the high moral ground to justify, to the public, third-party payers, and healthcare service providers, that they deserve priority in providing consultative advice, [and] complex clinical services” and, presumably, the increase in funding that accompanies these activities. However, in doing so, gastroenterologists and cardiologists made many (most?) of their high-paying procedures the exclusive realm of practitioners with fellowship training. However, few regional anesthesiologists desire a similar end-result for our subspecialty: Rather than make regional anesthesia the domain of a few extensively trained specialists, most would prefer to train as many generalists as possible in these techniques and subsequently bring the benefits of regional anesthesia and analgesia to the maximum number of patients.

ACGME Accreditation. An additional proposal to increase the number of physician scientists in anesthesiology is to increase the number of Accreditation Council for Graduate Medical Education (ACGME)-accredited anesthesiology fellowships (mandate at least a year of research via the ACGME enforcement mechanism).
However, regional anesthesia simply does not have the critical mass to achieve accreditation at this time: There are currently too few specialists and fellowship programs.

With a mandated research year potentially decreasing fellowship programs, applicants and subsequent graduates, the pool of individuals with advanced training in regional anesthesia could decline precipitously. The proposed theory is that even with an initial decrease in graduating fellows, those individuals who do complete their training will 1) more likely choose a research-oriented career path and 2) be better prepared to compete for NIH-level research funding. This combination would eventually lead to a resurgence in academic anesthesiology and increase the future pool of mentors, applicants and programs. But regional anesthesia fellowships are currently in such tenuous condition that these few programs — in effect, this “spark” of academia — may not be fueled by fanning but rather extinguished completely.

Possible Options: While we do not believe that the proposal to extend fellowships in regional anesthesia would have a net-positive effect, we do agree that academic anesthesiology is in crisis and that resolute steps must be taken to improve this condition. Our subspecialty must face the reality that while we have trained outstanding clinical fellows, we are failing to train an adequate number of academicians dedicated to and prepared for a predominantly research-based career. There are multiple reasons for this situation that are not unique to regional anesthesia, including a lack of applicants interested in a research career track (regardless of research exposure); the cost of extensive training and the tenuous future of academic medicine itself.

Future Mentors: Training fellows to be physician scientists capable of competing for extramural funding requires a critical mass of physician scientist mentors with extramural funding. Since regional anesthesia currently lacks this critical mass of mentors, we are in a “chicken or the egg” situation and must do what we can to create the mentors of the future. To be successful, this effort will require financial support for both fellows and prospective mentors. The NIH has created training grants (T-series mechanism), which are provided to institutions to fund fellows on a recurring annual basis. Currently our subspecialty — as a whole — does not compete effectively with others for training grants. Therefore, it is necessary to create our own form of training grants by regionalists specifically for regionalists. ASRA is in the process of creating its own Regional Anesthesia Training Grants in addition to the Koller Grant (ASRA training grants already exist in pain medicine).

Related to this, programs are presently free to offer two-year research-centered fellowships, as a few have done (Mayo Clinic College of Medicine, University of California-San Diego, and Virginia Mason). Expanding the number of such fellowships may be encouraged by ASRA and other organizations with the use of regional anesthesia fellowship training grants. Furthermore, fellows and junior faculty should be encouraged to seek NIH (K-series mechanism) and/or Foundation for Anesthesiology Education and Research (FAER) mentored career development awards that will increase their ability to compete for national-level research funding in the future.

If and when the number of regional anesthesia fellowships has reached the required critical mass (25 fellowship programs at a minimum), the possibility of ACGME accreditation may be revisited. If ACGME approval is sought, only then should the possibility of mandating a full year of research during fellowship be proposed. Unfortunately there is no single intervention that we in the regional anesthesia community may make to easily reverse the trajectory of academic anesthesiology, but there are promising options to help ensure that regional anesthesia’s academic flame is strengthened and not extinguished.

References:
It is well-known that the population is aging and that older patients have a disproportionately high rate of surgery. Those over 85 years old are the fastest-growing segment of the population and will number more than 20 million in the United States by 2050. Postoperative central nervous system (CNS) dysfunction is among the most common complications in elderly surgical patients. For example, up to 60 percent of older surgical patients experience postoperative delirium (POD). Delirium is associated with increased medical morbidity, mortality and costs. More relevantly for older patients and their families, it is associated with a loss of independence. Thus postoperative CNS dysfunction is a significant public health issue, one that is of particular concern to anesthesiologists. What can we do to influence cognitive outcomes in elderly patients? Should we choose general or regional anesthesia? Does postoperative analgesic management matter?

Postoperative CNS dysfunction in the elderly was first reported more than 50 years ago. Unfortunately, despite being common and representing impairment in the target organ system for general anesthetic agents, comparatively little research was done on the subject. In part, this may have been because of a lack of appreciation of the frequency of the problem; signs and symptoms of postoperative CNS dysfunction often present well after anesthesiologists have completed their postoperative rounds. In addition, the study of postoperative CNS dysfunction is difficult. Standardized tools for detecting delirium were not available until decades later, and there still remains no universally accepted definition of postoperative cognitive dysfunction (POCD). However, the aging population and recent laboratory evidence that volatile anesthetics induce changes in neurons consistent with Alzheimer disease have renewed interest in postoperative CNS dysfunction both for the lay public and within our specialty.

“In an observational study of elderly patients undergoing major lower-extremity joint replacement, the use of continuous postoperative peripheral nerve catheters was associated with a more than 58-percent decline in the incidence of POD.”

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There are two main forms of postoperative CNS dysfunction: delirium and POCD. In contrast to emergence delirium (which occurs immediately following general anesthesia), the onset of POD occurs between postoperative days one to three. POD is a disturbance of consciousness that develops over hours to days, tends to fluctuate in intensity and cannot be explained by a previously existing dementia. Risk factors for POD include age, type of operation, severe metabolic abnormalities, and poor preoperative medical, physical and cognitive status. Many drugs used in the perioperative period are associated with delirium, including opiates, benzodiazepines, anticholinergics, corticosteroids and some antibiotics. In addition, the incidence of POD is higher when pain is poorly controlled. The mechanism of delirium is not well understood. There are, however, a number of theories involving neurotransmitter imbalances (especially in the cholinergic system), cytokines and hormones.

The definition of POCD is evolving. Generally it consists of deficits in one or more cognitive domains following surgery, and diagnosis requires neurocognitive testing. Unlike delirium, patients with POCD tend to be alert and oriented. Like POD, however, little is known about the etiology of POCD. Age, major surgery and pain are risk factors.

The March 2007 issue of Anesthesiology contains selected reports from the Journal Symposium on Postoperative Cognitive Dysfunction, which was held at the 2006 ASA Annual Meeting in Chicago. It also includes two excellent reviews of postoperative CNS dysfunction. The first, by Jeffrey H. Silverstein, M.D., and colleagues examined the general topic of postoperative CNS dysfunction. In the other, Stanton Newman, D. Phil., and colleagues systematically reviewed literature pertaining to POCD. Interested readers should refer to these articles for more information.

Regional anesthetic techniques are intuitively attractive options for patients at risk for postoperative CNS dysfunction. They minimize exposure to drugs associated with CNS dysfunction, blunt the surgical stress response and provide excellent pain control. In theory all of these effects may contribute to a reduction in the incidence and severity of postoperative CNS dysfunction. Unfortunately, in studies to date, regional techniques have not been associated with decreased incidence of either POD or POCD.

For example, in a trial published in 1995, Williams-Russo and colleagues randomized 262 patients undergoing total knee arthroplasty to receive either epidural or general anesthesia. Patients were evaluated with standardized neurocognitive tests on postoperative days one through seven and at one and six months. There was no difference in the incidence of POD or early or late POCD between groups. In fact there was a trend toward more delirium in patients who received an epidural anesthetic.

More recently the International Study of Postoperative Cognitive Dysfunction (ISPOCD) investigators examined the effect of regional versus general anesthesia on POCD on patients undergoing a variety of noncardiac surgical procedures. Four hundred twenty-eight patients from 12 institutions were randomized to receive either regional or general anesthesia. The investigators found no difference in the incidence of POCD at three months between groups.

A systematic review of 24 trials examining the effect of regional versus general anesthesia on postoperative CNS dysfunction also concluded that choice of intraoperative anesthetic does not influence the incidence of POCD. The authors noted, though, that methodological and design concerns in the available studies prevented their results from being definitive. For example, in both the Williams-Russo and ISPOCD group studies, postoperative analgesia was not standardized.

There are a number of reasons why the timing of the use of regional techniques may be important. For instance, paravertebral postoperative analgesic regimens often include drugs associated with CNS side effects (e.g., opiates) and may not provide optimal pain control. Because of this, they may contribute to postoperative CNS dysfunction. Thus for regional anesthetic techniques to confer a benefit on postoperative cognitive outcomes, it may be necessary to continue them into the postoperative period. The key issue with regard to preventing postoperative CNS dysfunction may be the analgesic rather than the anesthetic regimen.

Epidural catheter infusions are a mainstay of regional analgesic techniques. When properly managed, their benefits include reductions in opiate requirements and excellent pain control. In addition they modulate the surgical stress response. Unfortunately epidural catheters cannot be used in patients receiving certain forms of thromboprophylaxis because of the risk of spinal hematoma. They also are associated with undesirable side effects, including urinary retention and difficulties with ambulation.

For appropriate procedures, catheter-based continuous peripheral nerve blockade is an attractive alternative to neuraxial analgesia. First described more than 60 years ago, advances in catheters and placement methods have led to increased popularity in recent years. These techniques provide excellent pain control and reduce opiate consumption. In addition they encourage ambulation, can be used with a variety of thromboprophylactic regimens and do not lead to urinary retention. Thus they may be ideal for use in the elderly.

There is a paucity of data on the impact of continuous peripheral nerve catheter analgesia on cognitive outcomes. Preliminary evidence suggests, however, that their use may result in a substantial reduction in the incidence of POD. In an observational study of elderly patients undergoing major lower-extremity joint replacement, the use of continuous postoperative peripheral nerve catheters was associated with a more than 58-percent decline in the incidence of POD.
Will regional techniques play a role in improving neuropsychological outcomes in elderly surgical patients? Possibly. The issue is far from settled, though, and more study is needed. Rather than focusing solely on whether intraoperative management affects postoperative CNS dysfunction, future trials also should consider the impact of postoperative analgesic care. As the population ages, improving our understanding of the influence of perioperative management on postoperative CNS dysfunction will be increasingly important and may allow us to improve outcomes for older patients.

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From the Crow’s Nest: Descent Into Darkness?

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forget that those very emotions are often the determining factor in what makes us good physicians. This is the essential lesson of The Enemy Within.

While we must acknowledge that it is within us, may we, as anesthesiologists, never see our evil side.

— D.R.B.

References:
At the very time that resident candidates grade the excellence of their potential training programs by the quality of the regional anesthesia rotations therein and while regional anesthesia/analgesia techniques are finding greater application in clinical practice worldwide, there comes growing evidence that there is a new and effective treatment for local anesthetic (LA) toxicity emerging. The first reported clinical applications of lipid therapy in humans are attributed to Rosenblatt et al. and Litz et al. Their patients had undergone an interscalene block with bupivacaine and mepivacaine and an axillary block with ropivacaine, respectively, with clinically appropriate doses of local anesthetics.1,2 When the patients were failing to benefit from conventional cardiopulmonary resuscitation after manifesting LA toxicity (hypotension and arrhythmias leading to cardiac arrest), lipid emulsion therapy was administered. The use of this novel technique led to the patient’s rapid and successful response to resuscitative measures. These reports have triggered a cascade of similar reports, which are providing enthusiasm for this unique therapy, modifications in the original protocol described, and confidence that the risk of a patient suffering detrimental consequences from LA toxicity is less likely.

The concept of using a lipid emulsion to create a lipid bank into which wayward LAs could be deposited from (cardiac) tissues is not new. Weinberg et al. showed that this might occur, in that rats and dogs were easier to resuscitate from LA overdoses after lipid administration.3,4 In commentary about the theoretic clinical application of this therapy, Groban and Butterworth stated in a 2003 editorial that lipid emulsion therapy (for bupivacaine overdose) should be used “…only after other, more conventional treatments have proven unsatisfactory.” That is exactly what occurred in the two reported cases cited above.

What, though, is the incidence of LA toxicity? In publishing the results of a survey of U.S. academic centers about their preparedness to manage patients

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**Resuscitation of Local Anesthetic Toxicity with Intralipid**

*John C. Rowlingson, M.D.*

“We should admire the persistence of Dr. Weinberg and his associates in establishing the basic science rationale for lipid therapy to be of benefit in the face of local anesthetic toxicity with cardiac arrest.”

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John C. Rowlingson, M.D. is Cosmo A. DiFazio Professor of Anesthesiology and Director, Pain Medicine Services, University of Virginia Health System Department of Anesthesiology, Charlottesville, Virginia.
with LA toxicity, Corcoran et al. projected that the incidence of LA toxicity (7.5 to 20 per 10,000 peripheral nerve blocks) was in decline, even as the total number of peripheral nerve blocks performed in today’s anesthetic practices was increasing. Because LA toxicity can be fatal, they assert that having a corporate plan to manage this clinical event is necessary. The plan needs to be known to practitioners and readily accessible in an emergency situation. Their survey documented the widely varying number of block procedures performed within institutions and a preference for choosing bupivacaine or ropivacaine for long-lasting effects and lidocaine or mepivacaine for shorter-duration blocks. The extent of the use of standard ASA monitoring varied among institutions, as did the choice of emergency drugs for treatment of ventricular tachycardia and hypotension. Fifty-nine percent of the responding programs declared that they had no established plan for using cardiopulmonary bypass, yet 84 percent of the programs stated that cardiothoracic surgeons would be available within 30 minutes to provide advanced circulatory support. At the time of the survey (prior to any reports of lipid therapy in human care), 74 percent of the programs said they would not consider using lipid emulsion therapy. Corcoran et al. concluded that there is a “…wide range of current practice patterns … in U.S. academic centers, and variability in nearly all aspects of treatment strategies for managing severe local anesthetic toxicity” and that “there is no consensus strategy for how to best treat severe local anesthetic toxicity.” The published case reports bode of new insights into experiences that might foster a modification of the last-mentioned conclusion.

Soon after the case report by Rosenblatt et al.,1 was published, Weinberg established a Web site www.lipidrescue.org to serve as an informational resource about LA toxicity and lipid therapy (the site now lists four published cases) as well as to provide a readily accessible forum for the exchange of ideas about the presentation, diagnosis and management of LA toxicity (and eventually toxicity from other drug classes) and the possible mechanisms of action of lipid therapy. There also is a section for the demographic accumulation of clinicians’ experiences with lipid emulsion therapy. While these particular submissions do not share the scientific rigor of published cases, per se, they do demonstrate a positive, if not remarkable, performance profile for lipid therapy in the face of a variety of presentations of LA toxicity. The current protocol listed on the Web site emphasizes its application in “…local anesthetic-induced cardiac arrest that is unresponsive to standard [resuscitation] therapy.” It recommends a bolus of Intralipid™ 20 percent 1.5 mL/kg over a minute, followed by an infusion at a rate of 0.25 mL/kg/min. The bolus can be repeated every three to five minutes up to a dose of 3 mL/kg total dose until circulation is restored. The infusion should be continued until hemodynamic stability is achieved and the rate increased to 0.5 mL/kg/min if the blood pressure drops. A total maximum dose of 8 mL/kg is recommended (www.lipidrescue.org).

We should admire the persistence of Dr. Weinberg and his associates in establishing the basic science rationale for lipid therapy to be of benefit in the face of local anesthetic toxicity with cardiac arrest. The challenge of Groban and Butterworth and Corcoran et al. that clinicians should have a departmental/institutional plan for managing LA toxicity seems easier to confront when one appreciates the growing number of reports of patients being “rescued,” as found at the Web site referenced above. This oracle of contemporary information raises lipid therapy to at least a high level of attention for the astute practitioner. Putting this new therapy in perspective, Picard et al. pointed out the similarity and evolution of our understanding and use of dantrolene for malignant hyperthermia (MH) to that of lipid therapy for LA toxicity. Both of these conditions are unpredictable and infrequent and associated with a potentially fatal outcome. In that vein, clinicians should consider co-locating lipid emulsion to areas where large doses of LAs are used, so that as with MH, lives can be saved if toxicity occurs because the most up-to-date treatment is readily available. The use of lipid emulsion therapy seems to be a circumstance about which we should learn from the experience of others and the wisdom of their decisions.

References:

Anesthesia Practice Models, Perioperative Risk and the Future of Anesthesiology

Raymond C. Roy, Ph.D., M.D.
Randy W. Calicott, M.D.

How we as anesthesiologists address perioperative risk will define the future of our profession. In our own clinical research literature, the definitions of anesthesia’s contribution to perioperative risk have expanded from “anesthesia-only” to “anesthesia-contributory” to “anesthesia-related” [Table 1]. Many anesthesiologists fear that others, both within the profession and outside, are assigning us responsibilities that we should not assume or at the very least not shoulder alone. The pro-versus-con discussion of pay for performance in the July 2007 ASA NEWSLETTER reflected this concern. Our acceptance of accountability and liability for the growing number of associations between what we do, can do, or facilitate a surgeon or interventionalist doing, and adverse outcomes range from no to cautious to enthusiastic. The goal of this article is to convince you that it is time to find ways to embrace additional patient care responsibilities in our local practices if we want to secure the future for the next generation of anesthesiologists.

How we construct our practice reflects our view of our contributions to perioperative risk. Currently anesthesiology practice in the United States may be loosely divided into two broad categories: 1) a “limited” practice that confines itself to preoperative assessment on the day of surgery, operating room anesthesia and care in the postanesthesia care unit (PACU) and 2) an “expanded” practice that incorporates all 10 elements in the definition of anesthesiology in the “Booklet of Information” published by the American Board of Anesthesiology (ABA) [Table 2]. Anesthesiologists adhering to a limited practice model may become progressively less essential as the following timeline plays out: standardization of care; reduction in anesthetic requirements associated with the shift from more invasive surgery to minimally invasive surgery or interventional radiology; improvement in the safety profiles of newer sedatives and analgesics; the development of patient-specific anatomically targeted sedatives and analgesics (pharmacogenomics); and the emergence of tele-anesthesia with direction from control rooms. The ASA Task Force on Future Paradigms of Anesthesia Practice in 2005 refers to our current salary expectations as an “anesthesia-operating room economic bubble” that may burst and asks, “Can the current economics be sustained in the long run, especially with the arrival of advanced technology and pharmacology requiring less skill for delivery of intraoperative anesthesia?”

Hypothesis #1: The limited practice of anesthesiology will lead to anesthesiologists being viewed as operating room technicians and to the death of the specialty.

ABA uses the adjective “perioperative” in elements 3 and 9 of its definition [Table 2]. Typically the perioperative period is defined based on time and location of care in the hospital or ambulatory care facility, e.g., preoperative evalu-
Analysis of the patient in the holding area, administration of anesthesia in the operating room, and postoperative care until the patient is discharged from the PACU or from the acute pain service. An alternative is to define the perioperative period as the interval of altered physiology that begins with the onset of the surgical illness and ends with the return to the baseline that was present prior to the surgical illness. Medical comorbidities will have a significant impact on the definition of baseline physiology.

Hypothesis #2: We as anesthesiologists should become the recognized experts in understanding and controlling the altered physiology associated with the perioperative period.

Conceptually an equation describing total perioperative risk (T) may be constructed as $T = M + S + (A^C + A)$, where $M$ is the medical risk, $S$ is the surgical risk, and $A$ and $A^C$ are the anesthesia-only and anesthesia-contributory risks defined in Table 1. When studies of perioperative mortality from 2002 are compared with those from 1954, an order of magnitude reduction is found to have occurred in the $T$ and $A^C$ terms of the equation [Table 3]. It is right for us to be proud of this accomplishment. But there is a very uncom-

### Table 1: Definition of Complications Involving Anesthesia

- **Anesthesia-only complication**: “Pure” or “intrinsic” anesthesia risk. Death or morbidity occurred despite the fact that the anesthesiologist properly applied an approved technique, properly used well-maintained equipment, made reasonable attempts to acquire pertinent information, and used reasonable judgment based on current therapeutic and diagnostic standards and available resources (i.e., in the absence of system errors described by Lagasse*).

- **Anesthesia-contributory complication**: The anesthesiologist used improper technique, misused equipment, disregarded important data, failed to seek appropriate data, displayed inadequate knowledge or exercised poor judgment, and this failure led to either death or morbidity (i.e., the human errors described by Lagasse*).

- **Anesthesia-related complication**: Anything adverse that manifests itself intraoperatively or postoperatively, or anything that is less likely to occur intraoperatively or postoperatively, based on a decision or intervention in the purview of an anesthesiologist (e.g., new associations established by evidenced-based clinical studies related to administration of adrenergic blocking agents, statins, antibiotics, or long-acting neuromuscular blocking agents and control of blood glucose or body temperature).


### Table 2: Anesthesiology Practice as Defined by ABA*

Anesthesiology is the practice of medicine dealing with but not limited to:

1. Assessment of, consultation for and preparation of, patients for anesthesia.
2. Relief and prevention of pain during and following surgical, obstetric, therapeutic and diagnostic procedures.
3. Monitoring and maintenance of normal physiology during the perioperative period.
5. Diagnosis and treatment of acute, chronic and cancer-related pain.
6. Clinical management and teaching of cardiac and pulmonary resuscitation.
8. Conduct of clinical, translational and basic science research.
10. Administrative involvement in health care facilities and organizations and medical schools necessary to implement these responsibilities.

* American Board of Anesthesiologists, Booklet of Information, Section 1.02A, March 2007.

### Table 3. Total Perioperative Risk of Death

$T = M + S + (A^C + A)$ where the risk terms are defined $T =$ total perioperative, $M =$ medical, $S =$ surgical, $A^C =$ anesthesia-contributory, and $A =$ anesthesia-only.

<table>
<thead>
<tr>
<th>Date</th>
<th>$T$</th>
<th>$M$</th>
<th>$S$</th>
<th>$A^C$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1954</td>
<td>1.75</td>
<td>1.95</td>
<td>1.420</td>
<td>1.1,560</td>
</tr>
<tr>
<td>2002†</td>
<td>1.500</td>
<td></td>
<td></td>
<td>1:13,000</td>
</tr>
</tbody>
</table>

†Lagasse RS: Anesthesiology. 2002; 97:1606-1617.
fortable reality in these numbers.

We have reached the point that additional reductions in anesthesia risk \((A^c + A)\) will help individual patients, and we should certainly strive for them, but they will not significantly lower total perioperative risk. Why? Because \(M > S > (A^c + A)\).

If anesthesia risk is a third order term, then by definition it is not as important or relevant as first and second order ones, especially to health care system leaders and third-party payers. To significantly reduce perioperative mortality and morbidity, the \(M\) and \(S\) terms must be reduced. But these terms are likely to increase in the next few years as the percent of surgical patients on Medicare increases because of aging baby boomers. In Silber’s study, death within 30 days of surgery occurred in one of every 29 cases among Medicare recipients who had undergone general surgical or orthopedic procedures.\(^2\) Forty-one percent suffered some perioperative complication.

How can anesthesiologists help to reduce perioperative risk? One way is to take ownership of a portion of the “\(M\)” and “\(S\)” terms in the risk equation. If we expand our definition of anesthesia complications to include the “anesthesia-related” ones already identified in our own evidence-based literature, and others yet to be identified, we can help to reduce the \(M\) and \(S\) terms. The resulting total perioperative risk equation becomes \(T = M^* + S^* + (AM + AS) + (A^c + A)\), where \(AM\) is the risk resulting from the interaction of an anesthesia activity and a medical comorbidity, \(AS\) is the risk resulting from the interaction of an anesthesia activity and a surgical activity, \(M^* = M - AM\), and \(S^* = S - AS\). The new anesthesia-related risk term \((AM + AS)\) is closer in magnitude to the \(M^*\) and \(S^*\) terms than it is the old anesthesia risk term \((A^c + A)\), i.e., \(M^* > S^*, (AM + AS) > (A^c + A)\), and thus its reduction becomes more worthy of attention and funding. An interesting early example of the \(AM\) term is the association of postoperative pulmonary complications with the use of long-acting neuromuscular blocking agents.\(^3\) An example of the \(AS\) term is the recently reviewed association of site infection with intraoperative hypothermia, perioperative hyperglycemia, late antibiotic administration, and perhaps lower oxygen content and blood transfusion.\(^4\)

Hypothesis #3: If we as anesthesiologists want a significant reduction in perioperative mortality and morbidity, we must expand our definition of anesthesia complications to include anything that manifests itself intraoperatively or postoperatively, or anything that is less likely to occur intraoperatively or postoperatively, based on some decision or intervention in our purview.

A limited practice model focuses on just the \((A^c + A)\) term of the total perioperative risk equation. An expanded practice is more open to addressing the \((AM + AS)\) term. The cost of treating perioperative complications is significant. Medicare has already announced that it does not intend to pay for the treatment of certain ones. Demonstrating that we improve the quality of care by reducing perioperative complications is good for the patient and good for the profession. Demonstrating that we reduce the cost of treating complications by reducing their frequency and intensity is good for a hospital’s bottom line and the overall cost of medical care. Protecting a hospital’s operating margin may become a better basis for determining our income in the future than relying on the current inadequate reimbursement from Medicare. How best to quantitate our efforts is part of the challenge we face.

Hypothesis #4: If we as anesthesiologists become experts in controlling the altered physiology in the perioperative period and work to reduce overall perioperative mortality and morbidity, then anesthesiology will not only survive as a specialty, it will grow.

Over the past decade, leaders in our profession have been suggesting that we need to expand our role as physicians:

- “I propose perioperative medicine and pain management (PMPM) as a term that is both unambiguous and describes the totality of what we do (or what we should do).” Saidman LJ. What I have learned from 9 years and 9,000 papers. Anesthesiology. 1995; 83:191.

- “We propose a series of time-dependent departmental name changes from anesthesiology to anesthesia and perioperative medicine to perioperative medicine and pain management . . . The rate of change will depend on when we can achieve a consensus definition for perioperative medicine and how successful we are in our efforts to convince those outside the profession of the validity of this project.” Alpert CC, Conroy JM, Roy CA. Anesthesia and perioperative medicine. A department of anesthesiology changes its name. Anesthesiology. 1996; 84:712-715.

- “Our specialty needs to diversify its practice paradigms in order to ensure its future leadership position in medicine. To have an increasingly dominant role in perioperative management, including critical care, seems well within our grasp.”

Miller RD. Report from the Task Force on Future Para-
• “It is premature and counterproductive to content ourselves with the fact that few patients experience intraoperative deaths due solely to anesthetic mishap; we need to take ownership of the substantial perioperative morbidity and mortality that is the reality of modern American surgery.”
Evers AS, Miller RD. Can we get there if we don’t know where we’re going? Anesthesiology. 2007; 106:651-652.
• “Who better than anesthesiologists to lead health care in the coming century?”

Over the next decade, we need to invest our time and resources to figuring out the right way to expand the scope of anesthetic practice — and do it. Addressing overall perioperative morbidity is a natural extension for us. Success depends on a concerted national effort that is well-organized, demonstrably effective and ultimately reasonably funded.

References:

Ernest Fourneau produced a local anesthetic initially marketed to the English-speaking world as “Fourneau-caine.” Embarrassment over confusion with “fornicate” soon forced a new marketing strategy. The proprietary name of the new synthetic local anesthetic was changed to Stovaine. (His name, Fourneau, is the French word for stove.)

Stovaine Ampoules, ca. 1910

The Wood Library-Museum of Anesthesiology (WLM) ranks among the world’s premier collections devoted to anesthesia history. Housed in the headquarters building of the American Society of Anesthesiologists, the WLM also serves as an active, specialized medical library. Visit us on the Web at www.ASAhq.org/wlm.
Orin F. Guidry, M.D., Awarded Honorary Membership to AAGBI

Eugene P. Sinclair, M.D.

Orin F. Guidry, M.D., ASA Immediate Past President, has been awarded Honorary Membership to the Association of Anaesthetists of Great Britain & Ireland (AAGBI). He is the first ASA member in 27 years to be given this honor. Past AAGBI honorary members from ASA include:

- Francis H. McMechan, M.D. (1932)
- Ralph M. Waters, M.D. (1936)
- Ralph M. Tovell, M.D. (1943)
- Stuart C. Cullen, M.D. (1976)
- Francis F. Foldes, M.D. (1976)
- Emanuel M. Papper, M.D. (1976)
- John J. Bonica, M.D. (1977)
- John S. Lundy, M.D. (1978)
- M. T. “Pepper” Jenkins, M.D. (1980)

Honorary Membership was instituted the year AAGBI was founded in 1932. Election takes place at the AAGBI Annual General Meeting, and the award is accompanied by a citation and certificate. Dr. Guidry is currently Professor and Vice-Chair for Professional Development in the Department of Anesthesia and Perioperative Medicine at the Medical University of South Carolina and is President of the American Board of Anesthesiology.

Dr. Guidry’s nomination letter for Honorary Membership to AAGBI appears below. It was written by 2005 ASA President Eugene P. Sinclair, M.D.

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Orin F. Guidry was born and grew up in rural Opelousas, Louisiana, where he attended school, and his aptitude for leadership first became apparent when he was elected treasurer of his high school student body. Following graduation from high school, Dr. Guidry completed undergraduate and medical school studies at Louisiana State University in Baton Rouge, and New Orleans, Louisiana, respectively, receiving the degrees of Bachelor of Arts in Chemistry and Doctorate of Medicine.

After several years as a general surgery resident at New Orleans’ Charity Hospital, Dr. Guidry moved to Jackson, Mississippi, for an anesthesiology residency at the University of Mississippi. He continued at the University of Mississippi for two years after residency as a faculty member in the department of anesthesiology before entering private practice in Jackson in 1977 and soon becoming the managing partner of the group.

His involvement in the board certification process began shortly thereafter with his selection as an Associate Examiner of the American Board of Anesthesiology (ABA) in 1979, leading to his election as a Director in 1996 and current service as president. ABA is a member board of the American Board of Medical Specialties (ABMS), and Dr. Guidry serves as a director and member of the finance and governance committees of ABMS. He was nominated by ABA and currently serves on the Residency Review Committee for Anesthesiology.

“Fred” began service to ASA in 1981 as a member of its House of Delegates and has served as Chair of House Reference Committees, the Committee on Governmental Affairs, the Committee on Surgical Anesthesia, the Ad Hoc Committee on Academic Anesthesiology and Task Forces on Procedure Based Reimbursement, Data Collection and Graduate Medical Education. He was elected to the ASA Board of Directors in 1988 and served as

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Committee on Rural Access to Anesthesia Care: Spreading Care Across the Country

Mike P. Schweitzer, M.D., Chair
Committee on Rural Access to Anesthesia Care

Medical Student Rural Scholarship

Attention medical students interested in rural anesthesia rotations! This year the Committee on Rural Access to Anesthesia Care focused on developing a rural medical student scholarship program. The 2005 ASA House of Delegates (HOD) passed a resolution to study rural anesthesia classes for third- and fourth-year medical students. The 2006 HOD passed a resolution to support a three-year pilot scholarship program. The application for financial assistance for this rural medical student anesthesiology rotation is on the ASA Medical Student Web page www.ASAhq.org/msd. Look at the top right corner under “What’s New?”

This assistance is awarded under the Foundation for Anesthesia Education and Research (FAER) to allow for tax-deductible donations to supplement ASA’s funding of this scholarship. The ASA HOD agreed to fund the scholarship program with $10,000 per year for three years. The scholarships awarded will be up to $750 per student to help pay for expenses for travel and lodging for a rural anesthesiology clerkship. We encourage medical students interested in anesthesiology to apply. We also encourage donations to FAER earmarked for this scholarship to increase the number of students assisted. You can donate online as I have at www.faer.org. Click on “Make a Gift” on the left side of the Web site. While filling in the online donation information, please type into the “comments” section, “Rural Medical Student Scholarship.” As a Montana anesthesiologist, Paula Roos, M.D., told me, “This is a great way to pay it forward in anesthesiology.” We also plan to work closely with the ASA Resident Component to support efforts to encourage rural rotations.

Rural Medicare Payments

The Rural Access to Anesthesia Care listserve encouraged its participants to send letters to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed anesthesia conversion factor increase. We have worked with Congress to increase Medicare reimbursement directly to rural physicians and hospitals. The 2003 House of Delegates passed a resolution to support legislation for parity in Medicare payments. It was a major accomplishment when the 2003 Congress supported the concept of “equal pay for equal work.” The geographical practice cost index was raised to set a floor at one. This increased 2004 Medicare conversion factor payments by about 8 percent to 9 percent for rural providers because of legislation in the Medicare Modernization Bill. The Committee on Rural Access to Anesthesia Care supported legislation this year in the House, H.R. 3162, Section 621, “Two-Year Extension of Floor on Medicare Work Geographic Adjustment,” which would extend the current floor on rural Medicare payments to the end of 2008. The House and Senate have scheduled a conference committee in September to resolve the differences in the State Children’s Health Insurance Program, or SCHIP. The committee will continue to support this rural floor in whatever legislative vehicle is appropriate. Of course we also support ASA’s efforts to fix the flawed sustainable growth rate formula and teaching rule issues in Medicare payments.

Small Component Assistance

North Dakota Society of Anesthesiologists Director John C. Chatelain, M.D., proposed a resolution passed by the

Many rural hospitals and anesthesiologists have agreed to payment arrangements to help compensate anesthesia and improve recruitment and retention of anesthesiologists and nurse anesthetists.”

Mike P. Schweitzer, M.D., is Medical Director of Perioperative Services, St. Vincent Healthcare, Billings, Montana.
Board of Directors in August 2007 to assist small component societies with the transition from one director to the next. It was resolved “that the President of the ASA ask a committee of his choice to consider offering funding for the expenses of bringing alternate directors from components with limited numbers of active members to attend one board meeting during the final year in which their current board member is planning to retire.” The committee supports this referral. ASA already provides some administrative assistance to small, often rural, components.

Obstetrical Coverage Issues

Concerns continue about providing better labor analgesia coverage and vaginal birth after cesarean section (VBAC) availability while still servicing the operating room with limited staff. Some hospitals are requesting labor epidurals instead of intrathecal narcotics even in areas with fewer than 500-700 deliveries per year. This labor epidural coverage requires more anesthesiologists/nurse anesthetists to be available to provide coverage for the same number of patients. Some hospitals are asking for in-hospital coverage for VBACs, even when there are fewer than 20 per year. Many rural hospitals and anesthesiologists have agreed to payment arrangements to help compensate anesthesia and improve recruitment and retention of anesthesiologists and nurse anesthetists. Some states have significantly increased their Medicaid payments toward commercial parity to encourage access to medical care for patients.

Join Rural Anesthesiology Discussions

The committee encourages any ASA member interested in joining our listserv to subscribe to rural@listserv.ASAhq.org. When sending a message, please write “Subscribe” in the subject line of the e-mail. We encourage open discussion — the best ideas have come from these open Internet comments. The committee has presented informational sessions at the ASA Annual Meeting in 2006 and 2007 regarding the challenges and joys of rural practice. The objective is to increase awareness of professional opportunities and the ease of implementing “best practices” in a rural setting. Our goal is to improve access to high-quality rural anesthesia care.

Members of the committee are: Lee A. Balaklaw, M.D. (adjunct), John C. Chatelain, M.D. (adjunct), Paul G. Loubser, M.D., Kenneth Martay, M.D. (adjunct), Paul D. Martin, M.D., Ray J. Nichols, Jr., M.D., H. Douglas Roberts, M.D., William A. Roberts, M.D., Ph.D.

Orin F. Guidry, M.D., Awarded Honorary Membership to AAGBI

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chair of its Committee on Legislative Review. He served on ASA’s Administrative Council for 11 years as Assistant Treasurer, Treasurer and then as President in 2006. During this time, his significant contributions have included guiding the effort to have academic anesthesiologists more involved in ASA governance by developing a Committee on Academic Anesthesiology and establishing representation for academic anesthesiologists on the ASA Board, changing the process of financial support of foundations affiliated with ASA, establishing a restricted reserve policy for ASA’s funds, increasing member oversight of the ASA Executive Office, and raising the awareness of the paucity of research in anesthesia. He was spokesperson for ASA when physician involvement in lethal injection became a subject of much media interest.

His commitment to anesthesia research is evident by his serving on the Board of the Foundation for Anesthesia Education and Research since 1995 with a five-year term as Treasurer.

He returned to his home state in August of 1999 to accept the chairmanship of the Department of Anesthesiology at the Ochsner Clinic in New Orleans, a position he held until September 2004. At the Ochsner Clinic he was credited with revitalizing the residency and developing a strong clinical service.

In July of 2007, he moved to Charleston, South Carolina, to become Professor of Anesthesiology at the Medical University of South Carolina. His duties include Vice-Chair for Professional Development and Anesthesiology Chief for Ashley River Tower.

As the Vice-Chairman for Professional Development, he will be involved in the mentoring and career guidance of faculty members within the department of anesthesiology and will chair the department’s Promotion and Tenure Committee.

Fred is married to Nancy and has two adult sons, an attorney and an anesthesiologist. Boating is his primary recreational interest.

It is truly an honor for me to propose that Orin F. Guidry be granted the award of Honorary Membership of the Association of Anaesthetists of Great Britain and Ireland.
It was near the end of June 1944, and as I was waiting in line in my jeep to cross over a bridge repaired by the army engineers in Normandy, my eye caught activity in the ravine below. I could see four jeeps scurrying like red chiggers churning up dust below. Squinting against the bright overhead sun, I could make out red painted jeeps emblazoned with white letters reading “BDS.” It was a bomb disposal squad, considered by us infantrymen to be among the bravest of the brave, rightfully belonging in the Pantheon of Heroes, along with the paratroopers, commandos, Rangers and amphibious engineers.

As the Normandy Campaign unfolded, I had the privilege to meet members of this elite, unique group, whose life expectancy would undoubtedly receive a not very high insurance risk rating. Capt. “Red” Ethridge appeared at our sick call infirmary one day dragging a most reluctant master sergeant who we will call “Willie D. Wilkes” and who was wearing a sling on his left arm, the result of an accident while removing a large unexploded U.S. Army Air Force bomb.

One of the other identifying marks of this group is that they would carry on their person a bell-shaped medical stethoscope to listen for unusual sounds emanating from the munition they were trying to disarm. Both Sgt. Wilkes and the captain were sporting these detectors partially hanging from one of their pockets. I arranged for one of our medical officers to see the sergeant and inquired whether the captain might like some liquid refreshment while waiting for his sergeant to be seen. Receiving a laconic stare and a muttered “absolutely,” he went to his bright red jeep and informed his radioman that he would be with me for a while and where he could find us. We then repaired to a tent that served as a patient triage area as well as a medical supply center. I opened one of the medical chests, found a bottle of Spiritus Fru menti and poured him a slug in a canteen cup.

In the half an hour that we conversed, I found out that the carrot top Capt. Ethridge was, as I suspected from his accent, a fellow native of Brooklyn, that he graduated from a competing high school named James Madison (mine was Abraham Lincoln High School) and that he received his mechanical engineering degree from a university in upstate New York. After entering the armed forces, he volunteered for service in military explosive disposal, and after training in the United States, he was sent to Great Britain for six months to study the techniques used by the experienced British forces in disarming all types of bombs. One of the problems these BDS units had concerned itself with was the Germans booby-trapping these munitions with delayed-action triggers or changing the arming schematics to cause the bomb to explode during the disarming process.

“The captain proceeded with his efforts, reporting every step he was taking, when suddenly there was a large explosion, the line went dead, and many in the team were knocked over by the force of the explosion.”

The U.S. Army BDS organization that I encountered was modeled after that in the British Army. Capt. Ethridge explained to me that his squad consisted of two teams of men — an officer, a sergeant and four technicians, each team having two jeeps and a truck equipped with devices to remove these bombs. These units had the right to go into any part of the battlefield, and the officer was authorized to requisition any equipment or personnel needed to help them in carrying out their mission.

When a bomb was being disarmed, an officer and a technician were always present, with the technician not only assisting the officer but describing by telephone all the steps taken, which would be logged in by a technician at the other end of the line a goodly distance away. Thus in the event that the bomb would explode prematurely, a record would be available of the disarming steps taken,

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Maurice S. Albin, M.D., M.Sc., is Professor of Anesthesiology in the David Hill Chestnut Section on the History of Anesthesia, University of Alabama School of Medicine, Birmingham, Alabama.
The ‘Big Three’ Were Not Only Roosevelt, Churchill and Stalin

Maurice S. Albin, M.D., M.Sc.

It was the end of April 1945, and the war in Europe was winding down. Our division was pulled off the line for a brief rest after having participated in intense combat continuously for nearly three months. The U.S. Army had set up a number of services to help entertain the troops at rest areas, and organizations such as the American Red Cross and the United Service Organizations (USO) were helpful in recruiting personnel to travel where the U.S. forces were serving, much like is done today with our troops in the Middle East and Far East.

In World War II, the U.S. Army basic entertainment provider group was called the Special Services. They set up and escorted the entertainers at the presentation level and made sure that the 16mm full-feature sound movies were delivered to the divisional, regimental and battalion Special Services officers. The arrival of movies while in a rest center would evoke considerable excitement in the troops. It was a contact with home, and the escapist types were the most popular, including musicals, comedies and even the cartoons.

A Song to Remember

A short time after arriving at the Rest Center, we were informed that a musical would be shown in the evening. There were probably about 200 GIs in attendance, and they were drawn to the title, which was A Song to Remember, starring Merle Oberon, Paul Muni and Cornell Wilde. It turned out that the “musical” was about the life of Frédéric Chopin and his role in battling for Polish independence. Within 10 minutes of the film’s beginning, only a handful of soldiers were left to view it, and that included yours truly who loved classical music and opera. The music was wonderful, and for a few moments the war was blotted out and one could luxuriate in the sounds of Chopin’s music that filled the area.

A Night to Remember

Just before we were leaving the rest area to go back into combat, the Special Services posted an announcement that there would be a special event taking place shortly. The next day, a most unusual happening occurred as a security detail entered our encampment followed by a number of large trucks and jeeps. As the trucks disgorged their cargo, a small stage was assembled, complete with lights, microphones and speakers, the final touch heralding a ramp from which a piano was moved from the truck to the stage. Finally a party emerged from one of the nearby barracks, and the Special Service officer announced that we were in for a treat tonight since we were fortunate to have in our midst three of the most famous violinists in the world who would give us a concert, and these included Jascha Heifetz, Nathan Milstein and Isaac Stern! As a young boy, I was taken to many concerts at Carnegie Hall, and I attended productions at the Metropolitan Opera House. Yet the thought that these three great violinists were going to play right in front of me, that I might have a chance to speak with them and even shake their hands, really made me feel almost giddy. And another unusual happening occurred, for it appeared that almost none of the GIs left the concert area as these musicians launched into their concert.

I really don’t remember the whole program, but I was overwhelmed by the roaring reception that greeted Jascha Heifetz when he finished playing a version of the “Flight of the Bumblebee” as the opening piece in the concert. I do have the fond memory of Milstein playing a portion of Johann Sebastian Bach’s “Brandenburg Concerto” and Isaac Stern bringing the house down with “Saint-Saëns Rondo Capriccioso.” The concert went on for nearly two and a half hours, and I doubt if many of these hard-nosed infantrymen left the concert area. A great number of encores were played, and I still will never forget Jascha Heifetz playing a portion of Nicolo Paganini’s “First Violin Concerto.” When requests for encores were made by these musicians to the audience, I very timorously raised my hand and asked for a portion of the Felix Mendelssohn “Violin Concerto.” I was sitting right across from Isaac Stern when he rose to play it, and sitting at almost a hand’s reach away from him, I was enveloped by the lovely sounds that appeared to resonate with everyone, for a deep silence greeted him when he finished, followed by a persistent roar from the audience who rose and burst into wild applause intermixed with whistling and hurrahs.

Afterward I was taken aback by the universal acclaim tendered by everyone there, most of whom had probably never heard of these musicians nor the classical music they played. Yet somehow, in the midst of a terribly destructive war, these great musicians were able to penetrate one’s very being and awaken this marvelous feeling of inner peacefulness and joy. Over the years, I followed the musicianship of these great violinists, purchased their recordings and attended their concerts. Yet never had their wonderful violins touched me more than an impromptu concert during World War II in a rest area in Germany. Yes indeed, to us, at that time, the real Big Three were named Heifetz, Milstein and Stern!
Massachusetts Anesthesiologists Represent ASA Before National Conference of State Legislatures

Lisa Percy, J.D., Manager
State Legislative and Regulatory Affairs

For its seventh year, ASA attended the National Conference of State Legislatures (NCSL) Annual Meeting. Approximately 9,000 people, including 1,700 state legislators, attended the meeting in Boston last August. ASA was one of 13 groups who participated as exhibitors in the “Physicians Advocating for Patients” joint booth. NCSL’s Annual Meeting provides ASA with an opportunity to increase the visibility of anesthesiologists and educate state legislators about anesthesiologists and their achievements in advancing patient safety as well as other issues facing physicians.


Participating on behalf of the Massachusetts Society of Anesthesiologists were Alexander A. Hannenberg, M.D., Mark D. Hershey, M.D., and Jesse M. Ehrenfeld, M.D. Thank you to everyone who generously volunteered their time. ASA has already begun planning for the NCSL 2008 Annual Meeting, which will be held in New Orleans on July 20-27, 2008.
“Two are better than one, because they have a reward for their toil. For if they fall, one will lift up the other; But woe to one who is alone and falls and does not have another to help. Again, if two lie together, they keep warm; but how can one keep warm alone? And though one might prevail against another, two will withstand one. A threefold cord is not quickly broken.”

— Ecclesiastes 4:9-12

One of the many social “ailments” that faces the countless, nameless masses is isolation from others. The reasons may vary, but the loneliness that ensues may contribute to chronic stress. It is a well-known fact that if babies are left completely alone at birth, they will likely suffer from “failure to thrive” and can actually die if they are not held and nurtured as part of their basic care; this may occur even if their other basic needs are met, e.g. food, shelter and clean clothing. While we as adults are not known to die from the same affliction, our bodily and our psychological health are still dependent on our healthy and appropriate physical and emotional enmeshment with others. Two independent university studies found that premature death occurs at twice the rate in adults who are isolated and do not cultivate friendships. The impact of the isolation described in these studies is considered to be the equivalent of the effects of hypertension, hypercholesterolemia, obesity and/or lack of physical exercise.

Many adults find themselves alone or isolated as a result of burnout or stress. In today’s world, more often than not, our first line of communication is nonpersonal in almost every facet of our daily existence: We suffer through multiple and annoying computer voice selections just to reach an operator (person) at a department store, we text message instead of talking, use ATMs instead of interacting with a bank teller, and we utilize all manner of cold, alienating and people-eliminating methods to communicate with each other. Even something as simple as booking a plane flight or as complicated as booking a month-long safari with our local travel agent is done “online.” We are financially penalized for using a person rather than a computer to perform either of these tasks and, likewise, if we want a “paper” plane ticket. Even in a perfect world, most of us have less communication with those whom we consider very important in our lives than we might have had even a decade ago. That is in a perfect world. Most of us don’t live in our idea of a perfect environment, either at work or at home or both.

This is an “egg or chicken” conundrum: It is not known whether being isolated is a symptom of burnout or a condition that leads to burnout and/or stress. Social scientists do know that one of the most primitive actions that humans strive for is connection. We are actually born with “an insatiable inner need for meaningful interaction with others.”

When there is a lack of meaningful personal attachments in our everyday lives, we suffer — some individuals more than others. The total social context in which we live dictates our response to lack or loss of personal relationships. In other words, this part of the stress response doesn’t occur in a vacuum. Many of life’s other stressors (discussed in a previous article by the author in the November 2000 ASA NEWSLETTER) may contribute to how someone deals with the particulars of their personal relationships. The loss of such attachments, however, may be one of the most profound symptoms or causes of stress and burnout.

“Intimate attachments to other human beings are the hub around which a person’s life revolves.”

— John Bowby

Why Do We Find Ourselves Isolated?

Despite previous perceptions and plain simple dogma, social scientists now believe that burnout occurs most commonly as a result of the breakdown in the social context of
the workplace environment, not because of flaws in the individual. Maslach hypothesizes that it is an individual’s efficiency and an ability to control his/her work surroundings that determines response to stress. More importantly we now know that the more significant factor in managing stress is the structure of the organization and its ability to allow each person to interact productively within the organization and with each other. Perhaps the most important fact in this restatement of how the “organization” may be the “culprit” in an individual’s stress response is that it does not appear to preferentially affect those with any particular place in the hierarchy of that “organization.” The loss of an organization’s ability to “treat its employees with humanity leads to a loss or erosion of the soul.” Maslach further describes burnout as “the index of the dislocation between what people are and what they have to do.” This erosion of “humanity” includes a loss of values, dignity, spirit and will.

Maslach’s description of a triad of emotional exhaustion, cynicism/depersonalization and a feeling of ineffectiveness or perceived lack of personal accomplishment paints the modern picture of burnout as most people experience it in today’s already detached society. As individuals tend to fall into this “Bermuda Triangle,” it is not just a psychological morass; it is possibly a matter of life and death.

How Do We Recognize When We Are Burned Out?

It is not unusual for an individual to ignore or simply not recognize the signs and symptoms of burnout until they are physically, mentally and/or emotionally at risk. When someone is faced with the loss of control — one of the outward manifestations of stress — that individual can become overwhelmed by stress hormones that accompany exhaustion. Their physical health may be threatened. These hormones represent the “fight or flight” response, which over time can lead to a plethora of medical problems that may include hypertension, heart disease, headaches, chronic fatigue even with adequate sleep, or chronic sleeping or insomnia, among many other maladies.

Additionally pathologic emotional issues such as anxiety, depression, sleep disturbance and/or anger and aggression may accompany the physical symptoms. These may progress to increased thoughts of death or suicide. If we bring our burnout home (which is hard not to do!), it is not unusual for our relationships to suffer, particularly with those whom we love the most. Any “toxic” relationships in which we may be involved tend to deteriorate or in some cases to insidiously “poison” those involved. If you are in “burnout,” you may find it more and more difficult to control interactions in these unhealthy situations, many of which may need to be severed.

When individuals are in full “burnout,” they may start to isolate themselves from or avoid interaction with others.

“‘It is not unusual for an individual to ignore or simply not recognize the signs and symptoms of burnout until they are physically and mentally at risk.’”

Social opportunities and invitations to spend time with family, friends and/or relatives may start to feel like “traps” from which they feel the need to withdraw or even “cages” from which they respond to in recoil. They may start dreading going to work or feeling like work is a “dead end.”

Substance abuse or other compulsive behaviors, including over-work, are not unusual. Even if “work-aholism” is part of our burnout pattern, we may have a sense that we are accomplishing less despite seeming to work harder. We may find ourselves involved in a dysfunctional work environment, including team interaction failure (e.g., with our anesthesia care team), partnership issues, trans-generational problems (old versus new partners) and call or work-sharing issues.

If we start to make patient care errors or to question our ability to perform our work without incident, we have to act immediately to reassess our status. If we fail to do so, that intervention may be done for us, usually after a sentinel event occurs. It is imperative to inventory our lives to avoid getting to this point.

Why Is It Important to Look at the Quality of Our Relationships?

It is a given that all of us have a very limited amount of time to spend on relationships. Yet connections to one another are literally our lifeline to a long and happy life. Jeffrey Gitomer has said: “I’ve heard the saying: ‘There’s only two big decisions in life, where you’re going, and who you’re going to take with you.’” This is so true. It is important to spend time with the people who are “traveling” with us; without this time together, we do not get the emotional support that we need to remain healthy. It is therefore essential to constantly assess the quality of our relationships and friendships, to eliminate those that are no longer working, and to refresh those that are indispensable to our emotional health.

How Do We Optimize Our Ability to Make and Keep Quality Friends?

Any type of personal relationship, whether romantic, collegial or those in our intimate circle of “best” friends,
As the time comes around for the ASA Annual Meeting, we are offered a good opportunity to take stock of the year from the viewpoint of the “Residents’ Review.” Just as we do when performing a busy anesthetic — sitting back and trying to take in the big picture can reveal ways to optimize the task at hand.

This column, the “Residents’ Review,” offers anesthesiology residents the most consistent vehicle for presenting their viewpoints within ASA publications. As such, it is important that the editorial schedule and the commentaries put forth in the column be decided upon and selected by the elected editors.

At publications where the stakes are high, different constituencies can sometimes act in ways that undermine editorial independence. In fact, I feel the stakes are of significant importance for the ASA NEWSLETTER. At the same time, it seems to me that great care has been taken to allow the resident editors to operate free from interference. We certainly appreciate the autonomy.

The staff at ASA headquarters has been extremely helpful. Communications Executive Assistant Karen Yetsky, in particular, helps to keep the trains running on time. Without her generous assistance, the column overall would have been a much poorer product.

This year there have been some really outstanding contributors. It is appropriate to use the column to discuss issues of political importance to residents — such as the Legislative Conference, governmental affairs, elections and the roles of different posts in the resident leadership. We had the opportunity to hear from the residents who participate actively in the anesthesia subspecialties as well. And, of course, it is of critical importance that medical students interested in the specialty have the chance to participate. But the column really shines when residents take it upon themselves to make submissions.

For example, residents from New Orleans in 2005 gave us a snapshot of what disaster preparedness might look like for us all in the future:

“Within a week of my return, power was returned to uptown New Orleans, and my neighbors began to move back home,” wrote Kristie D. Osteen, M.D., then a resident at Ochsner Health Systems. “With no trash removal service, the streets became cluttered with garbage. Because of the lack of refrigeration, many residents relied on a few operating restaurants for their meals. The lines at these restaurants were long, and they frequently ran out of food. It was unbelievable what had happened to this amazing city.”

Anthony R. Plunkett, M.D., writing about his work volunteering with a military mission in Ho Chi Minh City, offers us an experience of a type of practice many of us will never see:

“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 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.”

Christina M. Reiter, M.D., supplied perhaps the most powerful column written this year. In it, she described the emotions one encounters when dealing with the repercussions of substance abuse by a colleague:

“Most days I don’t even think about those syringes I carry around in my pockets. They help me care for my patients by treating their anxiety and pain. They can be a nuisance when I forget to fill out my controlled substances
As an editor of the column, I wish I could take credit for soliciting Dr. Reiter’s column. But I have to say the benefit goes to Anagh A. Vora, M.D., a very capable writer and editor. Unfortunately Dr. Vora has since decided to leave the field of anesthesiology and subsequently vacated his position as co-editor of the “Residents’ Review.” In his place, the Resident Governing Council has appointed Todd J. Smaka, M.D., a second-year resident at Oregon Health & Science University. Dr. Smaka brings a wealth of talent and life experience to the position, and both he and the incoming elected editor (as of the ASA Annual Meeting) will no doubt have plenty to offer.

I started as co-editor as a first-year resident two years ago. At the time, I wrote a column reflecting on resident training in procedures, “A Tempest in a Teapot?” The theme was intended to take after the ASA seal: “…the pilot wheel, perfect circle, shield, stars, clouds, moon, ship, sea and lighthouse. The motto is VIGILANCE. The patient is represented as the ship, sailing the troubled sea with clouds of doubt, waves of terror, yet being guided by the skillful pilot (the anesthesiologist) with constant and eternal (stars), vigilance (motto) by his dependable (lighthouse) knowledge of the art of sleep (moon) to a safe and happy outcome of his voyage through the realm of the unknown. The perfect circle denotes unity of a closed group (the Society).”

I would like to thank the residents of anesthesiology for the opportunity to represent them in the happy and fruitful position as co-editor of this column.

What’s New In: Stress Management

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depends on the same basic tenets. The relationships that we choose to nurture require attention and careful selection. At a minimum, they all involve good listening skills, the type of listening that the late psychologist Carl Rogers called “growth-promoting.” This involves the ability to convey an authentic interest in what the other has to say and the ability to empathize. It also includes the ability to reciprocate without overwhelming the other. True friendship doesn’t include keeping score in any context or at any level. There is an understood belief that “what goes around comes around,” that we will eventually get back what we put in. If the relationships in your life don’t seem to fit within these parameters, reassessment of their worth is essential.

Conclusion

The take-home message is that none of us will lead healthy lives without close connection to others. When circumstances occur that may cause us to find ourselves “circling the drain” of burnout, these connections may suffer and sometimes fail. Without nourishment, we may lose the greatest lifeline(s) that we (hopefully) have to draw us back. The qualities of loyalty, forgiveness, honesty, dedication, commitment and personal sacrifice allow us to weather the bumps in the road with any true friend; for without these qualities, we will likely be unable to sustain meaningful friendships for the long haul. The absence of these important connections may literally mean the difference between life and death for any one of us at any time.

“Be courteous to all, but intimate with few, and let those few be well tried before you give them your confidence.

“True friendship is a plant of slow growth and must undergo and withstand the shocks of adversity before it is entitled to the appellation.”

— George Washington

References:
SNACC: 35 Years of Progress in Neuroanesthesia

Cor J. Kalkman, M.D., Ph.D., President
Society of Neurosurgical Anesthesia and Critical Care

The Society of Neurosurgical Anesthesia and Critical Care (SNACC) started life 35 years ago as a multidisciplinary group of anesthesiologists and neurosurgeons with a shared vision to create and disseminate knowledge about neurosurgical perioperative care. The previous decades had seen the development of techniques for the measurement of cerebral blood flow, metabolism, intracranial pressure and neurochemical compounds. These new research tools were used to examine the effects of anesthetics on cerebral blood flow and metabolism, on cerebrovascular responses after traumatic brain injury and on the dynamics of intracranial hypertension.

A consistent focus on original scientific research has remained an important characteristic of SNACC. At annual meetings, held immediately prior to the ASA Annual Meeting, a large proportion of time is allocated for presentation of scientific work: Typically more than 100 posters will be presented (to a total of 200-plus attendees), making SNACC one of the most research-driven subspecialty societies in anesthesiology. Junior researchers are encouraged to submit and present their work at the annual meeting, and various awards and travel grants serve as further incentives to our junior members. In addition at the SNACC Annual Meeting, there will up to two keynote speakers who present the latest in cutting-edge basic neuroscience. Recent topics have included neurodevelopment, neural repair, stem cell research, neuroprotection, preconditioning, anesthetic neurotoxicity and central nervous system (CNS) inflammation. The importance of these topics for clinical practice may not always seem obvious at the time, but these lectures are always well received. Many of the topics presented several years ago, which may have seemed esoteric at the time, have recently found clinical application.

SNACC is increasingly aware of the need to practice “evidence-based neuranaesthesia.” For example in the 1990s, a large number of studies showed significant neuroprotection by mild hypothermia in experimental models of cerebral ischemia. This prompted clinicians to induce mild hypothermia intraoperatively in their patients undergoing surgical clipping of cerebral aneurysms. The Intentional Hypothermia for Aneurysm Surgery Trial, or HAST-2, study was designed to test the hypothesis that this practice will improve neurological outcome.

The study protocol for this randomized, controlled trial was designed and executed by a group of highly committed neuroanesthesiologists and neurosurgeons. A total of 1,001 patients undergoing aneurysm surgery were randomized to intraoperative mild hypothermia or normothermia — with only a single patient lost to follow up. The results showed that there was no clinical benefit of routinely cooling these patients, which underscores the need to rigorously test neuroprotective strategies that seem promising in the experimental setting in clinical trials before incorporating them in clinical practice.

Some important adverse neurologic outcomes are too rare to study in randomized trials. The ASA Postoperative Visual Loss Registry aims to increase our knowledge about causes and contributing factors to this rare but disastrous postoperative complication. These ongoing, important efforts highlight the maturation of the Society — from one whose members primarily generated basic research — into an organization that defines how neuroanesthesia is practiced around the world.

SNACC’s official journal is the Journal of Neurosurgical Anesthesiology (JNA), which is produced under the able leadership of James E. Cottrell, M.D., and John D. Hartung, Ph.D. Founded in 1989, the journal publishes original material in the form of clinical and laboratory investigations, clinical reports, review articles, journal club synopses of current literature, presentation of points of view on controversial issues, book reviews, correspondence and selected abstracts from affiliated neuroanesthesiology societies. Neuroanesthesia societies from Austria, France, Germany, Japan, Korea, Mexico, Switzerland and...
APSF Conducts a Conference on Technology Training

Robert K. Stoelting, M.D., President
Anesthesia Patient Safety Foundation

The topic for the Anesthesia Patient Safety Foundation (APSF) Board of Directors’ workshop to be held on Friday, October 13, 2007, at the San Francisco Parc 55 Hotel from 1 p.m. to 5 p.m. will be “Formal Training Before Using Advanced Medical Devices in the Operating Room — Voluntary or Mandatory for the Anesthesiologist?” The conference has been organized by Michael A. Olympio, M.D., chair of the APSF Committee on Technology, and will include speakers representing clinical anesthesia, equipment manufacturing, hospital administration, the airline industry and the legal profession. ASA Annual Meeting attendees are welcome to attend this conference.

APSF envisions that all anesthesiologists who apply advanced medical devices, which directly affect a patient’s vital functions and immediate safety, will be certifiably trained prior to such clinical application. The manner in which such training is applied or successfully accomplished is not known and requires deliberate investigation. For example the most effective method of introducing a new anesthesia machine (“workstation”) into the operating room has not been thoroughly investigated despite recent and dramatic increases in the complexity of these machines.1,2

New anesthesia machines often introduce unique and subtle variations in breathing circuit design, automated checkout, volatile drug delivery, hidden piston ventilators, fresh gas delivery and ventilation modes. New designs intended to enhance patient safety can actually have unintended and adverse consequences, particularly in stressful clinical situations. Despite conventional pre-use instruction with or without simulation, anesthesiologists may not be able to reliably assess their ability to safely use new equipment in clinical practice.3 Anesthesiologists who received additional simulation training with the equipment were more likely to correctly apply anesthesia machine features during a simulated anesthesia emergency.3

Although the incidence of equipment-related critical events is infrequent, morbidity associated with these events may be catastrophic.4 The question is: “Should this training be voluntary or mandatory?”

Current Practice

Conventional “in-service” programs are often recognized as superficial and inadequate because they do not require advanced preparation, are not mandated, do not allow individual practice, do not test for learning or application skills and are frequently abandoned for lack of time on the part of the anesthesiologist. These programs typically occur only once when new equipment is installed, do not account for personnel who are away from work that day, and do not accommodate new personnel.

Experience With an APSF Pilot Program

Members of the APSF Committee on Technology designed a training program for clinicians who would be using newly purchased anesthesia machines.2 Although all the clinical leaders agreed that additional anesthesia machine training would be valuable, it was difficult to reach a consensus on issues such as 1) requests for proof that training was necessary, 2) convincing anesthesiologists that the program was necessary, 3) providing time and resources for those being asked to take the training, 4) measuring the outcome and value of the training process and 5) determining the consequences of refusal or failure to participate.

Results of the APSF Pilot Program

The effort to justify, organize and accomplish a comprehensive technology training program prior to the installation of new and unfamiliar anesthesia machines proved to be an intimidating challenge. In retrospect the greatest mistake was to not mandate the program for all categories of clinicians (residents, student nurse anesthetists, nurse anesthetists and staff anesthesiologists) who would be responsible for using the equipment upon installation.

The chair of the department where the pilot program was conducted endorsed the training but did not mandate it.7 Perhaps not surprising, participation by staff anesthesiologists in all phases of the training was disappointing. In retrospect this chair would now view the program not as a clinical study but as a major departmental safety initiative.
Buy-in from faculty would be prospectively sought, and fac-
ulty members who failed to complete the training course
would not be assigned clinically until they did so. The chair
asked, “What private or academic anesthesia group wants to
recruit an anesthesiologist … who declined to participate in
a mutually agreed-upon safety initiative?”

Conclusion
How would a patient likely respond if asked whether
training before using complex anesthesia equipment in the
operating room should be voluntary or mandatory?

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Subspecialty News: SNACC

Continued from page 28

the United Kingdom also have chosen JNA as their official
dournal.

Most of SNACC’s clinician members practice neuroanesthesia on a daily basis, and their interests typically
focus on anesthesia and the CNS. Many exciting new areas in anesthesiology can be considered “neuron” anes-
thesia, but they are not necessarily linked to the practice
of anesthesia for neurosurgery. Some examples that have
captured the interest of SNACC members are: neurologic
complications of carotid endarterectomy, cardiac and
noncardiac surgery, intraoperative and intensive care unit
neuromonitoring, visual loss due to ischemic optic neu-
ropathy, quantitative evaluation of hypnosis and analge-
sia, and neurocognitive decline after surgery.

As a result of this widened scope, SNACC recently
redefined its mission as: an organization dedicated to
improving the perioperative and intensive care of
patients, who are neurologically impaired or at risk of
developing neurological complications, through
advances in medicine and research.

Despite a decrease in membership in many anesthesi-
ology subspecialty organizations, SNACC membership
has remained at a stable 400-plus anesthesiologists and
basic scientists worldwide, half of whom typically visit
the annual meeting. One element of this stable member-
ship has been an increasing proportion of overseas (non-
U.S.) members during the last decade. This makes
SNACC a truly international anesthesiology subspecialty
organization. With the widened scope, we encourage
those who traditionally do not consider themselves to be
neuroanesthesiologists, but who are actively engaged in
some aspect of the wider neuroscience community, to
join SNACC.

To join, please complete and submit an online
SNACC membership application form (which can be
found on the SNACC Web Site: www.snacc.org.

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ASA is pleased to announce the 2008 Certificate in Business Administration Program. The program is designed to provide physicians with the business skills needed to successfully manage the operations and functions of their health care organization or medical practice. The first on-site session will be held the weekend of March 1-2, 2008, at the Woodlands Resort and Conference Center in Houston, Texas. Three additional on-site sessions at the Woodlands will be held throughout the year. Please see the other dates below:

August 2-3, 2008
November 15-16, 2008
January 10-11, 2009

The program consists of a total of 10 modules. Five of the modules will be presented at the on-site sessions, and five of the modules will be completed through distance learning via DVD/ROMs. Space is still available for the course, so sign up today. The brochure is now available on the ASA Web site at www.ASAhq.org/conted/cba.htm. Please feel free to call Mary Teister in the ASA Executive Office at (847) 825-5586 for additional information.

ASA gratefully acknowledges the following sponsors of the 2007 Annual Meeting in San Francisco, California. Their support in funding various noneducational activities allows the ASA Annual Meeting to continue as the premier anesthesiology meeting in the world.

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Denise M. Jones, ASA Executive Office, 520 N. Northwest Highway, Park Ridge, IL 60068; e-mail D.Jones@ASAhq.org; or fax (847) 825-2085.

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American Society of Anesthesiologists NEWSLETTER

October 2007 • Volume 71 • Number 10
ASA Member ‘Washingtonian to Watch’

The May issue of the Washingtonian featured Yewande J. Johnson, M.D., as a young “Washingtonian” to watch. Dr. Johnson was included for her caring work at Children’s National Medical Center.

MUA Warnings Highlighted

John C. Rowlingson, M.D., commented on the controversial practice of manipulation under anesthesia (MUA) in the May 14 edition of the Modesto Bee (Modesto, California). Dr. Rowlingson questioned the safety of MUA and said research has indicated that patients risk injury by undergoing the treatment.

Awareness in Philly Health Segment

Lee A. Fleisher, M.D., was interviewed for a May 23 KYW-TV (Philadelphia, Pennsylvania) health segment on anesthesia awareness. Dr. Fleisher commented on the rare occurrence of anesthesia awareness and the unique anesthesia needs of each patient.

Anesthesiologist Elected to ISMS Board of Trustees

The May 24 Kane Country Chronicle reported that Wayne V. Polek, M.D., was re-elected to the Illinois State Medical Society Board of Trustees. Dr. Polek has served as a member of the society’s Council on Communications, Council on Membership and Advocacy and the Finance and Medical Benevolence Committee.

SOAP Awards ASA Member With DSA

The May 27 News & Record (Greensboro, North Carolina) announced that Frances M. James III, M.D., received the 2007 Distinguished Service Award of the Society for Obstetric Anesthesia and Perinatology.

AZ Anesthesiologist Has Story With Bite

The Kingman Daily Miner (Kingman, Arizona) reported on May 28 on the efforts of Gordon Thomas Burns, M.D., to educate area children and residents about venomous animals that reside in northwest Arizona.

Dr. Cottrell on ‘Good Morning America’

ASA Past President James E. Cottrell, M.D., appeared in a May 30 “Good Morning America” segment discussing the rare occurrence of anesthesia awareness and patients believed to have experienced awareness.

Anesthetic Action in Scientific American

An article by Beverley A. Orser, M.D., Ph.D., in the June issue of Scientific American explored the research about how current potent anesthetics actually work and how this will lead to future generations of safer, targeted anesthetics with fewer side effects and complications.

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.
Advice From Past Prepares Us for Future

The description by Jeffrey R. Balser, M.D., of Debra A. Schwinn, M.D. (August 2007) encouraging “the discipline of anesthesiology to view the operating room as the last human physiology [and I would add pharmacology] laboratory,” struck a familiar chord for me. During my anesthesiology residency from 1959 to 1961, Robert D. Dripps, M.D., frequently stressed, “Every anesthesia is an experiment.” I continue to follow current thinking and developments in the specialty.

Allen E. Yeakel, M.D.
Mount Joy, Pennsylvania

Reader Would Like to Comply But Can’t Find the Time

Thank you for the article “Antibiotics Within One Hour: The Clock is Ticking” in the May 2007 ASA NEWSLETTER.

Unfortunately the detailed definition of time envisioned in the PQRI measure “on-time administration of prophylactic antibiotics within 60 minutes prior to incision” is never stated in the article.

From the red referral box on page 25, I went to the tan box on page 33 “30. ...for whom administration of prophylactic antibiotic has been initiated within one hour ....” I am a part-time anesthesiologist in several nearby facilities and would like to help each comply with this PQRI measure. I ask each director of pharmacy how to interpret the measure: a) initiate the I.V. infusion during the 60 minutes immediately preceding the incision, b) complete the I.V. infusion during the 60 minutes immediately preceding the incision, c) initiate and complete the I.V. infusion during the 60 minutes immediately preceding the incision, and then I ask d) what about fluoroquinolone, vancomycin and other slow infusion antibiotics? I get a different response from each, and on return visits, the response changes.

The evidence on which this measure of care is based proved that the infusion should be administered and completed so the peak tissue level is present at incision. This occurs 30 to 60 minutes after infusion completion, depending on the antibiotic.

It is very hard to comply when there is no detailed statement for exactly what “time” is being measured.

Wallace H. Good, Jr, M.D.
St. Albans, Vermont

Misleading Title Is One for the Ages

Eight years ago I retired from clinical anesthesia, and since then I have been lost in “The Wilderness of Not Being Needed.” It’s true, I’m still a member of ASA, the Massachusetts Society of Anesthesiologists and the American History Association and similar upper-case groupings. Even though vital and important, these organizations offer little in particular to the retiree.

Imagine my joy when in the May 2007 ASA NEWSLETTER, I read the title of the article by Deborah J. Culley, M.D., and Frederick E. Sieber, M.D. They had founded a Society for “Aging” Anesthesiologists. They looked a bit young to be running such an organization, but I knew the editorial office of the NEWSLETTER had a large collection of portraits taken in the 1980s.

I would join immediately, and at the first meeting find colleagues who started practice in the 1960s and 1970s. We would hide our ignorance of transesophageal echocardiography. All 5,000 of us would join.

United, we would become a storehouse of knowledge and experience and a resource to the specialty. We could write to Congress on your behalf. We could write history as we experienced it. We could mentor and befriend residents. Those of us who can still hear could help departments by conducting preoperative interviews. We would look back and help you look into the future. We could give advice to ASA’s leaders. We would meet regionally, sit in deep leather armchairs and quaff low-salt brandy; we would exchange “war stories,” i.e., gossip about surgeons. Most of all, we would have a collegial identity and feel useful.

Then I read the text of Drs. Culley and Siebers’ article. That is also quite important. It’s about taking care of us
when the time comes for hip replacements.
I hope the mistitling of this article will lead to something great for those of us no longer giving safe anesthesia in the operating room.

Gerald L. Zeitlin, M.D.
Chestnut Hill, Massachusetts

References:

Wood Library-Museum (WLM) at Work

I read with great interest “WLM: A Treasure Trove of Anesthesiology History” (May 2007) written by Shiva Birdi, M.D., Corry J. Kucik, M.D., D.M.C.C., and Alexander Wolfson, M.D., three WLM Board resident representatives for 2007. They wrote, “As anesthesiologists and residents, we cannot address many of the challenges facing our specialty today without the benefit of knowing our past.” The importance of this statement for the future of our specialty cannot be overemphasized!

To promote knowledge and understanding of fundamental concepts of anesthesia through a historical perspective, the chair of the department would bring to the residents antiquated pieces of anesthesia equipment. The chair would inquire about the name of the object, its use, clinical correlation and connection to modern-day equipment. The individual who wrote the most concise paper, connecting the historical significance to modern equipment, would receive a stipend. Through this intellectual “walk through time,” the knowledge gained and understanding achieved would be immeasurable.

Visit the WLM Web site, learn the history of your specialty, and make every effort to pass along all the knowledge you gain.

Thomas E. Schulte, M.D.
Omaha, Nebraska

Reader Tips His Hattox to 1980 President

I was pleased to see the emphasis on ASA’s ongoing political efforts in the July NEWSLETTER (2007 Government Affairs: All Hands on Deck).

However, I was disappointed that the article by Timothy J. Quill, M.D., “A Brief History of ASA Involvement in Governmental Affairs,” did not mention the immense contributions by John S. Hattox, M.D., to ASA’s efforts.

ASA has had so many incredibly talented presidents and others who have advanced anesthesia’s cause in Washington. Dr. Hattox truly needs to be recognized as an important organizer and leader of most of the early ASA Legislative Conferences. As ASA President in 1980 and chair of the Committee on Governmental Affairs for many years, John was truly out in front, blazing the trail for many of us to follow.

Thanks for the opportunity to comment!

Steven R. Young, M.D.
Indianapolis, Indiana
A Critical Appraisal of the Present and the Future of Neuroanesthesia Research

William L. Lanier, M.D.

We neuroanesthesiologists are to be given credit for introducing techniques into the laboratory and into clinical practice for monitoring basic physiology and, in clinical practice, facilitating the safe delivery of anesthesia for neurosurgical and neurologically impaired patients. When one evaluates our half-century of contributions to the cutting edge of medicine, however, it is easy to appreciate that, while we have been extremely creative in developing and introducing hypotheses and theories, we have been lacking in our follow-through. Accordingly, we have all too often accepted unproven or underevaluated theories and applied them to clinical practice. Additionally, much of the critical testing of our ideas in humans has come not at the hands of neuroanesthesiologists, but by others.

If we, as a discipline, are to make appropriate progress, I suggest several ideas for improvement:

We must realize that, in the current era, the gold standard for biomedical research is the improvement in patient outcomes or patient safety. As such, our research must be conducted with this endpoint as the ideal conclusion.

We must disabuse ourselves of comfortably assuming that “the whole is equal to the sum of the parts.” Indeed there is ample evidence — in studies of glucose, corticosteroids, cyanide and elsewhere — that results from laboratory test tube and culture plate experiments do not predict outcome in whole animal models, and outcome studies in whole animals do not ideally predict outcomes in complex human physiology. If we want to most accurately improve outcomes and safety in humans, we must study specific human situations. And we have to use appropriate endpoints in those studies, not convenient surrogate end-points, if our research is to have optimal validity and clinical utility.

We must embrace the idea that modern research is exceedingly complex, with single research projects typically requiring the input of experts from many disciplines, coordinated by leaders with considerable organizational and communications skills. As such, when recruiting our next generation of neuroanesthesiologists, we need to think not predominantly in terms of which training program candidates have the personality to sit with a single patient during a prolonged (and sometimes monotonous) neuroanesthetic, but also in terms of candidates who have the communication skills and leadership potential to engage in — and hopefully lead — team research. Then, we as mentors, department administrators and supporters need to encourage these individuals to acquire skills in logistics, statistics, epidemiology, pharmacology, genomics and the like so that they can bring fresh insights into solving age-old and modern problems.

We must accept the fact that the provision of neuroanesthesia is increasingly migrating out of the operating rooms and intensive care units into diagnostic and therapeutic radi-

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ology suites and other locations. These areas are associated with some of modern medicine’s greatest advances in the care of neurologically at-risk or impaired patients (e.g., as is seen with the rapid use of thrombolytic therapy after embolic or thrombotic stroke). We neuroanesthesiologists have the potential for some of our greatest contributions in these expanding venues, but only to the extent that we are comfortable working in teams with other experts, often in a role other than that of the principal leader. We should embrace these opportunities while realizing that, in the end, the patients benefit.

Finally we must look for opportunities to work with our fellow anesthesiologists in other disciplines to solve important problems. The understanding and prevention of neurologic injury in cardiac anesthesia has, in my opinion, been hindered by unacceptably poor communication and exchange of ideas between neuroanesthesiologists and cardiac anesthesiologists. (One need look no further than the management of cerebral perfusion pressures and the use of corticosteroids to see that this is the case.) Elsewhere, greater contributions from neuroanesthesiologists would be of substantial value in research related to peripheral nerve injury, ischemic optic neuropathy, intraoperative awareness and other conditions. Despite these opportunities, we neuroanesthesiologists have not taken optimal advantage of applying our expertise.

In summary, some five decades’ worth of neuroanesthesiologists can take pride in the intellectual and practice advances that we have contributed to modern medicine. If we are to maintain and advance the professional respect that we have long enjoyed, however, we must: 1) be more disciplined in our investigational follow-through, 2) interact more effectively with experts from other disciplines, and 3) re-evaluate the type of individuals we recruit to our discipline and the type of training we provide them. If we adhere to these three simple rules, neuroanesthesia can expect considerable advances for many more decades.

Truly Unsung Heroes

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so if a booby trap was involved, it could be established when the mishap took place. Red Ethridge further explained that most of their work had to do with unexploded American or British bombs since these combat areas had experienced heavy saturation bombing. Since the Allies still did not have total air supremacy, however, the Luftwaffe would still make its appearances, especially at night. One of our not so favorite nocturnal visitors was called “bed-check Charlie,” and this German Dornier bomber would punctually make an appearance at 10 p.m., dropping its cargo on bridges, supply dumps and other installations.

One day, while we were deep in France, I noted a BDS unit working not far from our encampment and stopped by to say hello. To my pleasant surprise, I encountered Master Sgt. Willie D. Wilkes and inquired about Capt. Ethridge. His face clouded, and taking my elbow, he walked me to a shed and then proceeded to tell me an unbelievable tale.

About a month before, they were ordered to remove a 500-pound unexploded German bomb that fell on a nearby French civilian hospital. The team first ordered all the patients and personnel to be evacuated, and then the sergeant and the captain went to work on the bomb with the rest of the team setting up a communication module a good distance away. Wilkes said that from the onset they had problems trying to disassemble this bomb. They continuously had to search through the updated Army field manuals and bulletins looking for this type of bomb, and at one point, Capt. Ethridge made a cryptic remark that he did not know how far he will have to go with this type of a bomb. It was only later that Wilkes realized the impact of these words Red Ethridge believed that it was booby-trapped! One of the alternatives was to purposefully explode the bomb if it was thought that it was not possible to disarm it manually. But since the bomb was located in a heavily populated area right off a critical highway and in a hospital complex, Red Ethridge decided to try a different mechanical approach. He told Sgt. Wilkes to join the others at the communications center, and when the sergeant said that he wanted to stay, the captain ordered him to leave. Again Sgt. Wilkes tried to convince Capt. Ethridge to allow him to help with the disassembly, but to no avail. The captain proceeded with his efforts, reporting every step he was taking, when suddenly there was a large explosion, the line went dead, and many in the team were knocked over by the force of the explosion. This quiet professional-type of engineer was vaporized!

Eyes tearing, Willie D. Wilkes walked away, knowing that his life was saved by the duty-bound, knowing sacrifice of “Red” Ethridge. Requiescat in pace, bro…!