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Ethics and Patient Care: Striking a Balance

ARTICLES

DEPARTMENTS

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

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

Anesthesiologists have unique ethical responsibilities beyond the Hippocratic Oath. When litigious, political and personal issues are thrown into the picture, ethical objectivity can become confusing. This issue explores the ever-changing world of medical ethics.

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Death in a Droplet

It is a hot, oppressive morning in an arid, third-world country. The last bags are loaded into the cargo bay. A service truck makes some final adjustments to the air-handling system. Soon, the 747 jet is bound for Washington, D.C.

The pleasant afternoon breeze on this perfect spring day is in direct contrast to the antiquated world left behind. The passengers deplane; some to meet family in the D.C. area, others to make connections with flights departing to all points across the United States.

A few days later in Chicago, a middle-aged businessman complains of abdominal cramping, asthenia, congestion and headache. His watery diarrhea is rapidly dehydrating him, and faint red lesions begin to appear on his body. If it were not for his hardy condition, he would have sought medical attention a day earlier; but now it is time to be healed by American medical care.

The disease advances into large black eschers, and he becomes extremely edematous. Rales, widened mediastinum, hypotension, meningitis, mechanical ventilation and death complete his hospital course. The doctors are baffled, but more puzzling are the reports of similar cases in Washington, D.C., New York and Los Angeles. The Centers for Disease Control and Prevention (CDC) has made the diagnosis of inhalational anthrax emanating from the airplane, reaching Washington D.C., from "somewhere east." Quarantines are now posted in the affected metropolitan areas. Transportation into and out of these cities is restricted. Houston, Des Moines and Portland also report cases of anthrax to the CDC. The first case of a hospital employee being afflicted is seen in Chicago. Americans are in a panic, staying in their homes, wearing surgical masks. Drug stores are being raided for any available penicillin, tetracycline, erythromycin or chloramphenicol. The comfortable life that we take for granted in this country has been transformed into a quarantined state with martial law being imposed.

This little vignette of medical horror is unfortunately only a terrorist's thought away from possibly occurring somewhere in the world in the next few decades. The threat of bioterrorism grows as the government, medicine and pharmaceutical companies struggle to address the possibility of its occurrence. With respect to the relatively slow progress being made, there is cause for hope — yet concern about preparedness.

We, as anesthesiologists, have a negligible (if any) presence in developing strategies for preventing or administering to the catastrophe. Certainly, this topic is never considered by annual meeting organizers, and if it were, few would be expected to attend the session. Depending on the inoculum, however, our specialty, along with surgery and emergency medicine and nursing, would probably be in the first wave of medical casualties. Perhaps it is appropriate for the ASA leadership and meeting organizers to begin introducing the topic at future meetings.

It is important to appreciate why I, as an anesthesiologist, continue my tirade about bioterrorism. Consider the following cases and statistics that strengthen my paranoia:

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

Our Patient Safety Record Is in Grave Danger

Barry M. Glazer, M.D.
ASA President-Elect

As your President-Elect, I will have to admit that this column is difficult for me to write. As I compose these words, my thoughts are overwhelmed by the Clinton Administration's decision, in its final days, to publish the rule removing the Health Care Financing Administration's (HCFA's) long-standing requirement that nurse anesthetists be supervised by a physician.

At the inception of Medicare, this requirement was included in the Conditions of Participation — rules imposed by HCFA on hospitals — with which they must comply to be eligible for payments from the Medicare system. Removal of the federal requirement for physician supervision will defer the decision to the states as well as to individual hospitals. While nurse anesthetists must still comply with state laws and hospital bylaws and rules, if this rule becomes effective, there will no longer be a federal minimum standard for the delivery of anesthesia care.

Barry M. Glazer, M.D.

This change takes place in an environment, both within government and within society, that permits lower levels of practitioners to deliver progressively higher levels of care in every area of medicine. A lack of understanding of the intricacies of medical care allows society to be tolerant of what Representative David Weldon, M.D., (R-FL) calls the "dumbing down" of medicine.

Mortality associated directly with anesthesia care has decreased 50-fold in the last half of the 20th century. While recognizing this high level of safety, HCFA has chosen to ignore the reasons for that safety record. Why is anesthesia care so safe today?

It is because of the contributions that anesthesiology as a medical specialty has made to patient safety. Most people think first of new monitoring devices and drugs as making anesthesia care safer, and that is somewhat true. But the fact is, anesthesiologists assured that those devices and drugs were suitable for clinical care and were incorporated in daily practice. Anesthesiologists set the standards of care that enabled those devices to become used widely. Anesthesiologists did the research to determine what the causes of anesthesia-related deaths were and developed the practice parameters that teach how to avoid those deaths.

ASA formed a Committee on Patient Safety and Risk Management, and our Committee on Professional Liability did the closed claims study. Anesthesiologists produced patient safety videotapes. ASA started the Anesthesia Patient Safety Foundation (APSF) — almost 15 years before the American Medical Association started its National Patient Safety Foundation, which was modeled after ours. The American Association of Nurse Anesthetists, several months ago, withdrew its contribution of $40,000 per year to APSF, while ASA continues to contribute $400,000 yearly to that foundation, in addition to our other activities in behalf of patient safety. And ASA contributes more than $1 million per year to the Foundation for Anesthesia Education and Research.

Long before newer monitors and drugs were introduced, the number of anesthesiologists involved in patient care was increasing steadily, and the number of deaths was decreasing even in the face of progressively more complex surgeries on older and sicker patients. Anesthesiologists have insisted on physician involvement in anesthesia care. In the study that showed a death rate of one in 250,000 from anesthesia —which HCFA uses to indicate how safe anesthesia care is today — every patient had an anesthesiologist involved in his or her care.

There are now strong scientific studies that demonstrate the importance of an anesthesiologist being involved in the anesthetic care of the patient and the contributions of the anesthesiologist to safe care and good outcomes. But even in the absence of those studies, at the inception of Medicare, common sense dictated that in the critical care inherent to the administration of an anesthetic, there must be a physician supervising such care to assure that the medical problems of the patient are managed in the perioperative period and that medical knowledge and sound medical judgment are a required component of the patient's care.

Nurse anesthetists are certainly valuable in the delivery of anesthesia care in a wide variety of settings, but none of those settings exists without the presence of a physician, even when no anesthesiologist is available. While the

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ASA Increases Efforts to Overturn Clinton 'Midnight' Supervision Rule

Michael Scott, Director
Governmental and Legal Affairs

Acting upon the opportunity provided by President Bush's sweeping suspension of the effectiveness of end-of-term regulations published by the Clinton Administration, ASA has called on its members, senior citizens and other concerned parties to express to new Health and Human Services (HHS) Secretary Tommy Thompson their opposition to the rule published January 18, eliminating physician supervision of nurse anesthetists for Medicare patients.

The Bush order extended the effective date of the rule until mid-May to give Secretary Thompson adequate time to consider the appropriate course of action. Even prior to his confirmation by the Senate, ASA sent a strongly worded letter to the new Secretary, criticizing the insensitivity of the prior Administration to legitimate patient safety concerns and urging him to overturn the rule.

In early February, the American Medical Association, the Association of American Medical Colleges, all 50 state medical associations and over 35 national medical specialty societies wrote Secretary Thompson, urging him to rescind the rule. The text of the joint letter appears in a box on page 4. At last count in mid-February, over 5,000 e-mails had been sent to the Secretary by ASA members, senior citizens and other rule opponents; several Senators and Representatives have also weighed in with the Secretary on behalf of anesthesia safety.

Also in early February, sponsors in the 106th Congress of the Safe Seniors Assurance Study Act of 1999 introduced a new version of the bill (H.R.716/S.332), calling for an anesthesia outcomes study of various anesthesia delivery modes prior to any action to eliminate the federal rule. ASA President Neil Swissman, M.D., will have sent an update to the membership on the new bill by the time this column appears. It will also serve as one of the focal points for ASA's Legislative Conference to be held in Washington D.C., April 29-May 2.

Opening Guns Sounded on Patients' Rights Bill

Seemingly taking up right where it left off last year, the Congress has already begun to focus on the terms of revised "compromise" legislation granting protections to managed care subscribers from abusive practices. The new player on the scene, however, is of course President George W. Bush, whose views on the issue vary significantly from those of his predecessor. Although he campaigned last fall on the basis of his pro-patients' rights record in Texas, the fact is that as Governor, he vetoed one such bill in Texas. The bill that ultimately was passed became law without his signature.

In early February, the Administration announced that it was preparing its own patients' rights legislation and, at the same time, expressed concern about any bill that would unreasonably open the door to litigation against managed care organizations and employers. The liability issue is of course the very same issue upon which this legislation foundered in the Senate last year, and very few attitudes appear to have changed in the past several months. It is doubtful much progress can be made until the Administration's position becomes clearer.

Bush Proposes Stop-Gap Indigent Drug Benefit Plan

At the end of January, President Bush fulfilled a campaign promise and proposed a plan to provide block grants to states to make drug coverage available to about 9.5 million Medicare beneficiaries at or near the poverty level. The plan would last for four years or would end sooner if a more comprehensive drug benefit plan was enacted. The cost is estimated at about $48 billion over four years.

In offering the proposal, the President endorsed more sweeping Medicare reforms, including drug benefit premium support, as proposed by a bipartisan commission last year. Democrats oppose this approach, believing that a drug benefit for beneficiaries should be developed as an integral part of the Medicare program.

HHS Under Clinton Sets Privacy Rules

As noted briefly in last month's column, the Clinton Administration prior to its departure issued sweeping final regulations designed to protect the privacy of patients' medical records. Development of the new rules was mandated by the 1996 Health Insurance Portability and Accountability Act (HIPAA) in the event Congress was unable to reach consensus on privacy standards.

The new regulations take effect in 2003, and regulations required by statute are not affected by President

Bush's regulatory suspension order issued January 20. They represent the second in a series of required administrative simplifications contemplated by HIPAA. The first of the required regulations, dealing with electronic exchange of health care data, was published in October 2000. Both sets of regulations will be reviewed by speakers at ASA's annual Legislative Conference, this year to be held April 30-May 2 at the J.W. Marriott Hotel in Washington, D.C.

The new privacy regulations require patient consent for the routine release by providers of any information from medical records and special consent for the nonroutine release of information such as for marketing and fund-raising. Covered providers include health care providers who transmit health care data electronically, health plans and health care clearing houses as well has health care Web sites and online pharmacies.

Covered providers are required to contract with their "business associates," e.g., independent billing agencies, to extend the privacy protections to those entities. Providers are not, however, required to monitor the activities of their business associates, as had been provided in the proposed regulations issued earlier. Covered providers may, however, transmit only the minimum information required for billing purposes, but they enjoy full discretion when sending information to other providers for consultative treatment purposes.

The new regulations are expected to create something of an administrative nightmare for provider groups in that they do not override stricter state requirements already in existence. The Administration has estimated that the new regulations will cost an added 19 cents per visit; provider groups believe this figure is much too low.

HHS Secretary Thompson Receives Letter With Renewed Support From Doctors

On February 1, a letter was sent to HHS Secretary Tommy Thompson that was signed by more than 80 physician organizations. Similar to the letter sent to his predecessor last year, the organizations call for Secretary Thompson to "take the action necessary to rescind" the rule published in the *Federal Register* on January 19.

Medical societies from all 50 states, Puerto Rico and the District of Columbia as well as the major surgical societies signed the following letter:

Dear Secretary Thompson:

The undersigned surgical and medical associations are writing to express our profound concern over issuance by the Clinton Administration on January 18 of a final rule eliminating physician supervision of nurse anesthetists from the Medicare/Medicaid Conditions of Participation for hospitals and ambulatory surgical centers. We urge you to take the action necessary to rescind that final rule.

We support the position of the American Society of Anesthesiologists and Anesthesia Patient Safety Foundation that revision of the pre-existing physician supervision requirement should be considered only after development and review of current scientific outcomes data. We are deeply troubled by the position of the Clinton Administration, set forth in the preamble to the final rule, that the elimination of physician supervision can be presumed to be safe — without scientific proof —in light of the overall improvement of anesthesia safety over the past several years during which physician supervision has been required. We believe Medicare and Medicaid beneficiaries deserve better than a mere presumption of safety that has no basis in the scientific literature.

We applaud President Bush's order suspending the effectiveness of this final rule for 60 days, and hope you will use the added time to construct a new rule that is more sensitive to the legitimate needs of Medicare and Medicaid patients.

[For complete list of signatories, see <www.ASAhq.org/HCFA/SpecialtySocLtr.htm>, or the February 15 *President's Update*.]

Specialty-Specific Ethical Issues for the Anesthesiologist

Stephen H. Jackson, M.D., Chair
Committee on Ethics

Transcending all recorded civilizations and cultures, the art of healing inevitably has been enveloped in moral and religious wrappings. The revered Hippocrates emerged from a Greek civilization in which physicians were priests, yet he espoused that healing should be a scientific activity based on observing nature's ability to cure illness. In so doing, he initiated the separation of medicine from religion, but he also maintained medicine's attachments to its moral origins.

To this day, physicians abide by Hippocrates' urging to bestow benefit to their patients while avoiding harm and injustice, and to care for patients in a moral manner. Accordingly, medieval guilds, as well as modern medical organizations such as ASA, have promoted the obligation of the physician to be trustworthy and reputable as well as competent. Thus, through the millennia, medical ethics has embodied a relatively unswayed set of moral admonitions and ideals.

The armamentarium of modern medicine's capacity to diagnose and treat disease would be largely unrecognizable by those physicians who practiced when I was a child. Yet our current body of clinical medicine is destined to change at an even more accelerated pace. Assuredly, as this new age of medicine offers the gift of life and health, it concomitantly will challenge the adequacy of traditional medical morality and ethics. As physicians strive to benefit patients while avoiding harm, we surely will encounter the dilemma of not always being certain what constitutes a benefit and, likewise, a harm.

With this background in mind, members of the Committee on Ethics in this issue of the *NEWSLETTER* have focused on several ethical issues of specific interest to our specialty, ones generated by the special skills that anesthesiologists possess. R. Dennis Bastron, M.D., and Robert J. McQuillan, M.D., begin by looking at the yearly affirmation required of all ASA members to abide by the "Guidelines for the Ethical Practice of Anesthesiology."[1] Gail A. Van Norman, M.D., and Susan K. Palmer, M.D., then follow with a discussion of restraint and coercion as these relate to the ethical obligation of the anesthesiologist to the uncooperative patient. Indeed, the Committee on Ethics has agreed that anesthesiologists should *not* use their skills to restrain or coerce *competent* patients, and shall be recommending incorporation of this statement into the guidelines. Carl C. Hug, Jr., M.D., Ph.D., follows by sharing thoughts he conveyed in the 1999 E. A. Rovenstine Memorial Lecture on intervention in patients near the end of life.[2] David B. Waisel, M.D., and Robert D. Truog, M.D., conclude by presenting information for the ethical management of patients with existing do-not-resuscitate orders who present for anesthesia and surgery.[3,4]

"As physicians strive to benefit patients while avoiding harm, we surely will encounter the dilemma of not always being certain what constitutes a benefit and, likewise, a harm."

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A Code of Conduct

R. Dennis Bastron, M.D.

Robert J. McQuillan, M.D.
Committee on Ethics

Statements of ethical behavior have been a part of medical practice for some 4,000 years, beginning with the Code of Hammurabi, circa 2,000 B.C.E., which established fees for medical practitioners and penalties for bad outcomes. These statements may take the form of prayers, oaths, creeds, declarations or institutional directives. The Oath of Hippocrates, 4th century B.C.E., is the most famous example in Western medicine. This oath stems from a highly developed system of moral belief — probably Pythagorean — and indicates that to be a good physician, one must first be a good and kind person.

Modern American codes of ethics began with the writings of John Gregory and Thomas Percival, both Scottish physicians. In 1794, Percival was asked to mediate a dispute among surgeons, physicians and apothecaries at the Manchester Infirmary. His manuscript, published as "Medical Ethics" in 1803, was more popular in the United States than Europe and was the model for the 1809 "Boston Medical Police," written by John Warren, Lemuel Hayward and John Fleet for the Association of Boston Physicians. "Medical Ethics" was also the model for the 1847 Code of Ethics for the newly formed American Medical Association. This was the first national code of professional ethics in the world.

Codes of medical ethics are valuable and necessary because of the nature of physician-patient relationships. The predominant characteristic of the covenantal relationship is the vulnerability of the patient. Anesthesiologists' patients are especially vulnerable. Depriving patients of their consciousness and protective reflexes heightens our level of responsibility and duties to them. This has been termed by some to be an "existential" vulnerability because, should their trust be misused or abused, devastating consequences can occur. This level of professional responsibility has historically been attributed to four professions: medicine, clergy, teaching and law. "Existential vulnerability" is at the heart of why these professions must have professional codes that maintain the trust of those they strive to serve.

Ethics always has been a part of the practice of anesthesiology. Crawford W. Long, M.D., received permission to administer ether to James Venable; and William T.G. Morton, asked the permission of Gilbert Abbott before administering "Letheon" (a term used by Dr. Morton to disguise the identity of ether). Moreover, John Collins Warren, M.D., who operated on Mr. Abbott, refused to allow Morton to administer "Letheon" at the Massachusetts General Hospital until he divulged the active ingredients. Morton finally admitted that it was sulfuric ether, and he administered an anesthetic for the first major operation under ether. The surgery was performed by George Hayward, M.D. It seems that the "Boston Medical Police" (written by the fathers of these two surgeons) proscribed the use of nostrums — medicines with secret ingredients.

The problem of increased vulnerability of anesthetized patients was recognized soon after the public demonstration of ether, even by proponents of painless surgery. Apparently their fears were justified. Within months, sexual assaults on etherized females were reported in France, New York City and Philadelphia. Fifteen-year-old Hannah Greener became the first anesthetic fatality in January 1848. Furthermore, prominent surgeons soon began to applaud anesthesia for allowing them to perform *involuntary* surgical procedures to "circumvent the opposition of the timid and unruly"; and "placing the patient in a passive condition gives the surgeon a control over him which could

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not possibly obtain in any other manner." It is no small wonder that ASA places so much emphasis on ethical behavior as espoused in its "Guidelines for the Ethical Practice of Anesthesiology!"

ASA first promulgated its ethical guidelines in 1967, and it endorsed and incorporated the American Medical Association's "Principles of Medical Ethics." At the August 1997 Board of Directors meeting, ASA District Director Peter L. Hendricks, M.D., a U.S. Navy veteran familiar with the development of the 1955 Code of Conduct for members of the U.S. Armed Forces, responded to an anecdotal reporting of unethical behavior of anesthesiologists. He proposed that ASA develop its own code of conduct. The Board of Directors referred this matter to the Committee on Ethics, which after two years of discussion determined that the "Guidelines for the Ethical Practice of Anesthesiology," originally constructed as a guide to ethical behavior, already served the purpose of a Code of Conduct.

The 1999 House of Delegates adopted the Committee's recommendation that every ASA member, in order to be a member in good standing, should sign their membership card as a yearly affirmation that they are bound to abide by the guidelines. In fact, the ethical guidelines are the only such binding ASA document. As a result, the membership card now contains the following statement above the signature line: *As a member in good standing of the American Society of Anesthesiologists, I agree to the ASA "Guidelines for the Ethical Practice of Anesthesiology."* Moreover, the annual dues invoice states that "Membership in good standing of the American Society of Anesthesiologists requires adherence to the ASA 'Guidelines for the Ethical Practice of Anesthesiology.'"

It is hoped that the prominence of these statements will enhance members' awareness of their ethical obligations and encourage them to study the "Guidelines for the Ethical Practice of Anesthesiology."

The authors wish to thank Stephen H. Jackson, M.D., Chair of the Committee on Ethics, for his helpful suggestions.

The full text of the "Guidelines for the Ethical Practice of Anesthesiology" is available online at <http://www.ASAhq.org/Standards/10.html>.

Administrative Update

Continued from page 2

technical skills of the nurse anesthetist deserve appropriate respect, every physician knows that medicine is often unpredictable and that the administration of an anesthetic may present a medical emergency at any time. Federal regulations requiring the involvement of a physician in anesthesia care are there to ensure the presence of the medical expertise for addressing medical emergencies rapidly. Now those regulations may not include that requirement even though medical emergencies will continue to occur.

Be assured that ASA will continue to advocate for physician involvement in the care of every patient receiving an anesthetic. Our efforts at the federal level are not yet exhausted; the Bush administration has delayed the effective date of this new rule from March 19 to May 18, and we are actively advocating for reversal of the Clinton Administration's decision.

We also are aware that this activity may shift to the states. Be assured that our commitment to this advocacy at the state level will continue and increase. Patient safety is our primary concern, and our ethical commitment to safe patient care will not allow us to abandon this effort.

Please write to Secretary Tommy Thompson today, and ask your family and friends to write as well: The Honorable Tommy Thompson, Secretary, Department of Health and Human Services, 200 Independence Ave., S.W., Washington, DC 20201; or e-mail at <hhsmail@os.dhhs.gov>.

For more information with a direct link to Secretary Thompson, go to the revised <www.AnesthesiaSAFETY.NET> Web site.

When Should Anesthesiologists Restrain Uncooperative Patients?

Gail A. Van Norman, M.D.
Susan K. Palmer, M.D.
Committee on Ethics

Case Description

"Timmy" is a healthy, unpremedicated 9-year-old boy scheduled to have restorative dental work under general anesthesia. Both parents have taken time off from work for the procedure. Timmy barely acknowledges the anesthesiologist when introduced. As the anesthesiologist discusses intravenous (I.V.) and mask induction with Timmy and his parents, Timmy becomes agitated, saying that he wants to go home. Timmy's father tells him that he cannot go home until his dental work is done, while his mother reassures him that "nothing is going to hurt." Timmy states that, "I don't want a mask." When the anesthesiologist approaches to start an I.V., Timmy becomes red-faced and begins to cry, saying loudly that he does not want a needle and that the doctor is going to hurt him. His voice becomes shaky, and he jerks away thrashing his legs as his parents attempt to physically restrain him.

* * * * *

How should the anesthesiologist approach the uncooperative pediatric (or adult) patient? What are the ethical and legal considerations regarding manipulation, coercion or restraint in the care of patients? Do anesthesiologists have special ethical and legal responsibilities when choosing to use their special skills on patients who have not or cannot give their consent?

Manipulation and restraint are two methods commonly used to control patients.[1-3] *Manipulation* of patients includes lying, omitting essential information or taking advantage of a patient's vulnerabilities to gain cooperation. Manipulation is unethical because it violates trust and exploits the inequality of power in the patient-doctor relationship.[1] Ethically speaking, *coercion* is the control of another person by use of a "credible and severe threat of harm or force," while *restraint* is the use of physical or chemical means of controlling a patient's unwanted behavior.[1] Withholding pain medications from a patient with a severely displaced femur fracture until a surgical consent is signed, for example, may be coercive, even if the physician's goal is to avoid claims that administering analgesics might invalidate the consent. Coercion is unethical because it destroys a patient's autonomy and thus violates a fundamental principle of Western medical ethics to promote and respect patient autonomy.[1,2]

Technically, patients with impaired competence cannot be "manipulated or coerced" since they are by definition not able to make autonomous decisions in the first place.[1] Such patients include minors and those with mental handicaps, psychiatric disease or organic or metabolic brain disorders. Restraint can be physical or chemical and can be voluntary or involuntary: Intramuscular (IM) injection of ketamine in an uncooperative patient is involuntary restraint, while convincing a 9-year-old who does not want surgery to agree to take oral midazolam prior to starting an I.V. is voluntary restraint.

Is it ethical for anesthesiologists to use physical or chemical restraint to manage uncooperative patients with impaired competence? Like all physicians, anesthesiologists have an ethical duty to preserve patient autonomy and dignity as much as possible.[1] If a patient is competent to refuse medical care, then proceeding against the patient's will is unethical and probably illegal. On the other hand, it may be ethical to restrain an incompetent patient if legitimate surrogate decision-makers for the patient have determined that the care is in the patient's best interest. Oral premedication, for example, is one humane way to restrain patients who will not be competent to consent to care on

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the day of surgery. For the unpremedicated, agitated patient, the ethical solution may be to choose to delay anesthesia in order to permit sedation for more humane restraint. Preventing stress and physical struggling preserves patient dignity and may be useful, provided it does not delay medical care so long that the benefits of medical therapy will be lost.

The first question to ask in any case where restraint is considered is whether the patient is competent to refuse medical therapy. Refusal of medical therapy is the moral and legal right of every competent patient, even if the therapy would be life-saving.[1-3] Examples of refusals of care that we commonly respect are the right to not be resuscitated, the right to refuse intubation and the right to refuse blood transfusions. Patients are competent to refuse care if they can understand what care is being offered, understand the risks and benefits of both receiving and refusing care, and can render and communicate a decision that is in part based on the medical information given to them.[4] Use of coercion or restraints with such a patient is unethical and might represent a criminal *assault.*

In the United States, unimpaired patients over the age of 18 are considered legally competent, while patients under 18 may not be. This is based on the assumption that most children and adolescents cannot fully appreciate the implications of their choices and may render decisions based on fears of short-term discomfort rather than long-term benefits. The courts have recognized, however, that some children are competent to make medical choices and that the rights of children to not undergo medical procedures to which they have not given their *assent* extends to very young ages.[5,6] It is against federal law, for example, to include a child over age 7 in medical research protocols without his or her assent.[5] When a child under the age of 18 refuses medical care and demonstrates all or at least some of the characteristics of *medical decision-making ability*, expert opinion may be necessary to resolve the issue.

The patient in the above example does not demonstrate behavior suggesting competence to refuse therapy. But that does not mean we can or should automatically proceed with physical or chemical force. The American Academy of Pediatrics Committee on Child Abuse and Neglect suggests that "significant restraint" should not be used in pediatric care "unless it is necessary for proper diagnosis and treatment in a sick child, as in the case of a child with a high fever and potential ear infection, or in emergency situations."[7] It has been argued that chemical and physical restraints may have no place at all in a pediatric setting and only limited use with other patients who have impaired competence.[8] It is a duty of the anesthesiologist to provide safe, humane medical care while preserving as much as possible the dignity and autonomy of the patient.

* * * * *

Timmy is old enough to exercise some choices in his medical care. At his age, it may be possible to try to calm him enough to proceed with the case while still preserving his dignity. Timmy may not be competent to decide that he does not need dental care, but he may be capable of decid-

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Definition of Terms:

Assault: Legal term describing unconsented touching of a person's body for any purpose.

Assent: Agreement given by minor patients to medical procedures or to participate in medical research.

Coercion: Control of a person's behavior by use of credible and severe threat of harm or force.

Informed medical consent or refusal: A legally binding decision to allow or refuse medical care by a patient who understands the consequences of their decision and who meets legal criteria for competence.

Manipulation: Altering a patient's behavior or decisions by lying or omitting essential information or taking advantage of a patient's vulnerabilities.

Medical decision-making ability: A spectrum of abilities that may be continuously or intermittently present in a patient who may or may not be competent for other purpose, e.g., a patient may never be competent for making his or her own financial decisions and yet have some ability to participate in decisions about his or her medical care.

Restraint: Physical or chemical means of restricting a person's behavior; can be voluntarily agreed to by a patient or can be involuntary.

> "It is a duty of the anesthesiologist to provide safe, humane medical care while preserving as much as possible the dignity and autonomy of the patient."

ing, for example, how he wants to go to sleep. Choices, wherever possible, can allow pediatric patients or patients with otherwise impaired autonomy to retain some control over their environment. Many authors suggest that offering such choices can mitigate the fears of such patients, providing a more humane experience.[9] Many pediatric patients can be calmed enough through creative use of fantasy or hypnotic suggestion to allow some medical procedures such as a blood draw or I.V. start to be done. Protecting Timmy from current and future harm may require delaying the case and approaching him later when he is calmer.[10]

* * * * *

What happens when, despite the parents and anesthesiologist's best efforts, Timmy cannot or will not accept the choices offered to him? Should he be restrained physically for an I.V. start or mask induction? Should he be given IM ketamine? Such a course of action may be justified if the need for medical care is urgent. Delaying an emergency appendectomy, for example, may put his life at risk, while delaying elective dental work probably does not. There are many pressures to proceed immediately, including the surgical scheduling, the potential economic loss to the physicians and the hospital, and the fact that the parents have each lost a day of work. However, it may be in Timmy's best interest to delay or reschedule his medical care in order to reduce the potential for traumatic stress, provide safer induction conditions and avoid promoting a future aversion to medical care. Timmy could be offered an oral premedication to take, for example, and then be anesthetized later in the day when he does not physically resist the anesthesiologist. When delays are not likely to provide better conditions for the patient, the anesthesiologist may have to proceed in a manner best designed to preserve patient safety and dignity.

In summary, coercion, manipulation or restraint of competent patients is generally unethical and may be illegal. An ethical and legal exception is the use of coercion or restraint to control behavior of competent or incompetent patients who pose a physical danger to themselves or to others. Premedication might be considered in incompetent patients to reduce trauma and stress to the patient and provide safer induction conditions. Patients with impaired competence should be offered as much choice in their anesthetic care as possible. Voluntary means of gaining cooperation of unpremedicated patients should be explored before resorting to involuntary restraint. When restraint is used, the anesthesiologist should choose, whenever feasible, methods that best preserve the patient's dignity and limited autonomy.

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Prospective Planning for Interventions in Patients Near the End of Life

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The marvels of science and technology applied to medicine have extended life expectancy and created an ever-expanding number of survivors of chronic disease and acute, life-threatening illnesses. When these survivors are threatened with a new disease or an acute exacerbation of their chronic illness, there is a strong inclination to intervene because of the availability of numerous therapeutic options, the high expectations of medicine and the demand to "do something!"

At the same time, there is growing concern among U.S. citizens about living with disability and pain, ending up in a nursing home, being abandoned, being dependent on machines and extending biological life (lung and heart function) but not meaningful life. As Morrie Schwartz said to Ted Koppel on "Nightline": "For me, Ted, living means I can be responsive to the other person. It means I can show my emotions and my feelings. Talk to them. Feel with them.… When that is gone, Morrie is gone."

Physicians, including anesthesiologists, are frequently confronted with dilemmas about the appropriateness of risky interventions and the balance of potential benefits versus risks. The risks include not only death and the pain and suffering related to the intervention but, even more importantly, the burdens of lingering disability, loss of independence and a poor quality of life.

Until the 1960s, the physician made decisions about therapeutic interventions with guidance from the Hippocratic principles of beneficence ("do good") and nonmaleficence ("do no harm"). But in the last 40 or so years, the principle of autonomy has become a mainstay of medical ethics. Autonomy is derived from the Greek *autos* ("self") and *nomos* ("rule"). Now the patient makes decisions with the guidance and agreement of the physician.

It seems that two questions bring the critical issues of medical decision-making into focus for the patient as well as for the physician, family members and friends: *1) What are your goals for this intervention? 2) What risks and burdens are unacceptable to you?*

Medicine has been described as the science of uncertainty and the art of probability. We have available all sorts of statistics on which to base predictions of outcomes. Seldom are the statistics so clear-cut as to make life-and-death decisions easy. Of course, they can be presented in a way that makes for "no-brainer" decisions: "95 percent of patients have their hearts fixed with this operation; only 5 percent of patients die." Who would not take those odds? But what about complications such as kidney failure and sepsis that are listed in fine print on the consent form? Each complication has a risk statistic, and the compilation of all risks of all potential complications is mind-boggling to patients and physicians alike. Seldom is there a certainty of a bad outcome. Hence, there is always hope until the actual intervention is made on each individual patient. The only way to be sure is to try and see. A therapeutic trial offers the following answer to the two questions posed above: *If your goals for this intervention are unlikely to be realized, if burdensome and unacceptable disabilities are likely to persist, then we will allow nature to take its course.* We will withdraw life-supporting measures.

"Medicine has been described as the science of uncertainty and the art of probability. We have available all sorts of statistics on which to base predictions of outcomes. Seldom are the statistics so clear-cut as to make life-and-death decisions easy."

It should be recognized that there are no significant ethical, moral or legal distinctions between withholding versus withdrawing life-supporting measures in the critically ill

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patient near the end of life. If anything, the moral burden of proof may be heavier when the decision is made to withhold treatments than when it is to withdraw treatments.

Surgical Trial

A surgical trial scenario might read as follows: An 80-year-old woman develops angina pectoris and mild heart failure that impairs her self-sufficiency. She is fiercely independent and fears permanent confinement to a nursing home. Coronary bypass is agreed to with the goal of relieving her symptoms and maintaining her self-sufficiency. She understands and accepts the use of life-supporting measures necessary to get her through the operation, which will include cardiopulmonary bypass, hemodynamic resuscitation, mechanical ventilation and other intensive care measures. She accepts these standard routines of perioperative care for the cardiac surgical patient for a time sufficient to allow recovery from anesthesia and the acute insults of surgery. But once it is clear that she has sustained a complication that is as disabling as her current symptoms, all extraordinary measures will be stopped and nature will be allowed to take its course.

The intent is to restore her self-sufficiency and to reduce or eliminate her pain and dyspnea. But if the effort fails, the patient (or more likely her proxy) is free to refuse further treatment and to have life-supporting extraordinary measures (including such aids as a feeding tube) withdrawn. This surgical trial is *not* a form of euthanasia or physician-assisted suicide.

The key to appropriate implementation of a surgical trial is thorough preoperative planning by the patient, the health care proxy and physicians and surgeons who will be involved in the patient's care. All must understand the patient's wishes in terms of the goals to be achieved and the burdens to be avoided. These should be accurately described in the patient's medical record and communicated to the family members and friends by the proxy and to the nurses and other care givers by the physician. Continuing communication about the patient's progress, or lack thereof, is essential. The patient or proxy should be informed about any significant complication as soon as it arises, and a decision should be made either to treat (perhaps on a try-and-see basis) or not to treat it. The decision to forego further interventions is virtually a do-not-resuscitate (DNR) decision. In some states, specific permission is required from the proxy to enter a DNR order on the chart.

But remember that DNR has another meaning: "Do Not Relax." In other words, all the existing, agreed-upon life-supporting and comfort care measures need to be continued to the very end, and the family members and friends need reassurance that the patient will not be abandoned. When it is clear that the complication or the patient's deterioration precludes achievement of the patient's goals and/or imposes a burden that the patient previously declared to be unacceptable, then withdrawal of life-support measures is appropriate.

Prospective planning of surgical trials may take considerable time and effort on the physician's part, but it has the advantages of 1) respecting the patient's autonomy, 2) making life and death decisions easier or at least more acceptable to all concerned, 3) reducing feelings of guilt and uncertainty among family members and 4) avoiding recrimination against the proxy who has to make the decisions.

Sooner or later, every one of us will face these dilemmas for our patients, family members and friends, and for ourselves. Although we prepare for death in regard to insurance, last wills and testaments, tax-avoiding trusts, and the like, it would be prudent to spend time informing ourselves and our loved ones about how we wish to be cared for at the end of life. We can designate a health care proxy by executing a legal document giving that person durable power of attorney for health care decisions on our behalf should we become incompetent; and it may be worthwhile to draw up a so-called "living will."

Morrie Schwartz said: "Everyone knows they're going to die, but nobody believes it. If we did, we would do things differently. … To know you're going to die and to be prepared for it at any time: That's better."

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Informed Consent for the Patient With an Existing DNR Order

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In 1993, ASA published "Ethical Guidelines for the Anesthesia Care of Patients with Do-Not-Resuscitate Orders or Other Directives That Limit Treatment." This statement endorsed patients' rights to refuse resuscitation in the operating room and suggested that standing do-not-resuscitate (DNR) orders be re-evaluated for the perioperative period instead of being automatically revoked. The American College of Surgeons published a similar statement in 1994.

While it is clear that re-evaluating orders for the perioperative period is ethically unassailable, it is equally clear that clinical implementation of re-evaluation is problematic. To that end, the Committee on Ethics developed the "Informed Consent for Anesthesia Care in the Patient With an Existing Do-Not-Resuscitate Order" form to facilitate discussion and documentation of perioperative DNR orders. The form consists of the four options discussed below.

OPTION 1. FULL RESUSCITATION

I, _____, desire that full resuscitative measures be employed during my anesthesia and in the postanesthesia care unit, regardless of the situation.

Most articles discuss methods for patients to refuse therapy in the perioperative period because historically the status quo has been to insist upon full resuscitation. This does not mean, however, that it is inappropriate for a patient to revoke the DNR order. Indeed, there are a number of reasons why a patient may prefer this option. A clear reference, such as revocation, avoids the question of determining "what is resuscitation" and reassures patients that no effort will be spared in performing resuscitation. In addition, outcomes from cardiopulmonary resuscitation (CPR) performed in the operating room are far superior to outcomes from CPR performed outside the operating room. Revocation works well for patients who will accept any burden in exchange for any possible benefit of therapy.

OPTION 2. LIMITED RESUSCITATION: PROCEDURE-DIRECTED

During my anesthesia and in the postoperative care unit, I, _____, refuse the following procedures:

Some patients may prefer the security of being able to define precisely what interventions are permitted. Anesthesiologists advise their patients based on the benefit and burden of the intervention as well as the likelihood of that intervention allowing the patient to achieve desired goals. Interventions on such lists include tracheal intubation or other airway management, postoperative ventilation, chest compressions, defibrillation, vasoactive drugs and invasive monitoring. Patients should be informed that inconsistent or incompatible requests cannot be honored. The inconsistent nature of some requests, such as receiving intravenous medications but not having an intravenous line placed, needs to be clarified to the patient. For another similar example, consider the need for general endotracheal intubation to relieve a bowel obstruction in a patient receiving chronic anticoagulation therapy. In this case, the patient needs to be informed that tracheal intubation is mandatory for the anesthesia and surgery to occur and that the patient can either have the surgery with the tracheal intubation or can refuse surgery. Although the patient must have tracheal intubation to facilitate anesthesia, the patient may still refuse other forms of resuscitation and may opt to define circumstances in which to have care withdrawn postoperatively.

Procedure-directed orders work well for patients who

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want to unambiguously define which procedures are desired and, for that benefit, are willing to forego the ability of perioperative caregivers to customize the extent of resuscitation based upon clinical situations that may be difficult to predict.

OPTION 3. LIMITED RESUSCITATION: GOAL-DIRECTED

I, _____, desire attempts to resuscitate me during my anesthesia and in the postanesthesia care unit only if, in the clinical judgment of the attending anesthesiologist and surgeon, the adverse clinical events are believed to be both *temporary* and *reversible*.

OPTION 4. LIMITED RESUSCITATION: GOAL-DIRECTED

I, _____, desire attempts to resuscitate me during my anesthesia and in the postanesthesia care unit only if, in the clinical judgment of the attending anesthesiologist and surgeon, such resuscitation efforts will support the following goals and values of mine:

The form also should offer two options for goal-directed orders. Clinical experience indicates that many patients prefer Option 3 as a standard goal-directed order, and we would recommend that as the starting point. If, however, the phrase "temporary and reversible" does not adequately describe the patient's desires, Option 4 may be used for the patient to clarify his or her goals.

The goal-directed approach arose from the idea that since many patients think in terms of outcomes, it is often more effective to talk about goals rather than procedures. By taking advantage of the operating room environment in which specific physicians take care of a patient for a defined period of time, patients may guide therapy by prioritizing outcomes rather than procedures. After defining desirable outcomes in individual discussions with the perioperative physicians, patients authorize those physicians to use their clinical judgments to determine how specific interventions will affect achievement of these goals.

The strength of the goal-directed approach is that physicians should feel that they could truly honor the patient's desires without having to worry about getting "caught" in a technicality inconsistent with the patient's desires. Even better, predictions about the success of interventions that are made by the anesthesiologist at the time of the resuscitation are likely to be more accurate than predictions made preoperatively, when the quality and nature of the problems are not known.

Goal-directed orders work well for patients who want their perioperative caregivers to customize the extent of resuscitation based on the caregivers' understanding of the patients' goals for the postoperative period. For this benefit, patients must accept the ambiguity that comes with relying on caregivers to apply their assessments of the clinical situations to their interpretations of the patients' goals.

Postoperative Planning: Using the Opportunity to Withdraw Care to the Patient's Advantage

While not included on the form, a useful adjunct to the decision-making involved in perioperative resuscitation is the opportunity to withdraw care. *This option is available no matter which of the options for perioperative resuscitation is chosen*. The ability to give the patient a trial of therapy, such as mechanical ventilation, is one of the better ways to fulfill patients' end-of-life requests to be the recipient of resuscitative efforts without the possibility of "getting stuck on the ventilator." Choosing this option, for example, is a way of declaring that the burden of a few days of ventilatory support may be worth the potential benefit of extubation of the trachea but that the burden of long-term ventilation is not worth it, especially if there is a decreasing likelihood of success. If the time-limited trial is deemed unsuccessful in light of the declared goals, then mechanical ventilation may be withdrawn. The act of withholding therapy requires greater certainty in the likelihood that a therapy will fail than does withdrawing a therapy after it has been shown to be unsuccessful.

Conclusion

Using a form with Options 1-4 will facilitate communication and documentation. Its success still depends on the willingness and ability of the caregivers to take the time to engage the patient in discussion and to ensure that patients' well-documented wishes are followed. DNR orders are predicated on the idea that patients may choose to forgo certain procedures and their possible benefits because they reject the associated burdens. The burdens may be related to either the resuscitation attempt itself or to the decrement in functional or cognitive capacity that may follow a suc-

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Infection Control Recommendations: Their Importance to the Practice of Anesthesiology

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When appropriate infection control precautions are used, the risk of occupational transmission of blood-borne pathogens such as hepatitis C virus (HCV) from patients to anesthesiologists is relatively low. Additionally, since the risk of occupational HCV transmission to patients is quite low, HCV-infected anesthesiologists have been permitted to continue to practice if they follow strict aseptic techniques and standard precautions.[1-3]

The importance of compliance with these infection control recommendations is emphasized by a recent report from Germany.[4] Using epidemiologic evidence and molecular viral typing, investigators demonstrated occupational transmission of HCV from an infected patient to an anesthesiologist's assistant who subsequently transmitted the virus to five patients.[4] The authors describe the tasks performed by the anesthesiologist's assistant as follows: he "was almost entirely responsible for the administration of general anesthesia, including the preparation of narcotic drugs, the placement of venous and arterial catheters, the intubation of the patients and the subsequent artificial respiration."[4] Questioning of the assistant revealed that he did not routinely follow standard precautions. "He usually did not wear gloves, because he claimed that they diminished his sense of touch and therefore impaired his work."[4] The portal of entry of the virus from the initial HCV-infected patient appears to be a thumbnail-sized wound on the assistant's finger that repeatedly bled and continued to weep when bandages were no longer used on the site. After infection, but prior to developing acute, icteric hepatitis C, the anesthesiologist's assistant appears to have transmitted the virus to five patients through an unknown mechanism, although it was most likely related to blood or secretions associated with the open finger lesion.

This report clearly demonstrates the potential for occupational HCV transmission both from and to patients via tasks performed by anesthesiologists. The disregard of appropriate aseptic techniques and the failure to use standard precautions likely were responsible for the adverse outcomes. In 1992, the Task Force on Infection Control of the Committee on Occupational Health published "Recommendations for Infection Control for the Practice of Anesthesiology" that contains specific suggestions for the use of standard precautions and strict aseptic techniques by anesthesiologists.[5] The second edition of the booklet containing current infection control recommendations can be obtained from the ASA's Publications Department or from its Web site at <www.ASAhq.org/ProfInfo/Infection/Infection_TOC.htm>. The importance of these recommendations for anesthesiologists' welfare and for patient safety is highlighted by the current report.

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Anesthesiologists? Assistants: Being A (Care) Team Player

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"Another group of nonphysician anesthesia providers also exists but remains unknown to many anesthesiologists because of state laws that restrict their ability to practice widely. This prevents anesthesia practices and their patients from enjoying the benefits of competition experienced by most other medical and surgical specialties. These practitioners are known as anesthesiologists' assistants (AAs) or anesthesiology physicians' assistants."

Over the last 40 years, medicine has seen a growth in nonphysician providers or extenders. In virtually every field of medicine, there are nurse practitioners and/or physician assistants in the office and operating room environment. Although the scope of practice of these two types of extenders often differ with regard to prescriptive authority and the degree of supervision required (depending on state law or regulation), there is significant overlap in their ability to provide care for patients. Therefore, competition among nonphysician providers and patients is beneficial because it often leads to a larger supply of practitioners and lower costs.

Many anesthesiologists are familiar with only one type of anesthesia nonphysician extender: nurse anesthetists. Another group of nonphysician anesthesia providers also exists but remains unknown to many anesthesiologists because of state laws that restrict their ability to practice widely. This prevents anesthesia practices and their patients from enjoying the benefits of competition experienced by most other medical and surgical specialties. These practitioners are known as anesthesiologists' assistants (AAs) or anesthesiology physicians' assistants. A brief review of their training and qualifications is provided.

In the late 1960s, due to significant changes in anesthesia care, personnel shortages and the increasing complexity of monitoring equipment, a need for a differently trained participant in the anesthesia care team was identified. The physicians' assistant (PA) model was investigated. The Board of Medicine of the National Academy of Sciences described generalist (type A) and specialist (type B) physician assistants. AA training is modeled after the specialist type B PA description: "*The type B assistant, while not equipped with general knowledge and skills relative to the whole range of medical care, possesses exceptional skill in*

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one clinical subspecialty or, more commonly, in certain procedures within such specialty. In this area of specialty, a degree of skill beyond that normally possessed by a type A assistant and perhaps beyond that normally possessed by physicians who are not engaged in the specialty. Because his/her knowledge and skills are limited to a particular specialty, the AA specialist is less qualified for independent action."

Rather than condensing a generalized overview of medicine within a relatively short training period, AA training focuses on anesthesia care. This is possible because AA teaching programs, the American Academy of Anesthesiologists' Assistants and state laws require anesthesiologists to direct AAs whenever they care for patients. As a leader of the anesthesia care team, it is expected that the physician will supply most of the required medical background. AAs, however, receive extensive training in the administration of anesthesia and monitoring and bring to the care team additional expertise in testing and calibrating anesthesia delivery systems that many anesthesiologists do not possess. Coursework on electric circuits, biophysics of life-support and monitoring systems are just a few of the classes and labs that AAs take but which are often missing from anesthesiology residency training programs. This makes for a care team where the AA can add to the anesthesiologist's fund of knowledge and experiences, benefiting the patient and practice.

AA training programs in the United States exist at two locations: Emory University in Atlanta, Georgia and Case Western Reserve University (CWRU) in Cleveland, Ohio. Both are accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) that succeeded the American Medical Association's (AMA's) Committee on Allied Health Education and Accreditation. It is the same body that accredits the nation's PA programs. Emory offers graduates of its AA program a Master in Medical Science in Anesthesiology and Patient Monitoring Systems (M.M.Sc.), while CWRU offers its graduates a Master of Science in Anesthesiology (M.S.A.).

Both programs are approximately two to two-and-one-half years in duration and have strict requirements for admission. All applicants for these training programs must have a bachelor's degree from an accredited college that contained coursework very similar to those required by medical schools, i.e., at least one year of coursework in college-level biology, chemistry, physics and mathematics. Organic chemistry is also required as is the Medical College Admission Test (for CWRU) or the Graduate Record Examination (for Emory). A minimum grade point average of 3.0 is suggested for the successful applicant. As long as these prerequisite courses are taken, no specific major is required. Recent graduates have had business, engineering and liberal arts backgrounds as well as more health science-oriented majors, including nursing, respiratory therapy and medical technology.

Graduates of AA schools are often hired in practices that have nurse anesthetists. In many cases, their job descriptions are identical. However, they must work under the supervision of an anesthesiologist, and some states such as Texas limit the anesthesiologist/AA ratio at 1:2. An example of some of these issues can be seen in the "Suggested Job Description" of the "Guidelines for Anesthesiologists' Assistants" from Texas:

1. Anesthesiology is the practice of medicine; AAs administer anesthesia under the medical direction of an anesthesiologist.
2. AAs may introduce themselves as "Anesthesiologists' Assistant" but may not refer to themselves as a physician or physician assistant.
3. AAs perform initial cardiopulmonary resuscitation/advanced cardiac life support in emergency situations until the supervising anesthesiologist is summoned.
4. AAs establish a comprehensive patient database (by chart/medical record review and patient examination and interview) to assist in anesthetic planning. AAs may order appropriate preoperative evaluations and premedications after consultation with the anesthesiologist, who is then responsible for these orders.
5. AAs initiate multiparameter monitoring prior to anesthesia or in other acute care settings. Modalities include but are not limited to ASA Standard Monitors and arterial and venous catheters. AAs may manipulate and interpret data from central venous, pulmonary artery and intracranial catheters and other monitors or devices that are indicated.
6. AAs administer the prescribed anesthetic with particular care to the cardiovascular, respiratory and metabolic health of the patient.
7. AAs utilize advanced treatment modalities to effect Section 6, including but not limited to advanced airway interventions and intubation of the trachea, starting and

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Backward or Forward, M-e-d-e-m and A-S-A Make a Great Team

ASA is proud to announce a new partnership with Medem, the premier physician-patient e-health network founded by the nation's leading medical specialty societies and the American Medical Association (AMA).

The ASA partnership with Medem is beneficial to both the physician and ASA as it will enable all ASA members to enhance their practices' exposure online and provide valuable and up-to-date information to their patients. In turn, ASA will be able to provide members and their patients with electronic access to the most current and credible clinical information along with secure e-mail for use in their individual practice Web sites.

Medem's flagship service, "*Your Practice Online*," offers ASA members customizable Web sites, enabling them to combine their own practice and patient education information with Medem's comprehensive library of reliable health information from all of Medem's society partners.

Individual Web sites may feature patient safety and education materials from ASA and other leading medical societies, including articles, fact sheets and brochures; physician curriculum vitae; and pre- and postprocedure instructional information. Sites also feature anesthesiology news from ASA as well as other specialty and state medical news. As most of the ASA materials revolve around empowering the patient through education and increasing the likelihood of meaningful exchange between patient and physician, members will be able to provide patients with a wealth of helpful materials and information. Insurance information, hours of operation, directions to the office/hospital and other office information also can be displayed on the individual's site.

Medem's new Secure Messaging service will be especially helpful to anesthesiologists for preoperative intake. For example, physicians will have the ability to post forms — including questions regarding history, current prescription usage and other preoperative instructions — on his or her Web site. This will allow the patient to review and reply to these in advance, resulting in a more thorough intake process. This can also help save time for both the physician's office and the patient. Secure Messaging also enables members to send automated appointment reminder messages to patients, saving time and money spent on telephone calls or mailings as well as decreasing patient "no show" rate.

By pooling together the combined resources of trusted medical societies, Medem gives physicians and their patients access to the most comprehensive and credible health care information available on the Internet. Built by physicians for physicians, Medem puts physicians back in the center of health care information, enabling them to provide their patients improved access, communication and protection from the increasing flow of inaccurate or incomplete health information on the Internet.

Medem was founded in 1999 by the American Academy of Ophthalmology; the American Academy of Pediatrics; the American College of Allergy, Asthma and Immunology; the American College of Obstetricians and Gynecologists; AMA; the American Psychiatric Association; and the American Society of Plastic Surgeons. In recent months, ASA and other societies have joined Medem, including the American Association of Neurological Surgeons, the American College of Preventive Medicine and several of the state medical societies.

Now, ASA members can harness the power of the Internet with this innovative member benefit. If you have any questions or would like to have a Web site built, please contact Medem Member Services toll free at (877) 926-3336 or by e-mail at <info@medem.com>. More information is also on Medem's Web site: <www.yourpracticeonline.com>.

Labor Epidurals and Billing Methods

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In May 1997, members of the Society for Obstetric Anesthesia and Perinatology (SOAP) responded to a survey regarding methods of billing for labor epidurals. The results, reported in the November 1997 *NEWSLETTER*, showed great variety. Half of the respondents reported that they used multiple methods, depending on the payer. Billing actual time subject to a cap was the most common method.

Following review of the SOAP results, the ASA Committee on Economics added a statement on obstetric anesthesia to the Relative Value Guide (RVG) that noted: "Unlike operative anesthesia services, there is no single, widely accepted method of accounting for time for neuraxial labor analgesia.

"Professional charges and reimbursement policies should reasonably reflect the intensity and time involved in performing and monitoring any neuraxial labor analgesic.

"Methods to determine professional charges consistent with these principles include:

1. Basic units plus patient contact time (insertion, management of adverse events, delivery, removal) plus one unit hourly;
2. Basic units plus time units (insertion through delivery), subject to a reasonable cap;
3. Single fee;
4. Incremental fees (e.g., 0 < 2 hrs, 2-6 hrs, > 6 hrs)."

There does indeed continue to be considerable variation, according to another obstetrics anesthesia survey conducted by the Anesthesia Answer Book (AAB) (United Communications Group, 11300 Rockville Pike, Suite 1100, Rockville, MD 20852-3030, telephone 877-397-1496) last year. The following percentages of respondents to the AAB survey used each of the billing methods listed:

- 44% Base units plus time (insertion through delivery), subject to a reasonable cap
- 19% Base units plus patient contact time (insertion, management of adverse events, delivery and removal) plus one unit hourly
- 16% Flat fee
- 11% Incremental fees
- 6% Base units plus face time only.
- 6% Total time from insertion through delivery

Billing for total time with a cap — negotiated or self-imposed — is clearly still the dominant method. Flat fees are no more common than they were in 1997. Twice as many SOAP respondents reported billing for total time from insertion through delivery, i.e., without a cap, but the apparent decrease may reflect very small samples rather than an actual change.

The AAB survey also asked for the Current Procedural Terminology™ (CPT) codes used to bill labor epidurals. Seventy-seven percent of the respondents cited 00857 ("Neuraxial analgesia/anesthesia for labor ending in a cesarean section") and 00955 ("Neuraxial analgesia/anesthesia for labor ending in a vaginal delivery"). Thirty percent used the general continuous epidural code 62319; 23 percent reported the surgical obstetric codes with the modifier "7," which denotes "type of service: anesthesia." Nineteen percent of the returned surveys indicated that Medicaid required the use of its own labor and delivery codes, and 9 percent reported billing for other codes.

One wonders at the cost of programming so many variations on both code selection and accounting for time.

On a related subject, there continues to be a lot of confusion about the appropriateness of using the emergency modifier (code 99140, with 2 base units) in conjunction with anesthesia for labor and delivery. The RVG defines "emergency" as "a situation in which delay in treating the patient would lead to a significant increase in the threat to life or body part." A vaginal delivery or a scheduled cesarean section would likely not constitute such an emergency. Neither would the fact that the patient goes into labor at night or on a weekend. (Note that the definition also doesn't mention "full stomach" conditions, though patient conditions qualifying as emergencies are most often the clinical justification for administering anesthesia under

such circumstances. In obstetrical anesthesia, however, this is less often the case, according to Alexander A. Hannenberg, M.D., of the Committee on Economics.)

When asked about the use of the emergency code for an after-hours appendectomy, L. Charles Novak, M.D., Chair of the Committee, once advised by e-mail that a practical way to analyze the applicability of the modifier was to ask the following question: "Does the surgeon drop everything else he or she is doing to get to the operating room to get the surgery done? That happens when there is a bad open fracture, and leaking or ruptured AAA, etc."

Hip Joint Procedures: Correction and Explanation

In the January *NEWSLETTER*, page 21, the ASA RVG base units for the two hip joint CPT codes that were revised for 2001 were inadvertently transposed. The correct ASA RVG units are as follows:

01214 Anesthesia for open procedures involving hip joint; total hip replacement: 8
01215 revision of hip arthroplasty: 10

Many readers have questioned the difference between the ASA base units and the Health Care Financing Administration (HCFA) (i.e., Medicare) base units for code 1214; HCFA allows 10 units rather than eight. The HCFA value appears in the list of 2001 anesthesia codes and their associated base units received electronically by the ASA Washington Office, by the American Medical Association and presumably by the Medicare carriers.

Accordingly, Medicare will be paying for 10 base units for both codes unless HCFA has amended its file since sending us our copy. Any private payer that uses the Medicare codes and base units would allow 10 units as long as Medicare does. Much more commonly, private payers follow the RVG itself, and since our own valuation is still eight base units, those payers would allow eight base units.

Upcoming Practice Management Conferences

1. The sixth annual ASA Conference on Practice Management took place in La Jolla, California, on February 2-4, 2001. Nearly 300 attended, and an impressive proportion stayed until the very end. Topics included "Pain Management Strategies for a Profitable Pain Practice," "Office-Based Anesthesia," "Continuous Quality Improvement and Internal Benchmarking," "Investing in Ambulatory Surgery Centers" and many others suggested by ASA members' questions. The compendium of monographs is available for $40 from <publications@ASAhq.org>.

2. The seventh annual Conference on Practice Management is scheduled for the first weekend in February 2002, in Phoenix, Arizona. Program development is now under way, and we welcome your suggestions for subjects and speakers.

3. On May 20-23, 2001, the Anesthesia Administration Assembly (AAA) of the Medical Group Management Association (MGMA) will be holding its annual conference in Scottsdale, Arizona. Breakout sessions will include such topics as office-based anesthesia, the results of the survey of hospital contracting first presented in La Jolla, "Putting the Web to Work in Physician Practices," governance and provider supply and demand. The conference will primarily educate your administrative staff, but note that there also will be a physicians' networking breakfast. For a copy of the program brochure and registration information, contact MGMA at (888) 608-5602.

Compliance Corner

From questions sent to members of the Committee on Practice Management:

Q. Can an anesthesiologist who is medically directing two or more cases give a lunch break to one of the nurse anesthetists?

A. *No. The anesthesiologist who allows the nurse anesthetist to leave the operating room would then be "personally performing" that anesthesia service. If the anesthesiologist were then to leave the operating room (patient #1) to monitor one of the medically directed cases (#2 and #3, hypothetically), no one would be able to bill for the case in which there was no anesthesia provider present. More importantly, the anesthesiologist would be abandoning patient #1. Furthermore, personally performing anesthesia for patient #1 would not be an allowable activity in so far as the medical direction of cases #2 and #3 is concerned.*

New York Issues Office-Based Surgery Guidelines: Nurse Anesthetists Sue

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

The New York Commissioner of Health, Antonia C. Novello, M.D., has endorsed "Clinical Guidelines for Office-Based Surgery" that were approved by the New York Public Health Council.[1] The guidelines are recommended as an appropriate standard of care subject to review by the Department of Health through the Board for Professional Medical Conduct (for physicians) and through the State Education Department (for dentists, podiatrists and nurses). The Committee on Quality Assurance in Office-Based Surgery, in its report to the New York State Public Health Council and the New York State Department of Health, stated that "surgical and anesthesia care, regardless of where performed or by whom should be provided in accordance with accepted standards of practice and in a manner that ensures the safety of the patient during the performance of surgery, administration of and recovery from anesthesia and discharge from the facility."

The guidelines for anesthesia include the following language:

> Anesthesia should be administered only by a licensed, qualified and competent practitioner. Registered professional nurses (RNs) who administer anesthesia as part of a medical, dental or podiatric procedure (including but not limited to CRNAs) should have training and experience appropriate to the level of anesthesia administered, and function in accordance with their scope of practice. Supervision of the anesthesia component of the medical, dental or podiatric procedure should be provided by a physician, dentist or podiatrist who is physically present, who is qualified by law, regulation or hospital appointment to perform and supervise the administration of the anesthesia and who has accepted responsibility for supervision. The physician, dentist or podiatrist providing supervision should:
> 1. perform a preanesthetic examination and evaluation;
> 2. prescribe the anesthesia;
> 3. assure that qualified practitioners participate;
> 4. remain physically present during the entire perioperative period and immediately available for diagnosis, treatment and management of anesthesia-related complications or emergencies; and
> 5. assure the provision of indicated postanesthesia care.

The guidelines state that anesthesia should be administered in the office in accordance with the Department of Health regulations for hospitals and ambulatory surgical centers. These regulations require, among other things, that nurse anesthetists must practice "under the supervision of an anesthesiologist who is immediately available as needed or under the supervision of the operating physician who has been found qualified by the governing body and the medical staff to supervise the administration of anesthetics and who has accepted responsibility for the supervision of the CRNA." [2]

The guidelines also set forth the type of equipment that should be available for conscious sedation and supplemented local anesthesia, regional anesthesia, unconscious/deep sedation and general anesthesia and identify the personnel required for each level of anesthesia.

The New York State Association of Nurse Anesthetists has filed a lawsuit challenging the guidelines. The nurse anesthetists claim that the guidelines require that anesthesia be administered only by or under the supervision of an anesthesiologist. The nurse anesthetists also allege that the guidelines require that only an anesthesiologist can perform the preanesthetic examination and evaluation and that only an anesthesiologist can determine the appropriate anesthetic agent. In general, nurse anesthetists claim that the guidelines unlawfully limit the scope of practice of nurse anesthetists. The Department of Health will, of course, defend the lawsuit.

Two ASA members, Scott B. Groudine, M.D., and Rebecca S. Twersky, M.D., served on the committee on Quality Assurance in Office-Based Surgery along with representatives from other specialties. The committee spent 18 months developing the guidelines that, in addition to the anesthesia provisions, include guidelines for written poli-

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S. Diane Turpin, J.D., is Assistant Director of Governmental Affairs (State) in the ASA Washington Office.

...Academic Anesthesia Practice

Roy G. Soto, M.D.

Congratulations for making it past the title of this article! If the current academic job market is any indication, not many residents are giving much consideration to an academic career. Indeed, in my graduating class, I was the only resident to take a job at a teaching center.

Although income is the obvious reason for many choosing private practice, other reasons include a desire to work alone and an urge to get away from the bureaucracy of a large academic institution. Having recently interviewed in both the private and academic sectors, there is no denying that there is a significant disparity in income between the two, but in my opinion, it is not enough to overcome the other advantages of working in a teaching environment.

When I interviewed for medical school, I was told "you'll be asked why you want to go into medicine...whatever you do, don't say it's for the money!" The inevitable question during the interview process was very easy for me to answer. I always assumed I would make a comfortable income, but the reasons for my pursuit of medicine then, as now, are not fiscal. My answer then was that I wanted to help comfort patients, have a rewarding job where I felt I was actually making a difference in people's lives and be involved in a constantly changing field allowing for a lifetime of learning and personal development.

Academic practice allows me to have a comfortable lifestyle, treat grateful patients (often patients who cannot afford private medical insurance) and be involved in the continuing evolution of our specialty. A frequent complaint about medical education is that there is a lack of good teachers available. By contributing to the training of those who will be following me, I am giving back to the medical establishment, which is a unique and powerful reward. Watching a resident adopt my own particular style during intubation, epidural or central line placement, or even preoperative interviewing, is remarkably satisfying, and I get a strong sense of passing along those invaluable tips and tricks taught to me during my own residency.

Perhaps I should be more cynical. Perhaps my "Pollyanna" attitude is a bit tough to swallow for some; but I was faced with the choice of supervising nurses for the next 20 years (or more) and/or removing myself from the teaching/learning environment where I have flourished for the past umpteen years. When a private practitioner once visited my training program and boasted, "You'll do 14 knee arthroscopies on healthy 20-year-olds each Friday," I was not thinking of dollar signs: I was thinking of repetition, boredom and possible stagnation.

By being involved in research and being surrounded by those pushing the boundaries of anesthesiology, I continue to be challenged, and hopefully, I will not become complacent or bored in my career. As a part of the academic world, I can stay true to the goals I set for myself in the dark and distant past (1986!), when my only goal was to get into medical school and prepare for a satisfying and challenging career.

Do not tell my chairman, but I think my income is just fine!

Roy G. Soto, M.D., is an Instructor at the University of South Florida School of Medicine, Tampa, Florida.

Erratum

In the December 2000 *NEWSLETTER,* it was mistakenly reported that Gary D. Gonsalves, M.D., was a resident at Good Samaritan Regional Medical Center, Phoenix, Arizona. He is in his PGY-1 as an internal medicine-preliminary program resident at Good Samaritan.

ABA, ASA and ACGME: Collaboration, Clarification and Less Confusion

Francis P. Hughes, Ph.D., Executive Vice-President
American Board of Anesthesiology

The American Board of Anesthesiology (ABA), ASA and the Accreditation Council for Graduate Medical Education (ACGME) are separate, independent and distinct organizations with different missions. However, ABA often works in concert with ASA and the Residency Review Committee for Anesthesiology (RRC) of ACGME to accomplish specific objectives. Their collaborative efforts help to explain why each organization often receives correspondence from anesthesiologists and residents about matters that are more appropriate for one of the other organizations to address. Understanding the mission of each organization may help to clarify their responsibilities and authority with regard to ongoing collaborative activities and to avoid confusion as they work in concert on new initiatives.

Organizational Missions

ABA exists to maintain the highest standards of practice and training in anesthesiology. It fulfills its mission by establishing and maintaining criteria for the designation of Board-certified anesthesiologists and by conducting examinations to determine whether candidates meet the required standards for certification as an ABA diplomate. ABA also informs the RRC about the training required for admission to ABA's system for examination and certification.[1]

The purpose of ASA is to advance the specialty of anesthesiology and safeguard the professional interests of its members. It does this, in part, through fostering and encouraging education, research and scientific progress in anesthesiology by recommending standards of postgraduate education for qualification as a specialist in anesthesiology and by recommending standards for approval of postgraduate training centers.[2] ASA also provides specific opportunities for the ongoing education of anesthesiologists.

ACGME's mission is to improve the quality of health in the United States by ensuring and improving the quality of graduate medical education for physicians in training. ACGME establishes national standards for graduate medical education. It delegates accreditation authority to RRC, which uses national standards to accredit and continually assess graduate medical education programs in anesthesiology.[3]

Although the three organizations have different missions, they share common educational and quality objectives and work in concert to accomplish them.

Ongoing Collaborative Efforts

ABA, ASA and the American Medical Association Section Council on Anesthesiology appoint three representatives each to RRC. Then, RRC considers applications for accreditation of new training programs. It reviews the ACGME-approved Program Requirements for Residency Education in Anesthesiology and anesthesiology subspecialties every five years and proposes revisions to them. The committee meets biannually to review reports prepared by trained residency program inspectors to assure that the programs are in substantial compliance with the program requirements.

ABA and ASA formed the Joint Council on In-Training Examinations in 1975 to develop one written examination to assess the progress of residents in training. Each organization appoints seven representatives to the In-Training Council. In 1975 and 1976, the Council administered the In-Training Examination to residents, and ABA administered a different written examination to candidates for certification. Since 1977, the Council has administered the annual In-Training Examination to ABA candidates as well as residents. The In-Training Council reports a score on the entire examination only to residents-in-training and their training program directors. ABA reports a score on a subset of the total test only to candidates in its certification system.

ABA develops the Board's voluntary recertification examination without ASA input. Nevertheless, based on examination analyses, the Board informs the Chair of the ASA Section on Education and Research about topics that could be useful for ASA's refresher courses and other educational programs.

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Francis P. Hughes, Ph.D., resides in Cary, North Carolina.

ABA, ASA and ACGME: Collaboration, Clarification and Less Confusion

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New Collaborative Initiatives

The American Board of Medical Specialties (ABMS), ACGME and the Council of Medical Specialty Societies (CMSS) are aware of the quality improvement concepts that have been widely applied within health care organizations. They independently approved a description of the competent physician that identifies six general competencies physicians should possess. They are working in concert to ensure that evaluations of physicians in residency training and throughout their professional career assess these competencies. Physicians representing ABA, ASA and RRC have drafted an anesthesiology resident evaluation plan that identifies specialty-specific elements of the six general competencies and methods to evaluate them. All ABMS member boards are committed to evolving their recertification programs into maintenance of certification (MOC) programs that assess these six general competencies.

One of the basic components of an MOC program is evidence of a commitment to lifelong learning and involvement in a periodic self-assessment process. ABMS and CMSS are encouraging their member organizations to collaborate to develop specialty-specific, lifelong learning and self-assessment programs. ABA and ASA have formed an ad hoc planning group to explore the potential for collaboration with development and maintenance of a program of lifelong learning and self-assessment for certified and non-certified anesthesiologists. ABA and ASA collaboration would ensure convergence of the program's educational curriculum and the content of the examination of cognitive expertise that ABA would administer to MOC candidates. There may also be the opportunity for ABA-ASA collaboration with the development of other components of the anesthesiology MOC program.

Education is the common bond among ABA, ASA and ACGME; however, there are differences among their purposes. RRC accredits programs that train anesthesiologists, ABA certifies anesthesiologists who meet its standards and ASA provides educational and self-assessment opportunities for practicing anesthesiologists to maintain and improve their competencies, in addition to advancing the specialty and safeguarding the professional interests of its members. These differences are not diminished by ongoing endeavors in which the functions of the three organizations converge. The differences will remain even as the three organizations explore new collaborative initiatives to accomplish common objectives.

Bibliography:

American Board of Anesthesiology. *Booklet of Information.* November 2000; Section 1.0, Purposes.

American Society of Anesthesiologists. *Bylaws.* 2001; Section 1.00, Purpose.

American Medical Association. *Graduate Medical Education Directory 2000-2001.* 2000; Section I, Introduction:11.

New York Issues Office-Based Surgery Guidelines: Nurse Anesthetists Sue

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cies and procedures, a performance improvement program, credentialing of physicians, patient admission and discharge procedures and emergency care transfer policies.

Further developments will be reported in this column.

The guidelines are available online at <www.health.state.ny.us/nysdoh/obs/colleague.htm> or from the ASA Washington Office upon request.

Reference:

NYCRR Title 10 Section 405.13(a)(iv).

Greetings From Your New 'Residents' Review' Editor

Mohammed A. Khan, M.D., Editor

In my first contribution as your incoming "Residents' Review" editor, I would like to emphasize the wide-ranging utility of this column, suggest a few ways of making the best use of it and motivate our readership to contribute to it. As I prepared to take over from outgoing Interim Editor John A. "Jack" Cooley, M.D., I was filled with mixed feelings. First, as the representative of trainee anesthesiologists for the *ASA NEWSLETTER*, I was worried and at times overwhelmed at the thought of maintaining the high standard set by my predecessor. Dr. Cooley has truly done a marvelous job during his tenure as the interim editor. Our hats are off to Jack for a job well done! He has indeed left big shoes for me to fill, and I wish him the best of luck in his future endeavors.

On the other hand, I was enthused about utilizing this opportunity to collaborate with my fellow trainees in realizing the true potential of this column for having a significant impact on our professional and personal lives. There is no doubt that, despite the physically exhausting and mentally draining rigors of residency/fellowship training, we still have a very important role to play in the advancement of our specialty, in the improvement of patient care and in serving society at large. Few of us realize how the inefficiencies and frustrations of our daily lives can shape our future. What is required, however, is the determination to discuss and share the problems that we encounter rather than enduring them and allowing them to disrupt our lives.

I am convinced that this column — actually, this precious space in the *NEWSLETTER* — can play an instrumental role in uniting us and in serving as a forum for the identification, discussion and solution of our problems. *Collectively we can make a difference!* The first step, then, is for individuals to take the initiative and share their concerns and experiences. Let the "Residents' Review" be the forum where all anesthesiology trainees bring forth and share their experiences. I implore you all to write about anything that concerns you, be it about our profession, environment or society. Do not let time constraints be excuses for inactivity; rather, make them an impetus for improved efficiency. Most importantly, do not forget that I am here to facilitate the conversion of your ideas into articles for publication. So, please contact me at any time.

A few examples will illustrate what we trainees are capable of achieving. How many of you were aware of the fact that:

- the resolution that was formulated into law banning cigarette smoking on all domestic airline flights originated in a resident component such as ours after a trainee like us decided to voice concerns about the dangers of smoking;
- the observation by an anesthesiology resident that medical students were unable to manage the airway in emergency situations led to a resolution being presented by your own ASA Resident Component delegates to the American Medical Association (AMA);
- and residents have in the past written AMA resolutions about the necessity of wearing protective gear during rollerblading, the dangers of bungee cords and paternity/maternity benefits.

All these recommendations ultimately became a permanent part of AMA and national policy. Thousands, if not millions, will reap the benefits of these policies. Why? Because a few residents were motivated enough to publicize their observations and concerns.

I am eagerly looking forward to working closely with all of you. Please feel free to contact me at any time to discuss your ideas, either by e-mail <makhan@zeus.bwh.harvard.edu> or by telephone at (617) 738-9550. The "Resident's Review" articles are due on the first of the month preceding the month of publication; therefore, please let me know well in advance about your planned contributions so that delays can be avoided. Good luck!

Mohammed A. Khan, M.D., is a CA-3 resident in anesthesiology at the Brigham & Women's Hospital/Harvard Medical School, Boston, Massachusetts

Ventilations: Death in a Droplet

Continued from page 1

• Nearly 1,000 people "died" in Denver after a terrorist sprayed airborne plague in a concert theater. Confusion reigned as hospitals became progressively overwhelmed with victims. This three-day, $3 million exercise by the Department of Justice concluded that "the systems and resources now in place would be hard-pressed to successfully manage a bioweapons attack."[1]

• A van inconspicuously parks outside of a packed ballpark in Washington, D.C., and "releases" a cloud of anthrax spores. Within two days symptoms begin; in five days a diagnosis is made. Of the 20,000 people in the park, 4,000 "died." This fictional scenario is based on reliable biological data and is used by the Johns Hopkins Center for Civilian Biodefense Studies.[2]

• Anthrax spores introduced in sufficient quantities into the Washington, D.C., water supply would likely produce 250,000 illnesses in seven days — in an area that contains 3,000 hospital beds.[3]

• In 1347, Tartars catapulted dead plague victims over the walls of Kaffa, gateway to the silk trade routes. The effects produced the Black Plague (or Black Death) that killed one-third of Western Europe's inhabitants.[4]

• In 1942, the Russians are thought to have deliberately infected German troops with tularemia during the Battle of Stalingrad. The outbreak spread to both sides causing 100,000 deaths.[4]

• In 1979, the Biopreparet program (the Soviets' bioterrorism section) caused the Sverdlovsk Incident. More than 100 people and countless livestock died suddenly along a narrow band directly downwind from the microbiology facility. Inhalation anthrax was released inadvertently when a shift worker removed a clogged biofilter, releasing spores over several hours before the error was discovered. In 1992, Boris Yeltsin acknowledged the event as a flagrant violation of the Bioweapons Containment Treaty.[4]

• In 1995, the Japanese apocalyptic cult Aum Shinrikyo released sarin gas in a Tokyo subway station, killing 13 people and hospitalizing more than 5,000. Few people know, however, that their experiments with aerosolized botulinum toxin and anthrax failed. They also failed to obtain samples of Ebola virus and rickettsia (Q fever). In all cases, real "experiments" near U.S. air bases and the Imperial Palace failed because of either their selection of bacterial strains or inadequate spraying mechanisms.[4]

Anthrax is the best biological agent, but smallpox and Yersinia (plague) are also suitable agents. When one evaluates anthrax, it emerges as the first-choice death germ. It is convenient and ubiquitous; great quantities of hardy spores can be grown; it is well-suited for aerosolization, long-term storage and widespread dispersal; it is not communicable, and the spores die with sunlight exposure (self-terminating); it is effective (80 percent mortality); and there is an effective vaccine to prevent disease in the aggressor. Smallpox is more insidious. Although it kills only 30 percent who contract it, it is the disease that "keeps on giving" because it is highly communicable. Vaccination is the only prevention. The plague is similar in infectivity with smallpox, but it is readily treatable with penicillin if detected early.

The time for action is now. This situation, unlike nuclear war threats, is real, practical and devastating. The cumulative worldwide risks must make the inhabitants of the global village reconsider the "low probability, high consequence" scenario of bioterrorism once thought to be the reality. We, as physicians first, should play an active role in addressing these threats. As anesthesiologists, we may suddenly become a "dying breed" — but not because of politics.

— M.J.L.

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1. *Biodense Quarterly.* 2000; 2(2):1-10
2. Marwick C. *JAMA.* 1999; 281(12). [www.JAMA.com]
3. Vertag B. *JAMA.* 2001; 285(1).
4. Block SM. *American Scientist.* 2001; 89:28-37. [www.americanscientist.org]

Task Forces Offer More Open Forums, Updates to Practice Guidelines

The Task Force on Pulmonary Artery Catheterization will hold an Open Forum for discussing revised pulmonary catheter guidelines at the 23rd Annual Meeting and Workshops of the Society for Cardiovascular Anesthesiologists, May 5-9, 2001, at the Vancouver Trade and Convention Center, Vancouver, British Columbia, Canada. The Open Forum for Pulmonary Catheter Guidelines Update will take place on Monday, May 7, from 8 p.m. to 9:30 p.m., and will use an audience response system.

As reported last month in the *NEWSLETTER*, the pulmonary artery catheterization task force will also hold an Open Forum during the 75th Clinical and Scientific Congress of the International Anesthesia Research Society in Ft. Lauderdale, Florida, on March 19. This task force is in the process of updating these practice guidelines that were first published in *Anesthesiology* in 1993. The guidelines will include recommendations on the use of pulmonary artery catheterization and its rationale, based on scientific evidence and expert opinion. For information on the open forums or the practice guidelines revisions, contact Frank Connell by e-mail at <f.connell@ASAhq.org>.

Another forum, "Practice Guidelines for Recovery Care," will take place at the Society for Ambulatory Anesthesia Annual Meeting in Palm Springs, California, at the Renaissance Esmeralda Resort. On Friday, May 4, from 3 p.m. to 5 p.m., members of the Task Force on Recovery Care will conduct an Open Forum to hear comments and suggestions about the creation of "Practice Guidelines for Recovery Care." **This Open Forum has been rescheduled from Saturday, May 5, to Friday, May 4.** Task Force on Recovery Care Chair Jeffrey H. Silverstein, M.D., stresses that the practice parameter process is highly dependent upon input from the anesthesia community.

For more information on the development of practice parameters for recovery care, contact Dr. Silverstein by e-mail at <jeff.silverstein@mssm.edu>.

All the above Open Forums provide opportunities for practitioners to meet with task force members and offer suggestions that will have a direct impact on the final product.

Workshop on Transesophageal Echocardiography Planned

The Workshop on Transesophageal Echocardiography is intended as an introductory course on intraoperative echocardiography. The program will be held on June 9-10, 2001, at the Hilton Cleveland East/Beachwood

2000 Art Exhibit Award Winners Earn Their Writes

As reported in the January 2001 issue of the *NEWSLETTER*, the 33rd ASA Art Exhibit took place at the Moscone Center in San Francisco, California, during the ASA Annual Meeting and was enthusiastically received by those in attendance.

At the time the January *NEWSLETTER* went to press, complete information regarding the winners in the Literature Category was not available. The winners in this category for the 2000 Art Exhibit are as follows:

Literature Winners:
1st: Audrey C. Shafer, M.D. — "Anesthesia"
2nd: Patricia Lynette Page — "Charlie"
3rd: David C. Lai, M.D. — "Searching for Grandma"
Honorable Mention: Magdalena E. Kerschner, M.D. — "A Life Well Spent/My Daughter's Face/Face of an Angel"
Honorable Mention: Carmen R. Green, M.D. — "We Pray"

Hotel in Beachwood, Ohio, just outside of Cleveland.

This workshop will introduce a number of topics that will provide the basics on the physics of ultrasound, the use of the echocardiography machine and the components of a complete transesophageal examination, along with the corresponding anatomical views and the pathophysiology of valvular heart disease and its intraoperative assessment.

Robert M. Savage, M.D., is one of the program's co-chairs. He will speak on "Basic Cardiac Anatomy and Imaging Planes," "Anatomy Wet Lab" and "Valve Workshop." Michael G. Licina, M.D., another program co-chair, will speak on "Physics of Ultrasound" and "Hemodynamics Workshop." Program co-chair Michael K. Cahalan, M.D., will speak on "Abbreviated Examination," "Assessment of Left Ventricle and Right Ventricle Systolic Function and Regional Wall Motion," "History of TEE," "Anatomy Wet Lab" and "Valve Workshop."

The other faculty and their topics are:

- Solomon Aronson, M.D., "Artifacts and Pitfalls";
- Charles Hearn, D.O., "Aortic Valve," "Anatomy Wet Lab" and "Valve Workshop";
- Colleen G. Koch, M.D., "Mitral Valve" and "Valve Workshop";
- Steven N. Konstadt, M.D., "Tricuspid and Pulmonic Valve" and "Thoracic Aorta";
- Erik J. Kraenzler, M.D., "Knobology — Improving the Image";
- Ivan S. Salgo, M.D., "Common Platforms and Knobs" and "Knobology — Improving the Image";
- Jack S. Shanewise, M.D., "Intraoperative Examination: Indications, Contraindications, Safety, Comprehensive Examination," "Cardiac Hemodynamics" and "Hemodynamics Workshop."

ASA is approved by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education programs for physicians.

ASA designates this educational activity for a maximum of 14 hours in category 1 credit toward the American Medical Association Physician's Recognition Award. Each physician should claim only those hours of credit that he or she actually spent in the activity.

Registration is suggested by May 9, 2001. Registration fees are $300 for ASA active members, $125 for resident members and $650 for nonmembers.

A block of rooms is being held at the Hilton Cleveland East/Beachwood Hotel until May 18, 2001. Reservation information will be sent to registrants upon receipt of registration.

Component Society News: NYSSA's DSA Winner Announced

Louis S. Blancato, M.D., is to receive the 2001 New York State Society of Anesthesiologists Distinguished Service Award. The award will be presented during the 55th Postgraduate Assembly in Anesthesiology in New York, New York, on December 7-11, 2001.

In Memoriam

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

Jeffrey S. Collins, M.D.
St. Louis, Missouri
July 14, 2000

David A. Corey, M.D.
Knoxville, Tennessee
August 2, 2000

Fabio M. Frullani, M.D.
Dei Marmi, Italy
September 8, 2000

Rex A. Gish, M.D.
Monterey, California
October 20, 2000

Alfredo P. Narciso, Jr., M.D.
Eau Claire, Wisconsin
September 26, 2000

Mehmet H. Nazli, M.D.
Griffin, Georgia
December 2, 2000

John W. Pender, M.D.
Placerville, California
February 18, 2001

Eric C. Schiller, M.D.
Daphne, Alabama
June 13, 2000

Wilbur F. Taylor, M.D.
Bay Head, New Jersey
July 6, 2000

Anesthesiologists' Assistants: Being A (Care) Team Player

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adjusting doses of vasoactive infusions, administering vasoactive and anesthetic drugs, administering blood and any other treatment modalities that are prescribed by the supervising anesthesiologist.

8. AAs will summon the supervising anesthesiologist for the induction of anesthesia, for extubation of the trachea, for consultation during unexpected or adverse perioperative events or at any other time when the prescribed anesthetic deviates significantly from its expected course.

9. AAs assist in the postoperative management of patients by managing ventilatory support and acute pain management in conjunction with existing protocols or the attending anesthesiologist.

10. AAs recognize that the choice of anesthetic drugs and techniques are prescribed by the attending anesthesiologist preoperatively. Exceptions exist when standard orders for a given situation exist or when life-threatening situations arise requiring the use of standard therapeutic or resuscitation techniques until the attending anesthesiologist arrives or is consulted by telephone.

11. The anesthetic prescription may consist of a verbal discussion between the AA and the supervising anesthesiologist; in this instance, the anesthetic record is considered to reflect the anesthetic prescription in the absence of other notations in the medical record.

12. The supervising anesthesiologist will remain at all times immediately available in the operating area and is reachable by beeper or overhead page.

13. The AA may engage in teaching and research functions as deemed appropriate by the supervising anesthesiologist.

A newly trained AA can expect to earn between $60,000-$80,000 his or her first year. Unlike nurse anesthetists, not every state allows AAs to practice. AAs are able to practice in Vermont, Michigan, Wisconsin, Texas, New Mexico, Alabama and, of course, Georgia and Ohio. Colorado, Oklahoma, Illinois, Kentucky and New York currently are considering the role of AAs in their state, but acceptance of this form of physician extender is not guaranteed. Nurse anesthetist groups have mounted strong lobbying efforts to prevent the acceptance of AAs in states where they are not currently practicing. In many cases, they have been successful in maintaining their monopoly with nonphysician-provided anesthesia care. Medicare will pay for a medically directed AA in the same manner it pays for medically directed nurse anesthetists.

After graduation, an AA is expected to become AA-certified. This test is sponsored by the National Commission for Certification of Anesthesiologist Assistants. Certification is maintained by submitting continuing education credits every two years and taking a Continued Demonstration of Quality examination every six years. The American Academy of Anesthesiologists' Assistants (AAAA), based in Atlanta, Georgia, is the professional organization that represents and provides continuing education to most AAs.

It is my hope that anesthesiologists unfamiliar with AAs will now have a greater understanding of the "other" nonphysician anesthesia provider.

Additional information can be obtained from the American Academy of Anesthesiologists' Assistants at (800) 757-5858 or at <www.anesthetist.org>.

Informed Consent for the Patient With an Existing DNR Order

Continued from page 14

cessful attempt at resuscitation. Discussions about perioperative resuscitation should focus on determining which option best fits the patient's views of the expected benefits and potential burdens.

Sounding Out on the PA System

In the October "Ventilations" editorial, Mark J. Lema, M.D., Ph.D., outlines some of the difficulties in American medical practice. We have all felt the frustrations of attempting to maintain the highest standards of medical practice in an environment that has made it increasing difficult to do so. The decrement in the resources of time, personnel and material ("doing less with more") has not enhanced the quality of care for either patient or practitioner.

One of the proposed solutions to help alleviate the physician's burden was to utilize physicians' assistants (PAs). Dr. Lema voiced several concerns about their use. As both a long-time ASA member (21 years) and PA (24 years), I would like to address his concerns.

The greater concern that Dr. Lema raises is quality of care. He fears that if patients are initially evaluated by individuals who do not have the physician's education and experience, new syndromes will not be recognized. PAs and anesthesiologists' assistants (AAs) are tied by both custom and law to the interdependent (not independent) practice of medicine with their physician supervisors. They are trained in the medical school paradigm to practice collaboratively with physicians. PAs are well-acquainted with normal historical, physical and laboratory findings. When the constellation of positive findings are outside the individual PAs experience level, the PAs consult the physician. I do not think that quality of care should be a point of concern. Conversely, by having the knowledge and experience of two individuals, it may be less likely for there to be oversight. Additionally, by sharing the patient load, the physician is likely to be less stressed and be better able to provide consultant services.

Dr. Lema's other comment concerns Medicare billing to PAs. It should be noted that the medical practice bills for AAs are reimbursed for PA services. PAs are not directly compensated by third-party payers; payment is to the practice.

PAs are no threat to the quality of medical care. They are colleagues who cannot practice without physician supervision. With supervision, they provide the highest quality of care to more of the patients whose lives are entrusted to us. Over three decades of experience show that the team concept works. Let us work together to knock down the walls of the Potemkin Village!

Shepard B. Stone, M.P.S., P.A.
Branford, Connecticut

General Anesthesia vs. Major Apathy

I accept the arguments of Mark J. Lema, M.D., Ph.D., in the October 2000 *NEWSLETTER* as adequately accurate regarding physician dissatisfaction and/or early retirement. For (only slightly) different reasons, I used to hear the same grumbles in the doctors' lounge of the hospital where I worked while in medical school in 1956! Technology has changed, our whining has not. So, what, if anything, are we going to do about it?

Our collective response is always the same: Grumble loudly and continuously, write letters, lobby lawmakers and do nothing proactively. In my first practice in 1961, a labor official on the hospital board told me that doctors' responses to challenges are predictable and easily manageable. He was, and still is, right.

"They," the constructors of Dr. Lema's Potemkin Village, have an important point that "we" have not heeded and assumed our proper responsibility. U.S. health care costs are by far the highest in the world and only recently have begun to level off. America's health is far from the best in the world: A June 2000 World Health Organization report ranked the United States as 39th! (Cuba was 41st). In another health-status ranking of "developed" nations reported in an October 2000 *Journal of the American Medical Association*, the United States was 12th out of a possible 13! Our number of uninsured continues to grow.

Seizing the future, improving health and health care is "our" problem: both "they" and "we." Working together, we can find systems to better use our health care resources,

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improve health and reduce physicians' moroseness. So far, "they" make changes in a vacuum because "we" are focused on fighting a losing rear-guard action, trying to maintain whatever is left of the status quo and hating every moment of it.

I am retiring soon from clinical medicine. It was fun and good, but it is time to go. I and probably many who retired early would be willing to lend our wisdom and creativity to a collaborative effort to positively reform health care.

But our "generals" have to first turn around, determined to face and mold the future and quit fighting rear-guard actions.

James E. Waun, M.D.
Okemos, Michigan

Beyond 'Armageddon'

Editor Mark J. Lema, M.D., Ph.D., had the luxury of 1,000 words to express his dismay about the future of medical practice in this country (October 2000 "Ventilations"). I will try to stay within the parameter of 300 words allotted to members of the Society.

His logic is subject to criticism, and his vision of "Armageddon in one year" verges on paranoia. I have lived through 30 years of residency training programs in which it was feast (all U.S. graduates) or famine (take-it-or-leave-it international medical graduates). There will never be a shortage of physicians in this country because we offer the only place for a decent monetary reward vis-à-vis the rest of the civilized world.

My prediction for next year and all the years to follow is that early retirement of U.S. physicians will be more than compensated for by an influx of international graduates — and the politicians will love it. The unsuspecting public will have no choice but to accept any physician certified by government decree.

Beyond "Armageddon and Potemkin" is the hope that a change in the policies of the past 40 years (Great Society, Deficit Reduction Act) toward Republican totems (free choice, smaller government, tort reform) will rescue this country from socialism and a one-party payer. Then, and only then, will U.S. graduates return to the fold.

The moral of this diatribe is that new political leadership will restore the dignity and respect for a patient-physician relationship and hopefully break the back of socialism once and for all.

Burton Rubin, M.D.
Alva, Florida

Anesthesiologists Left on 'Curb'

Although I do not always share your viewpoints on every issue, I read your "Ventilations" column in the *ASA NEWSLETTER* regularly. I would like to thank you for bringing to the membership's attention two recent court cases involving "corridor" or "curbside" consultations (November 2000).

You correctly point out that in both the New York and Arizona cases, the emergency room physician could have and probably should have requested formal consultation. That notwithstanding, the volume of medical knowledge and litigation are both increasing so rapidly that we anesthesiologists frequently find ourselves in the position of wanting to "run a case by a colleague." We do so to reassure ourselves about our intended course of management, without wanting to delay a case or needlessly burden the system financially. If the issue is complex, a formal consultation is usually requested.

I doubt seriously whether this was an issue for our predecessors in times past. Unfortunately, this is yet another example of people other than physicians (in this case, lawyers) deciding how medical care is best delivered. The need to practice medicine even more defensively will contribute nothing to patient care other than increased cost!

Berklee Robins, M.D.
Portland, Oregon

Every Mom's Crazy 'Bout a Sharp Dressed Physician

Boy, you sure are a glutton for punishment. I remember the flak that you caught when you broached the professionalism issue a couple of years ago.

I read your December *ASA NEWSLETTER* "Ventilations" ("A Tale of Three Men…or…Has Your GQ Subscription Expired?") and applaud you for saying it again.

When I told my mother that I was going to become an anesthesiologist 42 years ago, she asked, "Why, are you not going to be a doctor anymore?" It took her about 25 years to realize that I was more than a nurse; but that is all the people in our town of about 75,000 knew in those days.

As you have pointed out, this is not just an anesthesiology problem but also a cultural problem. Several years ago, a friend of mine became president of a company whose product you would recognize. Their office had gone to a casual dress code, and when he became president, he changed it back to a professional dress code with a lot of resistance because he said that it did not look professional. He was right, because I had visited his office several times and it did not look professional.

I believe anesthesiologists dress this way because they believe that no one sees them. Many of them do not want to be seen, and that is a problem in itself. I have always attempted to be a good physician first and a good anesthesiologist second. Physicians should look like physicians, and I wanted my mom to know that I was a physician even if she could not see me.

You are absolutely right about this, and I hope that you do not get too much negative feedback this time. You have to "talk the talk," "walk the walk" and "dress the dress" if you want to be recognized as a physician.

Bernard C. DeLeo, M.D.
Sun City Center, Florida

Dress for the Rest

You hit the bull's eye once again! Anesthesiologists come and go via the hospital backdoor wearing gym shorts and tank tops, avoid volunteering for hospital committee work or educational service such as advanced cardiac life support instruction and community outreach. Then we wonder why our professional image among our nonanesthesiologist physician peers is so mediocre. When it comes to our attire, anesthesiologists need to stop being so egocentric: We dress for our patients and for the professionals with whom we work, not for ourselves.

David C. Mackey, M.D.
Jacksonville, Florida

Don't Come as You Are Who Asked You Anyway,

I read with great interest your December "Ventilations" titled "A Tale of Three Men…or…Has Your GQ Subscription Expired?"[1] I am glad Dr. Lema has written again on the subject of dress code in spite of the criticism (much praise as well) to your earlier editorial.[2] I fully endorse his views on dress codes.[1,2]

Let me guess who was the anesthesiologist among the two men (gentlemen!) not wearing the suit: The person with the fancier and more expensive car was the nurse anesthetist.

Although it is true that business and law firms in particular have adopted a "dress down" policy for the work place, they still wear formal clothes when meeting their clients. Unfortunately, as hospital personnel and some physicians have started calling "patients" their "clients," it is important that all physicians should be attired properly when meeting their patients. T-shirts, shorts and sandals are not business casual dress.

Hennessey et al. in a study concluded "that dress worn by the anaesthetist at the first meeting did not diminish the esteem, and differences in dress (suit versus jeans) did not seem to play an important part in the performance of the medical staff."[3] However, patients thought a name tag, a white coat and polished shoes desirable. Undesirable items were clogs, earrings, jeans, sneakers and open-neck shirts. Patients over the age of 60 had a preference for formal clothing.

If the Accreditation Council for Graduate Medical Education Residency Review Committee requires that emphasis be placed on items important for the residents to learn and demonstrate commitment to business practices, then the chairpersons of anesthesiology residency programs should issue directives to the residents (and some faculty as well) for the dress code policy. A year's subscription to a fashion magazine may not be a bad idea!

M. Saeed Dhamee, M.D.
Milwaukee, Wisconsin

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1. Lema MJ. *ASA Newsl*. 2000; 64(12):1.
2. Lema MJ. *ASA Newsl*. 1998; 62(9):1.
3. Hennessey N, et al. *Anaesthesia*. 1993; 48:219-222.

Regarding Our Dress Code?

As a practicing physician anesthesiologist, I take exception to your continuing diatribe about the manner of dress chosen by your fellow professionals (December "Ventilations"). Your idea of what an anesthesiologist is constitutes mere perception rather than reality. No amount of gaudy, expensive dress will ever make **some** anesthesiologists professional — their lack of concern for their patients, absence from the operating room (O.R.) suite while supervising cases, lack of contact with patients after surgery and an overabiding interest in time off makes them somewhat less than professional in everyone's eyes.

Our surgeon colleagues sometimes hold us in low esteem if it appears to them that the nurse anesthetist at the head of the table is the one doing much of the work. It may frustrate them when things are going rough in the room and the anesthesiologist is not present for immediate consultation. Surgeons, O.R. nurses and O.R. staff may see a few anesthesiologists as mere exploiters of their hired help and wrongly hold the entire specialty in low regard because of the way some anesthesia care teams may practice.

Those of us who actually "squeeze the bag" and take care of patients on a one-to-one basis really do not care for your opinions on our dress when we come in at 5:30 a.m. or leave at 5 p.m. to 9 p.m. I will bet it might even surprise you to know that we even wear coats and ties and can dress ourselves appropriately for our other hospital obligations when the need arises — without any help from you. On more than one occasion, I have arrived in the emergency room to save someone's life while attired in somewhat shoddy-appearing dress. I have also arrived in full formal wear and cannot remember being treated as less than a professional on either occasion. A physician can act professionally regardless what he or she is wearing.

If I was 1,500 miles from home, severely injured and required life-saving surgery, do you really think I would care how my anesthesiologist looked as long as he got there and did his job? Perhaps you would rather wait while he took the Saville Row suit out of its wrapper, carefully knotted his Armani cravat and found his Allen-Edmonds shoes? For me, I do not want to wait.

Can you not find more pressing topics to write about, such as surgical outcomes being safer with an anesthesiologist at the head of the table than when there is an anesthesia care team approach for thoracoabdominal aneurysms? That might make a difference!

James A. Ramsey, M.D.
Brentwood, Tennessee

Give Me Liberty, Then Give Me Dress

You cite George Washington in your editorial on our profession and dress presentation ("Ventilations," December 2000 *NEWSLETTER*). Washington did indeed take dress, manners and presentation seriously. Yet considering the issues before us, the subject for which you seek the imprimatur of this great man is trivial. What do you think Washington, Jefferson, Madison, Franklin and George Mason would make of our profession's subservience to a growing socialist system and its bureaucracy? You get the government you deserve, they would cry. Resist: Your cause is noble.

Politically inclined anesthesiologists should join the Association of American Physicians and Surgeons (AAPS) and get involved in issues of substance. Largely Libertarian and iconoclastic, the AAPS provides a resounding voice not just for recapturing lost incomes but for regaining lost freedoms and a fading ethic. Miguel Faria, M.D., editor-in-chief of the AAPS' official journal, *The Medical Sentinel*, has written "Medical Warrior: Fighting Corporate Socialized Medicine." I highly recommend this book for any physician interested in understanding the larger sociopolitical and economic context of our profession's challenges. Dr. Faria, as a neurosurgeon and childhood escapee of Cuba's socialist nightmare, is a leader in the fight of the individual physician for his patients against health maintenance organizations and government-controlled medicine.

Now that is something George Washington would get excited about!

Henry C. Walther, M.D.
Granite Bay, California

'Slob'nobbing in the World of Medicine

Your excellent "Ventilations" in the December 2000 *NEWSLETTER* addresses the issue of dress in a way that reflects the real world.

How many times has the perception that we are slobs affected interactions with the public, other physicians, hospital administrations and health care organizations?

Dress standards should be set and maintained in residency. The chief sets an example. If there was ever a time we needed an image of being professional, it is now. Some need to grow up and enter the business world.

Currently, I am writing a book on practice and will certainly use your articles as references.

Keep up the good work, and do not let the slobs win. Then we will all be lost.

Frank W. Summers, M.D.
Santa Ana, California

Social Skills 101: Do You Have a Passing Grade?

Under the section "A piece of my mind" that appeared in *Journal of the American Medical Association* recently [2000; 284(16):2027], a physician describes his unpleasant experiences during his father's surgery for an aortic aneurysm. After the initial encounter with the surgeon, who totally ignored him and his mother, the anesthesiologist's visit occurred:

"Our next stop was with the anesthesiologist, whose obvious distaste for the chore of talking with the "day before" crows was palpable. We were never sure whether he was a staff anesthesiologist or a resident as he never introduced himself or asked any personal or social questions. His lack of interest in us as individuals was disheartening."

How sad and unfortunate this is, and yet, so common today! I have been in practice 30 years and have personally witnessed this behavior on several occasions. In fact, six years ago, one of my daughters had an epidural anesthetic for a cesarean delivery. The anesthesiologist behaved in exactly the same fashion. He never even acknowledged that my wife and I were in the room. His only remark was that he wanted to be sure that nobody passed out while watching the procedure.

It seems that with our difficulties involving nurse anesthetist supervision, this type of attitude will convey a very negative message to the public.

Throughout my years of practice, I have always found that the extra time spent introducing myself politely, shaking hands with patients and relatives, giving a pat on the shoulder, a smile or a kind word of reassurance is priceless in terms of not only establishing good rapport but in gaining their respect.

We may be producing sophisticated technicians and very knowledgeable anesthesiologists who lack bedside physician manners.

With people like these in our ranks, we do not need any enemies.

Edward G. De Miranda, M.D.
Jacksonville, Florida

Building Momentum for Research, Endowment and Partnerships

The Foundation for Anesthesia Education and Research (FAER) strives to foster progress in anesthesiology, critical care, pain management and perioperative medicine. We promote and encourage the development of physician scientists to improve and perfect the practice of anesthesiology.

FAER accomplishes these goals by 1) awarding research grants to anesthesiologists, 2) building an endowment and 3) partnering with members of the anesthesia community. The grants provide new investigators with time, money and peer-review approval to conduct preliminary research that, we hope, will make them competitive for further funding from the National Institutes of Health or other funding bodies. The goal of funding the endowment is to enable the foundation to operate and award grants in perpetuity independent of outside funding. The Foundation is long-term and aims to support anesthesiologists into the future. Partnering with the anesthesia community helps maintain an open dialogue between various constituents of anesthesiology: patients, universities, private practitioners, pharmaceutical and equipment manufacturers, researchers, educators and other interested parties.

Outcomes Achieved in 2000

The Foundation funded 11 first-year investigators and five second-year investigators in 2000. The award recipients submitted proposals to FAER that were peer-reviewed by the ASA Committee on Research. This committee scored and ranked the proposals and recommended funding to the FAER Board.

The Foundation's endowment totaled $12.4 million, $1.3 million more than last year.

FAER partnered with members of the anesthesia community in various ways. In addition to funding the abovementioned investigators, FAER sponsored the attendance at the 2000 ASA Annual Meeting of 60 residents from different academic programs, hosted an education panel and conducted an advisory meeting between anesthesiologists and industry to discuss how the groups can work together and assist each other to achieve the common goal of improved care for patients.

FAER is fiscally responsible. The operating expense remains modest at 10 percent of income. The income is composed of gifts from ASA, component societies, subspecialty societies, individuals, private practice groups and corporations. More than 300 individual anesthesiologists and private practice groups contributed to FAER, five new corporations supported anesthesiologists through FAER and 10 corporations increased their gift amounts to FAER.

Changes, Improvements and Additions to the Foundation

At the most recent FAER Board meeting, discussions were initiated to consider the need to increase the amounts of FAER grants, which have remained fixed for more than five years. This discussion was in response to a reduction in applications and feedback from academic department chairs that, with the press of clinical work and the impact of the balanced budget amendment, they are less able to provide time and matching funds to junior faculty in order to develop their careers. The Board will vote in May to approve changes to the grant programs. The two most significant changes are increasing the duration of all awards from one to two years and an increase in the amounts of the awards.

The Foundation will sponsor an Excellence in Research lecture at the ASA Annual Meeting.

The FAER Board will consider expanding and formalizing its mentorship program to encourage young investigators.

Evaluation Methods

FAER conducted a survey of FAER award recipients in 1995 to evaluate the effectiveness of its programs. The survey asked recipients about current research efforts, institutional appointment and rank, subsequent funding and mentoring of anesthesiology trainees in an attempt to measure the success of its former grant recipients. Another survey will be conducted by 2005. A shorter-term evaluation concerns the number of researchers and residents supported this year, the fund-raising results, the growing endowment, the low operating expenses and the efforts to improve the Foundation and its programs.

We encourage the ASA membership to contact FAER at any time with suggestions about the Foundation, its programs, fund raising, the evaluation or anything else of interest. There is no spin here. The FAER purpose is clear: to catalyze individuals and innovation in advancing the art and science of anesthesiology.

FAER Report (continued)

A FAER Representation of Anesthesiology's Brightest – Part Three

This article represents the final installment of FAER's award recipients. Previous winners, Hilary P. Grocott, M.D., and Warren Sandberg, M.D., Ph.D., were featured in the January NEWSLETTER; Zhiyi Zuo, M.D., Ph.D., and Shu-Ming Wang, M.D., were featured in February.

The Board of Directors of the Foundation for Anesthesia Education and Research (FAER) is pleased to announce the latest award recipients from the August 15, 2000, application submission. FAER is grateful for the generous support and contributions from ASA, its individual members, component societies, subspecialty societies and corporations. The funding of FAER grants is made possible by these donations.

FAER is particularly thankful to the following societies and corporations that have co-sponsored the awards: AstraZeneca Pharmaceuticals, Inc., Baxter Healthcare Corporation, the American Geriatrics Society, the Association of University Anesthesiologists, the Society for Ambulatory Anesthesia, the Society of Cardiovascular Anesthesiologists and the Society for Pediatric Anesthesia. FAER also wants to thank the applicants for their interest in the awards and research and for submitting such high-quality proposals. The following project summary was provided by the recipient.

Education Research Award

Murali Sivarajan, M.B.B.S., Yale University School of Medicine, New Haven, Connecticut: "Peer Evaluation of Teaching as a Tool to Improve Teaching Skills of Clinician Educators."

The current model of development of junior scientists is mentoring by established senior investigators and peer review of research that results in funding and publications. This research project seeks to apply similar principles of mentoring and peer evaluation for the development of clinician/educators. Both classroom and clinical teaching by junior faculty will be evaluated by two senior clinician/educators (peer evaluators) using criterion-referenced evaluation forms. Both peer evaluators will provide confidential feedback to the teacher undergoing evaluation. In order to detect improvement in teaching, blinded resident evaluations of classroom and clinical teaching before (year 1) and after (year 2) feedback will be compared to each other. It is hoped that feedback and mentoring based on peer evaluation will improve teaching skills and the prospects for academic advancement of junior faculty in the clinician/educator ranks.