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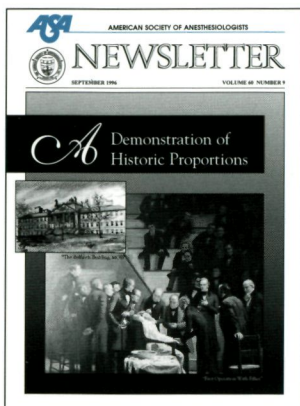
A Demonstration of Historic Proportions



"The Bulfinch Building, MGH"



"First Operation With Ether"



On October 16, 1846, William T.G. Morton performed a demonstration of historic proportions, as depicted by American artist Robert C. Hinckley. The landmark building that housed the event was captured in watercolor more recently by anesthesiologist and artist Leroy D. Vandam, M.D.

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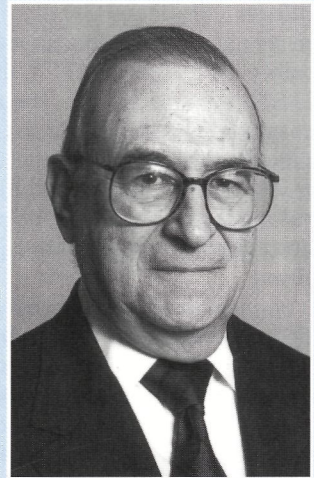
Contact the ASA Executive Office at (847) 825-5586 to obtain the addresses and telephone numbers for state medical society programs and services that assist impaired physicians.

Pre-emptive Analgesia: Variations on a Theme

As is customary, the September issue of the *NEWSLETTER* dwells on historical matters of relevance to anesthesiology and often medicine as a whole. It is especially fitting to consider our past, since this October 16 will mark the 150th anniversary of the first demonstration of the administration of ether for a surgery at Massachusetts General Hospital.

On October 15, 1910, as reported in the *Boston Medical and Surgical Journal* [1910; 163(24):893-904], George Washington Crile, M.D., delivered an "address" on the occasion of the 64th anniversary of "Ether Day." He set forth his theory on "Anoci-association." Dr. Crile stated, "The difference between anesthesia and anoci-association is that although inhalation anesthesia confers the beneficent loss of consciousness and freedom from pain, it does not prevent nerve impulses from reaching and influencing the brain." His concern was for the "fear, pain, shock and postoperative neuroses" that often followed surgery. In order to obviate the stated complications, his "anoci-association is accomplished by a combination of special management of patients [applied psychology], morphine, inhalation anesthesia and local anesthesia." It seems that a preoperative visit, some premedication and local anesthetic to the surgical site in addition to general anesthesia provided the patient with an ideal postoperative course.

In the July 1996 issue of *Anesthesiology*, an article on "Pre-emptive Analgesia" seems to have reinvented the wheel.



Erwin Lear, M.D.

A handwritten signature in cursive script that reads "Erwin Lear".

Erwin Lear, M.D.
Editor

ASA Communications Between Officers, Components and Members

Norig Ellison, M.D., President

Publications

There are many ASA publications, including the monthly *ASA NEWSLETTER*, that represent one form of ASA communications. The ASA Directory of Members is another publication, and it lists still more ASA publications on pages 44-46. Under the capable direction of Denise M. Jones, Director of Communications, working together with ASA members, ASA's Communications Department does a fine job in preparing these publications.

This column will not address that form of ASA communication. Rather, I will continue to provide my explanation of how ASA works by addressing the means of communication between ASA members and officers and will do so by reflecting on my own communications since being elected First Vice-President in October 1993.

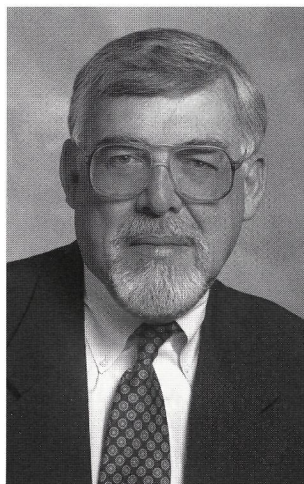
Officer Communications

Communication between the officers is continuous. The first two years as an officer are really training for the Presidency, but they require considerable time and travel commitments; e.g., copies of every letter I write are sent to the President-Elect and First Vice-President so that they are fully informed of what has transpired for when they become President. Similarly, commitments of Presidents are such that often the President-Elect and occasionally the First Vice-President must substitute for them.

Component Society Visits

There are 49 component societies, including the combined Maryland/District of Columbia and New Hampshire/Vermont societies, with South Dakota as the only state without a component society. During my year as ASA President, I will have visited 21 component, four subspecialty, four metropolitan and three regional societies. In the preceding two years, I visited another 20 component societies. To the four component societies where conflicts precluded my accepting their invitations, my apologies. I suggest that one way national officer visits might be made more effective is if the component societies contact the officers in advance when there is a specific issue they would like the officers to address. Then the officers can do research in advance, if necessary, to address the issue.

In both my travels and correspondence, I have observed much that is good and some that needs improvement in our



Norig Ellison, M.D.

specialty and in ASA. We are a strong, growing society, but the recent resident class sizes indicate that the rapid rate of growth will not be maintained. For that reason, it is important that we retain all anesthesiologists as active ASA members. ASA Secretary Ronald A. MacKenzie, D.O., and the Ad Hoc Committee on Membership Recruitment and Retention are actively addressing this important issue.

Member Communications

In recent months, I was surprised to discover that several anesthesiologists who contacted me were not active members. In each case, I tried to address their concerns but, at the same time, took the opportunity presented by our dialogue to invite them to join ASA. In each case, my message was the same: "*You need ASA, and ASA needs you!*" I urge all ASA members to deliver that same message to their anesthesiology colleagues who are not ASA members.

I also continue to be surprised that members do not appreciate the multiple routes available to contact ASA. At the local level, your component society officers are available to handle issues that would seem to be best handled locally such as a state legislative issue, or they can contact the ASA Executive Office or Washington Office for advice, additional resources or other support. Your district director and alternate director are logical conduits to ASA, but any member can contact the President directly, and many have!

Most of the telephone calls, letters and e-mail messages that I have received have been requests for action, advice or support. While I cannot handle every issue personally, I am confident that I can refer members to another source on those occasions when another's expertise is more appropriate. The office of ASA President is an elective position, and I ran for the office with the clear understanding that an important part of my job would be to communicate with members and respond to their needs. I have welcomed the opportunity to be of service to many members and am confident that my successors will also.

While it is human nature to express dissatisfaction or seek help on a given issue, receipt of telephone calls or letters expressing satisfaction or just saying "thank you" have been especially gratifying; e.g., one of the fondest memories I will retain of this year was of the telephone calls and letters I received concerning our success at the AMA/Specialty Society Relative Value Update Committee meeting last February to increase Medicare's work value for anesthesia. (No, HCFA still has not ruled on that recommendation!)

In summary, *communicate*. Communicate with your component society officers, and communicate with ASA officers. I stated that in the *NEWSLETTER* last November, and I repeat it now in September.

Congress Passes Insurance Portability Legislation

*Michael Scott, Director
Governmental and Legal Affairs*

An agreement in late July between Rep. Bill Archer (R-TX) and Sen. Edward M. Kennedy (D-MA) on provisions of the bill relating to medical savings accounts (MSAs) cleared the way for appointment of conferees on the long-stalled insurance portability legislation and ultimate passage of the bill in early August by both houses. President Clinton is expected to sign the bill promptly.

Members of both parties claimed credit for the bill. The portability provisions were essentially drawn from the President's health reform proposal of two years ago, which died in the face of savage opposition by the insurance industry and represented a major factor in the GOP gaining control of the Congress last year.

Congressional Republicans, on the other hand, emphasized their ability to work out portability terms acceptable to the insurance industry and to business interests. Principal architects of the legislation were Sens. Kennedy and Nancy Kassebaum (R-KS), Chair of the Senate Labor and Human Resources Committee, who is retiring this year.

The principal impediment to earlier passage of the legislation was the insistence of House Republicans that at least an experimental program for MSAs be included. An effort by Sen. Robert Dole, prior to his retirement from the Senate on June 11, to include an MSA provision in the Senate version had been narrowly defeated, which bore heavily on the controversy over appointment of Senate conferees when Democrats claimed he planned to "stack" the conference with pro-

MSA senators. The Archer-Kennedy negotiations resulted in the development of a compromise four-year experiment involving not more than 750,000 employees of small firms or self-employed individuals.

Of major interest to ASA members, the final legislation contains language advocated by organized medicine, including ASA, that addresses fraud and abuse, requiring that a provider act "knowingly and willfully" before criminal sanctions could be imposed and that the government provide binding advisory opinions on fraud and abuse issues when advice is requested by a provider.

Practice Expense Extension Introduced in House

During the latter half of July, the ASA Washington Office was active in generating support for H.R. 3859, introduced by Reps. Edward Whitfield (R-KY) and Ralph M. Hall (D-TX), the effect of which would be to extend the effective date for implementing new resource-based practice expense values under the Medicare Fee Schedule by one year, to January 1, 1999.

Impetus for the proposed legislation was the Health Care Financing Administration (HCFA) announcement that it had fallen behind in surveying indirect physician practice costs and that "proxy" data would be used instead in preparing a proposed schedule of practice expense values for public review and comment next spring.

Along with several other members of the Practice Expense Coalition, ASA successfully lobbied the AMA House of Delegates to adopt a resolution favoring delay in the practice expense implementation date. Since then, ASA legislative representatives and key contacts have been in touch with numerous congressional offices, seeking sponsors for the bill. The only apparent vehicle for the proposal in the present Congress is believed to be the omnibus Continuing Resolution for FY 1997, expected to be considered in September prior to recess for the elections.

Patent Bill Passes House

By more than a 2-to-1 margin, the House adopted on July 24 an amendment to one of the FY 1997 appropriations bills that would forbid the Patent and Trademark Office from using funds for the issuance of medical process patents.

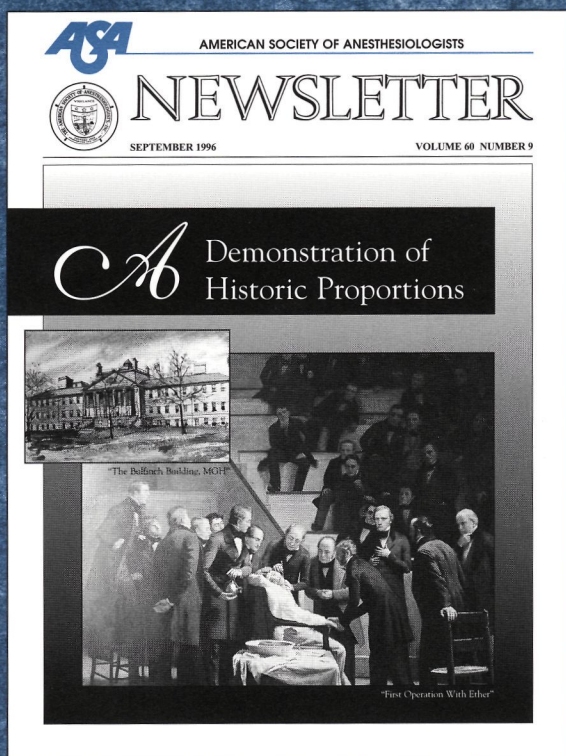
The amendment, originally introduced in slightly different form by Rep. Greg Ganske (R-IA) as H.R. 1127, had received strong support from the medical community, including ASA, in the wake of recently settled patent infringement litigation relating to an ophthalmic surgical procedure.

The Ganske amendment was vigorously opposed by the biotechnology industry, which was concerned about the impact of the ban on the patentability of biotechnological

Continued on page 32

About the Cover

The Most Significant Event in American Medical History



Adolph H. Giesecke, M.D., Trustee
Wood Library-Museum of Anesthesiology

The cover of this issue of the ASA NEWSLETTER portrays a beautiful image of the heroic painting of Ether Day by Robert C. Hinckley, completed in 1892. The inset is a painting of the facade of the Bulfinch building by anesthesiologist, artist and educator Leroy D. Vandam, M.D. The events of Ether Day, described by many as the most significant in American medical history, took place inside the Bulfinch building in an amphitheater known as the "Ether Dome." This site is now a national shrine managed by the United States Parks Department and should be a mandatory stop for any anesthesiologist visiting Boston.

The following cover story is abstracted from published writings of Henry R. Viets, M.D., Curator, Boston Medical Library in the Francis A. Countway Library of Medicine, Boston, Massachusetts, with his permission. The material on Dr. Vandam's painting was abstracted from *Harvard Medical Focus*, March 12, 1987.

(Continued on page 6)

Adolph H. Giesecke, Jr., M.D., is Jenkins Professor of Anesthesiology, Department of Anesthesiology and Pain Management, University of Texas Southwestern Medical School, Dallas, Texas.



Hinckley Painting: Dramatic Documentation of History

The painting of *Ether Day*, now in the Boston Medical Library, is by American artist Robert C. Hinckley (1853-1941). Beginning in Paris in 1882, the painting was done over a 10-year period by Hinckley, who carefully delineated the figures and historical background. Each figure was a true portrait of the man as only an artist in portraiture could paint him. Hinckley may well have interviewed some of the participants in the original *Ether Day*. This possibility accounts for his adding a local physician and two students to the group. He also painted in two surgeons who were known not to have been present.

The sources of inspiration and information for this elaborate composition to a young American artist working in Paris are unknown. Some have supposed that the original commission may have come from Massachusetts General Hospital; others have thought that Hinckley painted his canvas on "speculation," perhaps hoping ultimately to sell to the hospital. No satisfactory offer was received, and after letting it hang for 20 years in his studio, Hinckley was persuaded to give it to the Boston Medical Library in 1903, just as he was about to cut the canvas into smaller pieces for other use.

Most of the persons in the Hinckley painting can be identified with certainty. The principals are unmistakable; others pose some questions, but answers have been found with considerable assurance. Hinckley identified some of the minor figures on a photograph taken in Paris before the picture was complete.

All historians would agree that four persons were present at the first public demonstration of ether anesthesia on October 16, 1846: Gilbert Abbott, the patient; John Collins Warren, M.D., the surgeon; William T.G. Morton, who administered the ether; and Henry Jacob Bigelow, M.D., a junior surgeon and champion of Morton who was to write the first published account of that eventful day. House surgeon Charles F. Heywood, M.D., who wrote the patient's history in volume 30 of the "Surgical Records," was present. One newspaper reporter (standing on the chair at the left)



"First Operation With Ether," by Robert C. Hinckley, 1882-92 (Courtesy of Boston Medical Library)

wrote that he was a witness. Two other physicians were also there: Morton's friend Augustus Gould, M.D., an internist, and Solomon Townsend, M.D., a senior surgeon. Eben Frost, a businessman whose tooth was removed under ether by Morton on September 30, was also present. Seven students are recorded as having been present.

Photographer (daguerreotypist) Josiah Hawes is thought to have been there, but the sight of blood so unnerved him that he was obliged to retire, thus missing the chance of a lifetime. Three others in the painting are known not to have been present, but we can forgive Hinckley's artistic license in view of his warm and vivid portrayal of the memorable occasion.

The auburn-haired, tall, handsome dentist in a blue frock coat, Morton is a dignified, striking figure holding his glass ether vaporizer and gazing at Warren's first incision on the unconscious patient, Gilbert Abbott. Towering above all except Dr. Bigelow, Morton was backed by minor figures and set facing the all powerful Massachusetts General Hospital (MGH) surgical staff: Drs. Warren, Bigelow

and Townsend. Jonathan M. Warren is the smaller figure behind Morton holding the patient's head as if a little doubtful that Abbott might move at the touch of the knife. By his own statement, he was not present.

Dr. Bigelow stands tall and distinguished with blue eyes and pale hair, his hands on the patient's chest. It was he who caught the true significance of the occasion, talked it over with Oliver Wendell Holmes, communicated the news to the American Academy of Arts and Sciences on November 3

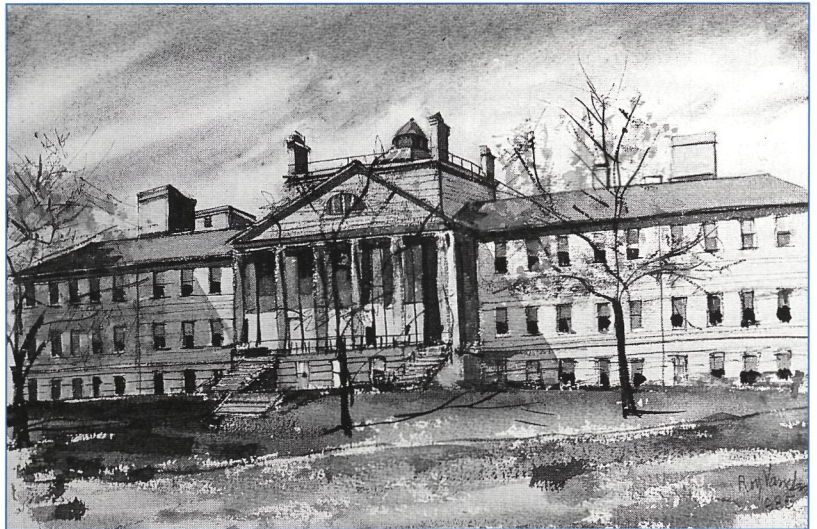
and published the full account on November 18. At age 28, he had been appointed as a visiting surgeon to the MGH staff in February. Hinckley balanced the figures of Morton and Dr. Bigelow in his composition, matching them in height. Without Dr. Bigelow's keen insights into Morton's previous experiments, no demonstration at MGH would have been possible. He was the key that opened the door for Morton.

The Hinckley painting stands today as a dramatic documentation of an event that changed the world and shaped the nation.

Vandam Painting: A Product of Planning and Inspiration

Leroy D. Vandam, M.D., is Professor of Anesthesia Emeritus at Harvard Medical School in Boston. The transformation of anesthesiology into a rigorous academic discipline has been accomplished in no small measure by his productive career. According to his colleagues, Dr. Vandam is a marvelous teacher, a consummate clinician and a superb man of letters who has written about, interpreted and shaped his profession. He is also an accomplished artist whose paintings grace the homes and offices of scores of important people.

As a child, Dr. Vandam drew constantly, winning prizes and lessons at the Metropolitan Museum of Art. While a medical student, he also studied etching, lithography and composition but resisted the temptation to give up medicine for art. In 1949, he turned to watercolor as his primary medium. "To turn out a good watercolor requires a lot of simultaneous planning and looking ahead," he says. "You might equate it with planning for an anesthetic." His paintings have appeared on several covers of the *ASA NEWSLETTER* and the *Journal of the American Medical Association*.



"The Bulfinch Building, MGH," by Leroy D. Vandam, M.D., 1985 (Courtesy of Massachusetts General Hospital)

Some years ago, Richard J. Kitz, M.D., asked Dr. Vandam to paint the Bulfinch building. "One Sunday in spring," says Dr. Kitz, "he sat down with his watercolor pad, and an hour later he had painted an absolutely outstanding rendering of the scene of the first [demonstration of the] use of ether." Dr. Vandam has also published an article on his analysis of the Hinckley painting in the journal *Anesthesiology* [1980; 52:62-70].

In October 1896, a distinguished group celebrated the 50th anniversary of the first public demonstration of ether anesthesia at Massachusetts General Hospital. Among those present were a few remaining physicians who had witnessed the horrors of surgery before anesthesia. They recounted ghastly images that a modern anesthesiologist can barely fathom. Now 100 years later, we celebrate the 150th anniversary of Morton's demonstration — with an ever-diminishing concept of what surgery was like before anesthesia.

Elective surgery was performed very infrequently prior to the advent of effective anesthesia. From 1821 to 1846, the annual reports of Massachusetts General Hospital recorded 333 surgeries, representing barely more than one case per month.¹ Surgery was a last and desperate resort. Reminiscing in 1897 about preanesthesia surgery, one elderly Boston physician could only compare it to the Spanish Inquisition. He recalled "yells and screams, most horrible in my memory

Surgery Before Anesthesia

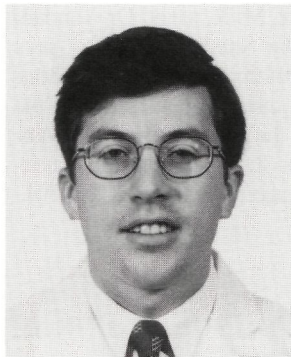
John T. Sullivan, M.D.

"Reminiscing in 1897 about preanesthesia surgery, one elderly Boston physician could only compare it to the Spanish Inquisition ... [with] 'yells and screams, most horrible in my memory now, after an interval of so many years.'"

now, after an interval of so many years. ... In one of these operations, performed by the hospital's senior surgeon, John Collins Warren, M.D., the cancerous end of a young man's tongue was cut off by a sudden, swift stroke of the knife, and then a red-hot iron was placed on the wound to cauterize it. Driven frantic by the pain and the sizzle of searing flesh inside his mouth, the young man escaped his restraints in an explosive effort and had to be pursued until the cauterization was complete, with his lower lip burned in the process.

In another operation, an unsuccessful attempt to reduce a dislocation of the thigh, a man was literally put to the rack for half an hour with a block and tackle arrangement."²

Before surgery, patients felt like condemned criminals awaiting execution, and if they survived the experience, the memory of it haunted them for the rest of their lives. In a letter written to Sir James Young Simpson, the renowned Scottish anaesthetist, a fellow physician who underwent amputation of the limb said, "I at once agreed to submit to the operation but asked a week to prepare for it, not with the slightest expectation that the disease would take a favorable turn in the interval, or that the anticipated horrors of the operation would become less appalling by reflection on them, but simply because it was so probable that the operation would be followed by a fatal issue...." Of the procedure itself, he recollected, "Suffering so great as I underwent cannot be expressed in words. ... The particular pangs are now forgotten; but the blank whirlwind of emotion, the horror of great darkness and the sense of desertion by God and man ... I can never forget, however gladly I would do so. ... Those are not pleasant remembrances ... and even now they are easily resuscitated and ... they can occasion a suffering of their own."³



John T. Sullivan, M.D., is a CA-2 anesthesiology resident at Massachusetts General Hospital, Boston, Massachusetts.

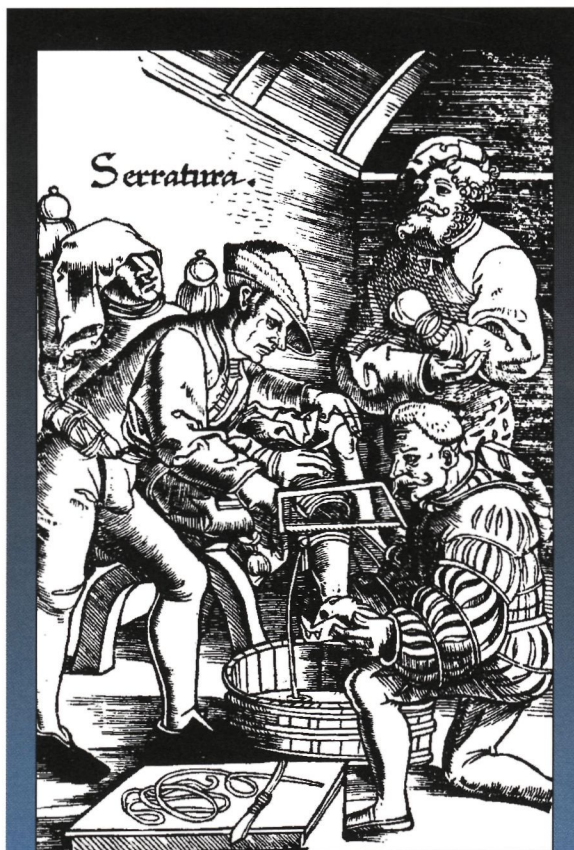
One of the most thorough descriptions of preanesthetic surgery can be found in a 12-page letter written by English author Fanny Burney to her sister Esther in March 1812, after surviving a mastectomy in 1811. For pain and induration in her breast, she sought the opinions of several respected medical and surgical consultants and was devastated when they concluded she had a life-threatening cancer: "[I]n time I was formally condemned to an operation by all three."

When the fateful day arrived, her only premedication was a "wine cordial," and she courageously submitted to the team of seven physicians who had arrived at her home in Paris. She tried to ignore the entire closet they filled with compresses and bandages, and one tactfully "inquired whether I had cried or screamed at the birth of [my son] Alexander ... what terrible inferences were here to be drawn." She lay on her bed, and although her face was covered with a light handkerchief, she could see the surgeon outline his intended incision with a forefinger and "the glitter" of his knife. "When the dreadful steel was plunged into the breast, cutting through veins, arteries, flesh, nerves, I needed no injunction not to restrain my cries. I began a scream that lasted unintermittingly during the whole time of the incision, and I almost marvel that it rings not in my ears still! So excruciating was the agony."

A second incision was made, and when the knife was withdrawn, "I concluded the operation over. Oh no! Presently the terrible cutting was renewed

and worse than ever...." Even when the tissue was severed from her body, "yet again all was not over," I then felt the knife rackling against the breastbone, scraping it! This performed, while I remained in utterly speechless torture...." When it was over, she was carried virtually lifeless from the bed but did recall looking up at her surgeon who was "pale nearly as myself, his face streaked with blood and its expression depicting grief, apprehension, and almost horror."

Out of necessity, the most valued surgical skill before anesthesia was quickness. English physician and medical historian Sir Clifford Allbutt recalled of preanesthetic surgery: "When I was a boy, surgeons operating upon the quick were pitted one against the other like runners on time. He was the best surgeon, both for the patient and onlooker, who broke the three-minute record in an amputation or a lithotomy."⁴ Under these circumstances, there was little opportunity for careful dissection or improvements in surgical technique. In fact, the atmosphere seemed to favor showmanship most of all. Langeback, a surgeon of Napoleon's day, claimed boldly that he could "amputate a shoulder in the time it took to take a pinch of snuff."⁵ The experience for surgeons ranged from those who emerged from the operating theater pale and sick themselves at the end of the case to some callous enough to tell their patients "Hush!" amid their agony. One young surgeon, who himself had to undergo an extremely painful incision of the hand for a deep abscess, said after it was over,



*A reproduction from a woodcut from Hans von Gersdorff's *Feldtbuch der Wundtartzney*, Strassburg, J. Schott, 1517, this is reputed to be the first known picture of an amputation. The four figures are the patient, the operator and his assistant, and probably a priest. (Courtesy of the American College of Surgeons)*

"I never again shall swear at a patient I am operating on."²

Over the centuries, numerous techniques had been used to dull sensation for surgery. Soporifics and narcotics were prepared from a wide range of plants, including marijuana, belladonna and jimsonweed. Healers attempted to induce a psychological state of anesthesia by Mesmerism or hypnosis. Distraction could be provided by rubbing the patient with counterirritants such as stinging nettles. A direct but crude way of inducing a state of insensitivity was to knock the patient unconscious with a blow to the jaw.⁶ But by 1846, "opium and alcohol were the only agents which continued to be regarded as of practical value in diminishing the pain of operations."³ Unfortunately, the large doses of alcohol needed to produce stupefaction were likely to cause nausea, vomiting and death instead of sleep. Opium, while a strong analgesic, had significant side effects itself and was typically not powerful enough to completely blunt a surgical stimulus.

The fact that a half century passed between the discovery of the anesthetic effects of the inhalational drugs and their widespread clinical use is remarkable and tragic. Sir Humphry Davy inhaled nitrous oxide to eliminate the pain of a toothache in 1795 and actually suggested its use as an analgesic during surgical operations. Shortly thereafter, his colleague Michael Faraday reported similar results with ether.⁶ Experimentation, recreational use and a few isolated clinical applications of inhaled anesthetics persisted until William T.G. Morton publicly demonstrated the value

"The fact that a half century passed between the discovery of the anesthetic effects of the inhalational drugs and their widespread clinical use is remarkable and tragic."

of ether for surgery at Massachusetts General Hospital on October 16, 1846.

The accounts and recollections of surgery before the days of effective anesthesia are gruesome. Remarkably, they were a reality only a few generations ago. Today, it is easy to forget the burden of surgical pain. On this 150th anniversary of the first public demonstration of anesthesia, we can reflect proudly on the achievements of Morton and others like him who have advanced the art and science of our field.

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Acknowledgment:

Special thanks to Charles C. Tandy, M.D., who provided the translation and transcription of the Fanny Burney letter.



October 16, 1846: A Day in History

*Doris K. Cope, M.D., Trustee
Wood Library-Museum of Anesthesiology*

**On the occasion of the
150th anniversary of W.T.G.
Morton's public demonstra-
tion of ether, the author takes
the reader back to October
16, 1846, and describes the
current events and social and
political climates of the times.**

On October 16, 1846, the war with Mexico is in full tilt with "Old Rough and Ready" Taylor, a Whig, leading an invasion on the Rio Grande into the heart of Mexico. However, his relations with President James K. Polk, a Democrat, are showing signs of cooling. The war with Mexico became all but inevitable after the annexation of Texas early last year. President Polk, supported by the Democratic majority in the Senate, had hoped to preserve the peace by sending John Slidell to Mexico with an offer of \$5 million to buy New Mexico and \$25 million to purchase California. His offer was refused. Last April 25, Mexican forces attacked American troops, injuring or killing 16 men. When news reached Washington, D.C., two weeks later, Congress declared war, appropriating \$10 million and authorizing the President to call for 50,000 volunteers. The nation, however, is divided in opinion about the war. The South favors the war as a way to extend slave territory, while the North generally opposes the war for the same reason.

Meanwhile, back in the East at the U.S. Military Academy at West Point, the recent graduates of the senior class of 1846 are impatient to join the fight against Mexico. These classmates included George B. McClellan, a bright, confident, aristocratic Philadelphian who was second in his class, and Thomas Jackson, known as "Old Jack" and who later will be known as "Stonewall." Jackson, an eccentric mountain boy from western Virginia, had been accepted at the very last minute when another candidate dropped out, and he had barely passed his first year. A.P. Hill, the soon-to-be-famous Southern general, and the even more famous

McClellan were roommates and best friends who both proposed to the same girl (she was later to marry McClellan). Another classmate, George E. Pickett, will lead the heroic charge at Gettysburg under fierce opposition from troops led by his Northern classmate John Gibbon. But now they are all classmates, united in their fervor to fight for the United States against all enemies.

Also in the news is John C. Fremont. He led his third expedition to California with 60 armed men, ostensibly to survey the central Rockies and the Great Salt Lake region. However, arriving in California this spring, he supported and probably even instigated the Bear Flag Revolt. In this recent uprising, the American settlers in the San Francisco Bay area seized the town of Sonoma, raising a standard that included the name of the republic, a grizzly bear and a star on a field of white. This led Robert F. Stockton, a naval

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officer commanding the U.S. forces on the Pacific Coast, to declare the annexation of California by the United States and to establish himself as governor only two months ago.

In the field of literature, Herman Melville is one of America's most promising young authors after the publication of his first novel, *Typee*, this year. This romance of the South Seas is based on his personal experience as a sailor and will foreshadow his later work, *Moby Dick*. Another hit, *Evangeline*, an idyllic tale in verse based on a story told to Henry Wadsworth Longfellow by Nathaniel Hawthorne, was also published in the last few months. Tall stories of the frontier are widely read and can be obtained in a popular collection called *Mince Pie for the Millions*, which came out recently, author unknown. Included in this collection are "Skinning a Bear," "The Death Hug" and "A Sensible Varmint," the last story involving the ubiquitous Davy Crockett. These stories are written in frontier dialect with colorful misspellings. They generally involve animals, particularly bears and game animals such as the raccoon (spelled *rakkoon* in "A Sensible Varmint").

An important event this year was the establishment of the Smithsonian Institution in Washington, D.C., by the U.S. Congress. James Smithson, an illegitimate son of the Duke of Northumberland, left more than a half million dollars in his will to establish such an institution. It took Congress more than 17 years to determine exactly how to spend the money.

Also, higher education is growing rapidly as evidenced by the chartering of the following universities: Baylor University in Waco, Texas (February 1, 1845), U.S. Naval Academy in

Annapolis, Maryland (October 10, 1845), Bucknell University in Lewisburg, Pennsylvania (February 5, 1846), and Grinnell College in Grinnell, Iowa (June 17, 1846).

This year, the first sewing machine with an eye-pointed needle was patented in the United States by Elias Howe. Also, the panorama, a moving picture mounted on rollers depicting travel down the Mississippi River, is being exhibited by John Barnard and is wildly popular. This has begun a craze for visual displays of popular subjects such as the burning of Moscow or the life of Napoleon Bonaparte, which are now seen mounted on the walls of circular buildings all over the country.

Baseball is an exciting new sport as Alexander J. Cartwright, a New York City firefighter, has drawn up a set of rules and organized the first baseball club, the Knickerbockers. Other clubs are also being formed adopting Cartwright's rules. Some of these rules are: four bases (not two, three or five) 90 feet apart in a square; flat, not raised bases; the batter standing in a box at home plate, not at some distance from it; and the outlawing of "plugging" a base runner in which a thrown ball hits a player "out."

Lyceum series is also a popular form of entertainment and inspiration. Lectures on "premature burial" and phrenology are well-attended, and Orson Squire Fowler has just published his bestseller, *Matrimony: Or, Phrenology and Physiology Applied to the Selection of Congenial Companions for Life*. Since the divorce rate remains low, this may be as good a process as any for the selection of a spouse.

A middle-class income is approximately \$1,500 a year,

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**October 16,
1846:
A Day in History**

but Sylvester Graham, for whom the cracker will soon be named, earns \$300 a night lecturing up and down the East Coast, extolling the virtues of bread as the mainstay of a healthy diet. The wholesome bread he describes should be baked entirely from whole grain by the woman of the house herself, not by any servants. In his lectures, he additionally warns of the debilitating effects of any stimulants, including not only alcohol but meat, warm baths and sweets. Graham also ascribes cholera, a common devastating disease, to both chicken pie and "excessive lewdness." Another popular lecturer is John Bartholomew Gough, a reformed alcoholic from England. After hearing his story of the evils of drinking, thousands of people in his audiences are signing the teetotaler's pledge, and grassroots support for the temperance movement is growing.

The metropolitan population of the United States is increasing dramatically after the great Irish potato famine, which began last year. A blight and British trade policy contributed to the precipitous decline of the population of Ireland from 8,500,000 to 6,550,000 this year, partly from starvation but also from the arrival of an estimated 1,600,000 Irish immigrants to American cities, where they can find work as cheap

October 16, 1846: A Day in History

"The metropolitan population of the United States is increasing dramatically after the great Irish potato famine, which began last year. A blight and British trade policy contributed to the precipitous decline of the population of Ireland from 8,500,000 to 6,550,000 this year...."

domestic and menial laborers. Also, other Americans are on the move as the Mormons have just left Nauvoo, Illinois, building and equipping 12,000 wagons to carry their families and belongings westward. By the middle of May, more than 16,000 Mormon settlers have crossed the Mississippi River. Later, in December, a pioneer group of 87 people who will be headed by two brothers, Jacob and George Donner, are planning to take a new shortcut through the Wasatch Mountains to begin new lives in the West.

These are exciting times. Books, lectures and scientific discoveries promise a cultural renewal and a better standard of living than ever before for Americans across the land.

These expansive times formed the social, political and intellectual setting for the first public demonstration of anesthesia. The environment encouraged innovations that occurred almost daily in every field of human endeavor.

Dr. Morton brooded about Horace Wells' failure two years before and was determined to succeed in demonstrating a new way to provide painless surgery. His success was the genesis of our specific practice of medicine. We owe much to the times and to that event.



Spreading the News of Anesthesia:

From W.T.G. Morton to the World Wide Web

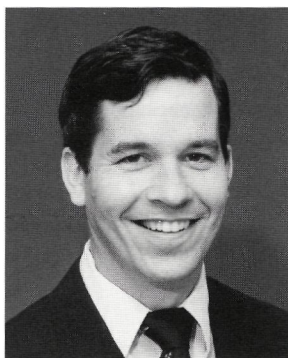
*George S. Bause, M.D., Trustee
Wood Library-Museum of Anesthesiology*



October 16, 1996, marks the sesquicentennial of William T.G. Morton's public demonstration of ether for surgical anesthesia. Though not the first to etherize, Morton was a successful communicator. Newspaper accounts and letters spread the news of anesthesia, shipped throughout the civilized world largely by steamship.

A fruitful voyage of one steamship, the *Acadia*, shared Dr. Morton's achievement serially with Canadians, Scots and the English. Departing Boston on December 1, 1846, this wooden paddle steamer harbored in Halifax on December 3 before arriving in Liverpool on December 16. The *Acadia's* surgeon, Dr. Fraser, took a steamer and connecting coach to reach his mother in Dumfries, Scotland, by December 17. Two days later, his surgical friends Drs. M'Lauchlan and Scott administered ether to a patient there in Dumfries. That same Royal Mail steamer, *Acadia*, brought Bostonian Jacob Bigelow's letter and his son's *Boston Daily Advertiser* story to Dr. Boott at Gower Street, London. Robinson etherized Dr. Boott's niece for a molar extraction on December 19, 1846. In contrast, the Canadian effort did not begin until January 18, 1847, when surgeon Dr. Peters excised Beatteay's arm tumor under Fiske and Adams' ether at St. John, New Brunswick.

Africa was introduced to Morton's ether by the steamship *Pekin*, which reached Cape Town, South Africa, by April 1, 1847. However, not until April 17 did Raymond



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extract a tooth there under ether. No early etherization has been documented for Egypt, in spite of prominence in the Mediterranean/ Egypt/Red Sea or "overland" route to the tea-rich nations of the East Indies.

Like Egypt, Asia was introduced to Morton's ether by the "overland route." Ships leaving England passed through the Straits of Gibraltar and traversed the Mediterranean. Reaching Egypt in 40 days, they initiated there the only truly overland part of the trip to the Red Sea. Connecting mail boats sailed onward to Bombay, Ceylon, Singapore, Manila and Hong Kong.

Australia received the news first from the ship Mountstuart Elphinstone. This vessel rounded Africa's Cape of Good Hope, stopping at Mauritius, Penang and Singapore. The S.S. Mountstuart Elphinstone reached Sydney, Australia, on April 28, 1847. Awarded the inaugural Wood Library-Museum Laureate in the History of Anesthesia, Gwenifer Wilson, M.D., has traced such voyages in her two-volume text, *One Grand Chain* (Melbourne: The Australian and New Zealand College of Anaesthetists; 1995).

These were indeed "slow boats to China" to Australia and beyond. Yet some argue that Great Britain spread the news to Paris, continental Europe and British Commonwealth nations faster than Boston impacted the rest of the United States. A second trans-Atlantic shipping delay slowed the Iberian relay of news to Latin America. Indeed, an etherization in Cuba on March 10, 1847, preceded the use of ether in nearby Merida (Yucatan, Mexico) by more than three months.

Fifty-year intervals have witnessed wonderful advances in communication and transportation. By 1896, locomotives linked bulk mail delivery, and rapid-fire communication was facilitated by telephone and rail telegraph. By the centennial celebration of Morton's ether demonstration,



radio receivers were widespread, and airmail was delivered by motorized airplane and jet. Today, we have faxes, electronic mail via the Internet and a vast opportunity for international exchanges of information on the World Wide Web.

And just what is the Web? A member of the ASA Committee on Electronic Media and Information Technology (EMIT) might define the Web as a menu-based, network-wide program linking hypermedia and hypertext to

other Internet information sources. But information can come through more than the written (typed?) word. For example, EMIT committee member George J. Sheplock, M.D., has digitally photographed a virtual tour of the Wood Library-Museum of Anesthesiology in Park Ridge, Illinois. Through the WLM's Web page, ASA members or anyone with Web access can soon take a guided tour through the WLM gallery without flying into the world's busiest airport, Chicago's O'Hare.

What will the future bring? Perhaps instant audio-video satellite communication from one anesthesiologist to the next a hemisphere away ... maybe voice-recognition, pocket-size personal computers with limitless, wireless links to databases worldwide ... instant voice translation from one human language to the next ... holographic projection of museum objects in three dimensions ... or maybe audiovisual-tactile-olfactory-gustatory virtual reality where you, the ASA member, can see and grab that virtual ether container ahead of you, hear that virtual safety pin pop through the top and virtually smell the ether.

Communicating in 1846 between countries took weeks by boat. Communicating the latest breaking news today by modem has been accelerated to transmissions that take 1/200-millionth of a second. From ether to ethernet, anesthesiologists have come a long way from Morton to the Web.



William T.G. Morton and the U.S. Congress

Discovering and then demonstrating to the world that insensibility to the pain of surgical operations could be achieved by inhaling the vapors of sulphuric ether was a boon for humanity and a great personal triumph for dentist/medical student, William T.G. Morton. This is a story, however, of intrigue, treachery, misrepresentation and political chicanery on the one hand and the durability of the human spirit on the other.

At first, Morton's energies were expended perfecting his discovery, teaching and promoting the use of his anodyne. The frenetic pace of these activities diverted his attention from his once-thriving dental practice, eventually bankrupting him. After he was obliged to reveal that sulphuric ether was the active component in his patented "Letheon,"¹ other serious matters usurped his time.

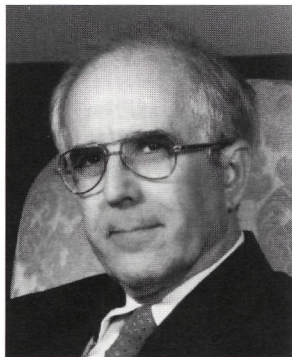
Upon the advice of friends, Morton, through his agent, Edward Warren, presented a memorial to the 29th Congress, 2nd Session, to have his priority to the ether discovery

Eugene H. Conner, M.D.
Wood Library-Museum of Anesthesiology

established and to request an award for the use of his patent (U.S. Patent No. 4848, November 12, 1846), which at that time was so important for the use of ether to provide comfort and care to those wounded in the war with Mexico. This first of many presentations to the U.S. Congress was heard by the Select Committee of the House of Representatives, consisting of five members, four of whom were physicians.* They listened but made no report, and their deliberations were not published. Members of the committee were apparently confused by the slanderous campaign against Morton by a group of dentists and a few physicians in Boston and vicinity, led by Josiah F. Flagg (1789-1853), a practicing dentist. This group's effort came to be known as the "Dental Manifesto" and was effective in ruining Morton's reputation, dental practice and income.

In the course of memorializing six sessions of four congresses, Morton's focus remained twofold — establishing his priority for the anesthesia discovery and petitioning remuneration from the U.S. government. These efforts over the years became more frustrating, exhausting and costly in time and money.

The 30th Congress first confirmed Morton's priority for the discovery, and this was reaffirmed in the 32nd Congress, although the Senate version hedged and stated that the honor of discovery belonged to one of three persons: William T.G. Morton, Horace Wells or Charles T. Jackson, M.D. The question was to be settled by Congress without judicial inquiry. A compensation amount of \$100,000 was



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* The physicians serving on the Select Committee of the House of Representatives were: George Fries, M.D. (Ohio), Chair; James H. Relfe, M.D. (Missouri); Bryan R. Young, M.D. (Kentucky); Owen D. Leib, M.D. (Pennsylvania); and Robert Toombs (Georgia).

agreed upon by the majority of the Select Committee of the House, contingent upon Morton's surrender of his patent to the commissioner of patents. The matter of funding was agreed to by the full House and Senate *but was to be paid out of any money in the treasury not otherwise appropriated.*

In spite of the statement in the Minority Report of the 32nd Congress, 2nd Session, there was a lengthy trial establishing Morton's claim. Transcribed interrogations, taken in December 1852 and February 1853, appear on nearly 200 pages appended to the House committee's deliberations in the 32nd Congress, 2nd Session.

All of the testimony and supporting evidence submitted during both sessions of the 32nd Congress was published and is of great historical value, but it was of no use in obtaining money for Morton. The appropriation bill for the \$100,000 was approved in 1852 and 1854 in the House but failed each time in the Senate. Even Morton's appeal in June 1854 to President Franklin Pierce was fruitless.

Morton's last appearance in Congress was before the Senate Committee on Military Affairs and the Militia in 1863. Alas, the committee concluded, "Your Committee are of the opinion that some compensation is due, but they report these facts for the information of the Senate, *without any recommendations*" [emphasis added].

Morton died without ever receiving any of the \$100,000 that was to be paid him for return of his patent to the U.S. government. This is a tragic commentary upon the political machinations of the U.S. Congress and an ultimate disgrace to the citizens of the United States that an opportunity to recognize the benefits from Morton's discovery was unrequited.

Reference:

1. Hodges RM. *A Narrative of Events Connected With the Introduction of Sulfuric Ether Into Surgical Use.* Boston: Little, Brown & Co.; 1891:51.



UNITED STATES PATENT OFFICE.

C. T. JACKSON AND WM. T. G. MORTON, OF BOSTON, MASSACHUSETTS; SAID
C. T. JACKSON ASSIGNOR TO WM. T. G. MORTON.

IMPROVEMENT IN SURGICAL OPERATIONS.

Specification forming part of Letters Patent No. 4,848, dated November 12, 1846.

To all whom it may concern:

Be it known that we, CHARLES T. JACKSON and WILLIAM T. G. MORTON, of Boston, in the county of Suffolk and State of Massachusetts, have invented or discovered a new and useful Improvement in Surgical Operations on Animals, whereby we are enabled to accomplish many, if not all, operations, such as are usually attended with more or less pain and suffering, without any or with very little pain to or muscular action of persons who undergo the same; and we hereby declare that the following is a full and exact description of our said invention or discovery.

It is well known to chemists that when alcohol is submitted to distillation with certain acids peculiar compounds, termed "ethers," are formed, each of which is usually distinguished by the name of the acid employed in its preparation. It has also been known that the vapors of some, if not all, of these chemical distillations, particularly those of sulphuric ether, when breathed or introduced into the lungs of an animal have produced a peculiar effect on its nervous system, one which has been supposed to be analogous to what is usually termed "intoxication." It has never to our knowledge been known until our discovery that the inhalation of such vapors (particularly those of sulphuric ether) would produce insensibility to pain, or such a state of quiet of nervous action as to render a person or animal incapable to a great extent, if not entirely, of experiencing pain while under the action of the knife or other instrument of operation of a surgeon calculated to produce pain. This is our discovery, and the combining it with or applying it to any operation of surgery for the purpose of alleviating animal suffering, as well as of enabling a surgeon to conduct his operation with little or no struggling or muscular action of the patient and with more certainty of success, constitutes our invention. The nervous quiet and insensibility to pain produced on a person is generally of short duration. The degree or extent of it or time which it lasts depends on the amount of ethereal vapor received into the system and the constitutional character of the person to whom it is administered. Practice will soon acquaint an experienced sur-

geon with the amount of ethereal vapor to be administered to persons for the accomplishment of the surgical operation or operations required in their respective cases. For the extraction of a tooth the individual may be thrown into the insensible state, generally speaking, only a few minutes. For the removal of a tumor or the performance of the amputation of a limb it is necessary to regulate the amount of vapor inhaled to the time required to complete the operation.

Various modes may be adopted for conveying the ethereal vapor into the lungs. A very simple one is to saturate a piece of cloth or sponge with sulphuric ether, and place it to the nostrils or mouth, so that the person may inhale the vapors. A more effective one is to take a glass or other proper vessel, like a common bottle or flask, and place in it a sponge saturated with sulphuric ether. Let there be a hole made through the side of the vessel for the admission of atmospheric air, which hole may or may not be provided with a valve opening downward, or so as to allow air to pass into the vessel, a valve on the outside of the neck opening upward, and another valve in the neck and between that last mentioned and the body of the vessel or flask, which latter valve in the neck should open toward the mouth of the neck or bottle. The extremity of the neck is to be placed in the mouth of the patient, and his nostrils stopped or closed in such manner as to cause him to inhale air through the bottle, and to exhale it through the neck and out of the valve on the outside of the neck. The air thus breathed, by passing in contact with the sponge, will be charged with the ethereal vapors, which will be conveyed by it into the lungs of the patient. This will soon produce the state of insensibility or nervous quiet required.

In order to render the ether agreeable to various persons, we often combine it with one or more essential oils having pleasant perfumes. This may be effected by mixing the ether and essential oil and washing the mixture in water. The impurities will subside, and the ether, impregnated with the perfume, will rise to the top of the water. We sometimes combine a narcotic preparation—such as opium or mor-

A portion of Morton and Jackson's "Specification forming part of Letters Patent No. 4,848, dated November 12, 1846." (Courtesy of the Wood Library-Museum of Anesthesiology)



Monument to a Momentous Event

Lydia A. Conlay, M.D.

John F. Ryan, M.D.

And God shall wipe all tears from their eyes; neither shall there be any more pain; for the former things are passed away.

—Revelations 21:4

In this, the 150th anniversary year of William T.G. Morton's public demonstration of ether as an anesthetic, it is fitting to discuss the impact of this extraordinary event upon those whom it affected most. Such triumphs may be measured not only in the remarkable advances in surgery and impact on society as a whole, but also by the tributes, offerings and monuments to such a discovery by societies of the time.

In 1866, 20 years after the demonstration, Thomas Lee, Esq., of Boston proposed to erect a monument at his own expense "in the form of a fountain, as an expression of gratitude for the relief of human suffering occasioned by the discovery of the anaesthetic properties of sulphuric ether."¹ This splendid 40-foot obelisk remains the oldest statue in Boston's historic Public Garden and is the only monument to a drug, to our knowledge, in the world. Moreover, it serves as a graceful symbol of our craft to the more than 1 million visitors passing through the Boston Public Garden each year.

Many have puzzled at the statue that crowns the monument's peak, which portrays the parable of the Good Samaritan tending wounds of a suffering man. Or perhaps what catches their eye is the beauty of the Venetian arches, the niches and columns in pink marble or the inscriptions on the four granite reliefs, depicting the Angel of Mercy, the interior of a field hospital, performance of a surgical procedure and an allegory of the triumph of science. The fountains that once sprang forth from the four lions have long been dry, as has the pool from which the monument rises. The fountains and pool were meant to symbolize the healing and comforting powers of calm waters.

This magnificent monument was designed by Boston architects van Brunt and Ware, who also designed Harvard's Memorial Hall and other noted buildings of the time. Mr. van Brunt's efforts were possibly aided by sketches from a flamboyant local artist, Mr. John LaFarge. Models of the Good Samaritan and the statue's four bas-reliefs were provided by the New York sculptor John Quincy Adams Ward and were executed in granite by Garrett Barry, a stone mason of Quincy, Massachusetts.

Although the group worked feverishly to complete the Monument to Ether as Mr. Lee fell ill, they were not successful, for the monument's benefactor passed away prior to the dedication of his beloved work. The friends of Thomas Lee selected Henry J. Bigelow, M.D., a surgeon at Massachusetts General Hospital, to present the monument to the city of Boston in 1868. In his address, Dr. Bigelow noted: "The philanthropist had indeed yearned to relieve suffering humanity; the poet had prophetically announced a world freed from physical pain; and the philosopher had made fruitless efforts to unveil the hidden secret. ... But when these experiments had been made, the entire civilized world simultaneously rose up to hail it with acclamatory welcome."¹

Alas, the 20th century has taken its toll on the Monument to Ether. Years of air pollution and acid rain have eroded its granite finish; its marble base is cracked and, if working, water would be supplied by 19th-century vintage pipes inside the statue. The last restoration effort was made more than a quarter century ago by a group of private individuals, under the leadership of Boston anesthesiologist Leroy D. Vandam, M.D.

"This splendid 40-foot obelisk remains the oldest statue in Boston's historic Public Garden and is the only monument to a drug, to our knowledge, in the world."

Today, on the 130th anniversary of the Ether Monument and the 150th anniversary of Morton's historic contribution to our specialty, the Massachusetts Society of Anesthesiologists has undertaken the task of restoring this monument and is committed to maintaining its beauty in perpetuity. Any member interested in participating may contact the Massachusetts Society of Anesthesiologists.

Reference:

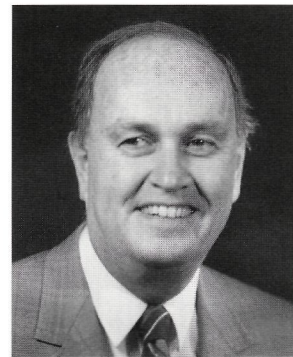
1. Proceedings at the Dedication of the Ether Monument. City of Boston. 1868; 101:6-10.



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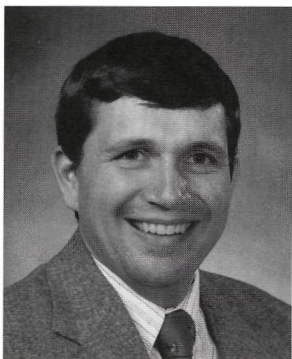


The Ether Centennial of 1946: A Celebration of Morton's Achievement

Douglas R. Bacon, M.D.
Wood Library-Museum of Anesthesiology Fellow (1989, 1991, 1994)

One of the most important moments in American medical history occurred on October 16, 1846. On that day, William T.G. Morton used "Letheon" to anesthetize Gilbert Abbott for the removal of a jaw tumor at Massachusetts General Hospital in Boston. For the first time, surgical anesthesia had been publicly demonstrated¹ and became the first American contribution to medicine that would forever change patient care. The magnitude of the event can be judged by the time it took for Morton's news to traverse the world. Within eight months, operations under ether anesthesia were being performed in Australia, literally half the world away from Boston.²

October 16, 1946, marked the centennial of Morton's demonstration. It was a curious time for America; World War II was over, and the nation faced economic challenges in shifting to a peace-time economy. Jobs were scarce, but labor was not. Demobilized soldiers searched for employment and places to live. America was in transition.



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The American and New England anesthesiology societies sensed that change. In a three-day joint meeting held on October 15-17, 1946 [Figure 1], the program for the centennial celebration led the audience from anesthesia's past to the present problems being encountered in the field.³ Each morning, clinical demonstrations were held in two different Boston hospitals to describe innovative anesthesia techniques. During the afternoon, prominent anesthesiologists from across the country summarized the knowledge in a specific area and described the challenges that lay ahead.

The conference opened on Tuesday, October 15. From 7:45 a.m. until noon, the program participants went to either the Boston City Hospital or the Massachusetts Memorial Hospital. From 9:30 a.m. until 12:30 p.m., they had the option to attend the Massachusetts General Hospital's symposium titled "On the Fundamental Nature of the Anesthesia Process." The afternoon session was devoted to "Some Basic Problems of Anesthesia." From 8 p.m. to 10:30 p.m., ASA and the New England Society of Anesthesiologists held a joint meeting. The group was addressed by the prominent surgeon Frank Lahey, M.D., on "Anesthesia's Aid to Surgery," while the well-established anesthesiologist Albert H. Miller, M.D., of Providence, Rhode Island, spoke about "Ether Anesthesia Yesterday, Today and Tomorrow." The papers were then discussed by no less than Henry K. Beecher, M.D., Chief of the Anesthesia Service at Massachusetts General Hospital and the Henry I. Dorr Professor of Research in Anesthesia at Harvard University.

The events on Wednesday, October 16, were no less auspicious. The morning operative clinics were held at the New England Baptist, Deaconess and St. Elizabeth hospitals

and the Lahey Clinic. The morning symposium at Massachusetts General Hospital was titled "Some Physiological Effects of Wounds." After lunch, Mayo Clinic Anesthesiology Chief and ASA President John S. Lundy, M.D., presided over a blue-ribbon panel of experts. ASA Immediate Past President and University of Wisconsin Chief Ralph M. Waters, M.D., spoke on "Absorption of Carbon Dioxide — Its History in Anesthesia." Wesley Bourne, M.D., ASA President in 1942 and an anesthesiologist from Montreal, spoke on "Gaseous Anesthetics." H.W. Featherstone from Burton-on-Trent in England rounded out the program with his paper on "Chloroform." That evening, the meeting concluded with the ether centennial program at Harvard University.

Thursday, October 17, opened with operative clinics offered at the Massachusetts General and Faulkner hospitals. After lunch at the Hotel Sheraton, New England Society President Leo V. Hand, M.D., led another afternoon panel. Stuart Cullen, M.D., Chair of Anesthesiology at the University of Iowa, discussed "Curare, Historical Review and Present Experiences." He was followed by Lahey anesthesiologist Philip D. Woodbridge, M.D., who spoke on "Spinal Anesthesia." R.C. Adams, M.D., from the Mayo Clinic closed the afternoon program with a paper on "Intravenous Anesthesia." That evening at the Sheraton, a formal dinner was held. Dr. Beecher was toastmaster, and J.F. Fulton, M.D., the Sterling Professor of Physiology at Yale, addressed the group.

Massachusetts General Hospital held a special commemoration ceremony for its staff and the general public

Figure 1



[Figure 2]. Admission was by invitation only, signed by both the medical staff and the Board of Trustees of the hospital.⁴ Interestingly, it was Nathaniel W. Faxon, M.D., who issued the invitation on behalf of the hospital's staff and not the more logical choice, Dr. Beecher, the hospital's chief anesthesiologist.

The *Journal of the History of Medicine and Allied Sciences* circulated an "Anesthesia Centennial Number" for the fall issue of the publication in October 1946.⁵ It was the final number of that year's issue, and it capped off a period of growth that ensured the establishment of the journal. The centennial issue sought to bring the entire history of anesthesiology together in one place. Starting with an overview of surgical anesthesia from 1846-1946 by Josiah Trent, M.D., the journal then plunged into a history of anesthesia from antiquity to 1946.

The history of anesthesiology was divided into two broad categories. First, several essays dealt with critical issues

and personalities from the past. Articles covered Mesmerism and anesthesia in obstetrics, pharmacology and endotracheal anesthesia. A special article covered the career of Britain's first full-time anaesthetist, John Snow, M.D., and was written by medical historian Thomas E. Keys, D.Sc. (Hon.).

The second major division in these essays concerned the arrival and subsequent history of anesthesia in countries around the world. Dr. Waters wrote about American developments and stressed the early history of organized anesthesiology. The anesthesia story in France, Germany, Sweden, Spain, Portugal, Latin America and Turkey was

spelled out within the pages of the journal. Peter Parker, an American missionary in China, introduced the Far East to ether anesthesia and had a most remarkable essay written about the event.

The ether centennial in 1946 was celebrated in the midst of tumultuous times for both America and the specialty. ASA was small but was growing both nationally and regionally as is evidenced by the joint meeting between ASA and the New England Society of Anesthesiologists. The worldwide nature of the event was clearly explained in the *Journal of the History of Medicine and Allied Sciences*.

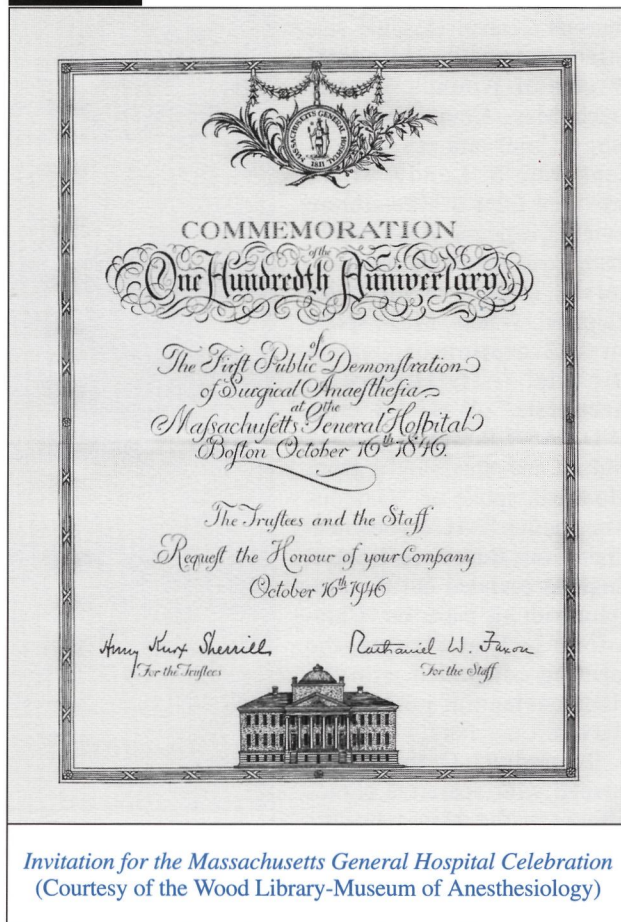
This year, as 150 years of surgical anesthesia is celebrated, the times are no less tumultuous and the history of anesthesiology no less fascinating than it was in 1946. This anniversary is a time to reflect upon the past, as is so well-documented within the confines of the Wood Library-Museum of Anesthesiology, and to use the lessons contained therein to guide us as anesthesiology moves toward the second half of its second century.

References:

1. Robinson V. *Victory Over Pain*. New York: Henry Schuman; 1946:124-128.
2. Wilson G. *One Grand Chain*. Melbourne, Australia: The Australian and New Zealand College of Anaesthetists; 1995:1-47.
3. Ether Centennial Program. Collected Papers of Albert Miller, M.D. Available in: The Wood Library-Museum of Anesthesiology, Park Ridge, Illinois.
4. Invitation to the One-Hundredth Anniversary of the First Public Demonstration of Surgical Anesthesia. Collected Papers of Albert Miller, M.D. Available in: The Wood Library-Museum of Anesthesiology, Park Ridge, Illinois.
5. Rosen G, ed. *Journal of the History of Medicine and Allied Sciences*; 1946:1:505-710.



Figure 2



Invitation for the Massachusetts General Hospital Celebration
(Courtesy of the Wood Library-Museum of Anesthesiology)

Questions to Ponder: Resources From the Wood Library-Museum of Anesthesiology

Sally S. Graham, M.L.S., M.A., Assistant Librarian
Wood Library-Museum of Anesthesiology

How would you anesthetize a chick embryo in outer space? What anesthetic would be appropriate for a specific reaction? This query was one of the more unusual ones that the Wood Library-Museum of Anesthesiology (WLM) had received in quite some time. But for a librarian at the WLM, answering reference questions is a daily occurrence.

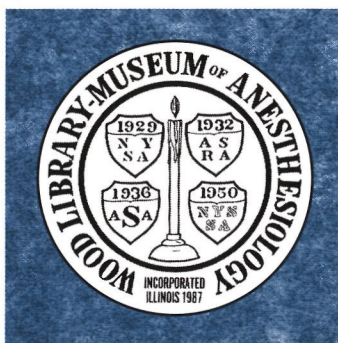
In 1995, the WLM supplied information for about 1,000 inquiries, and of course, each answer was needed immediately or within 24 hours at the latest.

Some of the more common questions have to do with an anesthesiologist's practice. Often, ASA members want to know where to find the latest ASA guidelines or practice parameters. They want to know about specifics that impact their practice, like relationships with nurse anesthetists, utilization or planning of operating rooms, or studies on new drugs. They may ask questions about liability issues, setting up an office, starting a career, standard equipment they need for a new facility or where to find a patient satisfaction survey.

Some inquiries are more clinical in nature. An anesthesiologist may ask about radial, lumbar or major plexus blocks, research on a dislocated jaw after anesthesia, if neuroanesthesia can be done without intubation or about recent studies on the use of intrathecal drugs for pain management. Whether the most current data are sought or a historical review of all of the medical literature for a specific question, the WLM provides a wide range of resources. Information available from the WLM may consist of a bibliography, an abstract or photocopies of supporting documents, or the loan of a book.

Many times, resource questions may require only a bibliography such as one compiled on latex allergies. Such an in-house bibliography is available with a comprehensive list of articles that track the subject matter back to when it first became a topic of interest. Others will soon be available on the ASA Web site <<http://www.ASAhq.org>> for browsing.

The WLM receives questions daily from ASA members, the general public and the media. It functions as a clearinghouse of information, routing inquirers to appropriate resources. It also provides book loans or copies of articles from the 100-plus anesthesia-related journals in its



holdings. The resources of the WLM are utilized for the 1,000-plus reference questions it answered in 1995. Answers are supplied via telephone, fax, mail or e-mail.

So, how would one anesthetize a chick embryo in outer space? What anesthetic would be appropriate for a specific reaction? To research such a question, we checked available literature in the MEDLINE database, looking for recent and earlier studies. After checking with the ASA Communications Department for its

input, three physicians were contacted for their input on this question. Since there was no definitive answer anywhere, the best answer was to coordinate a meeting via telephone of experts in research in anesthesia and provide a bibliography from MEDLINE as a resource. We are awaiting the launch of the space shuttle with anesthesia for chick embryos and the resulting article in the literature.

We invite you to use the WLM for your anesthesia information needs.



Sally S. Graham, M.L.S., M.A., has been Assistant Librarian for the Wood Library-Museum of Anesthesiology since 1988.

'From W.T.G. Morton to the World Wide Web': A Special ASA-Sponsored Exhibit at the Annual Meeting

George J. Sheplock, M.D.

Michael P. Smith, M.D.

Ad Hoc Committee on Electronic Media and Information Technology

The ASA committees on Communications, Electronic Media and Information Technology (EMIT), Overseas Anesthesia Teaching Programs, and Patient Safety and Risk Management, along with the Wood Library-Museum of Anesthesiology (WLM), will present an exhibit for the membership about their current and projected activities on Sunday through Tuesday, October 20-22, in the Morial Convention Center Exhibit Hall at the ASA Annual Meeting in New Orleans.

"From W.T.G. Morton to the World Wide Web" will be this special exhibit's overall theme and will trace the progress of the specialty and its communication capabilities over the last 150 years.

ASA's exhibit will be composed of a separate exhibit area for each of the four committees and the WLM. In total, ASA's 40-foot-by-80-foot exhibit (booth No. 1923) will utilize more than 17 computer workstations incorporating interactive hypermedia software and access to Internet resources. Highlights of the five displays are as follows:

ASA Committee on Communications

This section will include information and examples of ongoing ASA communications projects and how members can become involved in public relations efforts in their communities. Computer stations with Internet access will be available with tutorial information about electronic mail for communications worldwide. A brief survey will be included in the program so that members can e-mail their responses to the ASA Executive Office.

The 60th anniversary review of the *ASA NEWSLETTER* also will be featured. Representatives of the committee

and the ASA Resident Component will be available to discuss current programs and future plans.

ASA Ad Hoc Committee on Electronic Media and Information Technology

This section of the exhibit will have six computer stations featuring the ASA Web site. The exhibit will feature information about EMIT's function to promote the development of electronic resources, use of technology and networking among colleagues for educational and research purposes as well as consulting on patient issues facing all anesthesiologists today.

ASA Committee on Overseas Anesthesia Teaching Programs

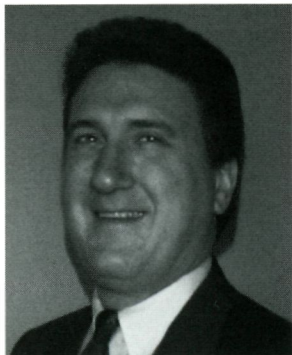
In keeping with the "worldwide communications theme" for this year's special exhibit, the ideals, purpose and activities of the Overseas Anesthesia Teaching Programs will be featured and explained with graphics, handouts and a videotape. Information about how to volunteer for the program also will be available.

ASA Committee on Patient Safety and Risk Management

The primary focus of this year's exhibit will be on those resources that help the anesthesiologist access safety information through the Internet and other electronic media. Also, the new electronic anesthesiology library on CD-ROM, which combines five years of content from the four leading anesthesiology journals, will be demonstrated. Educational pamphlets, printed reports and the latest releases in the ASA Patient Safety Videotape Series will be available for review. The Patient Safety area is a joint project of the Anesthesia Patient Safety Foundation and the ASA Committee on Patient Safety and Risk Management.

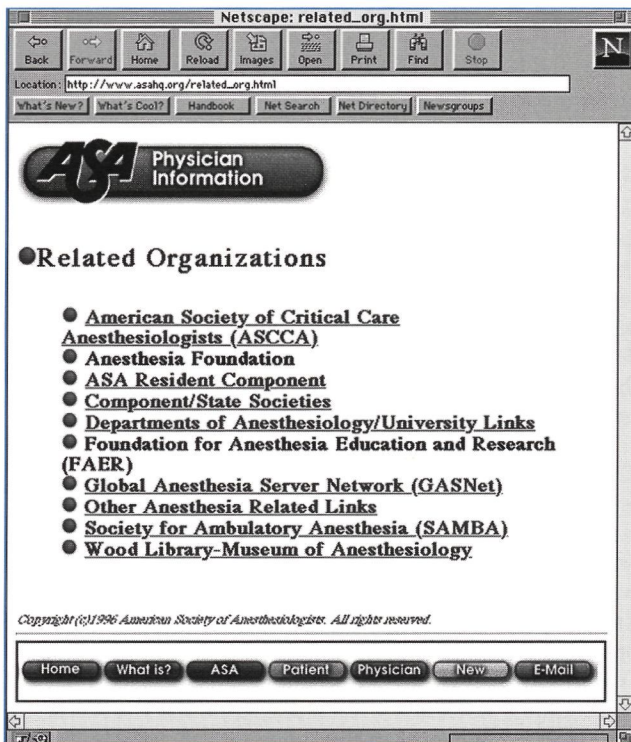
Wood Library-Museum of Anesthesiology

This year's exhibit will follow the historical roots of modern anesthesia, beginning with the public demonstration of ether by William T.G. Morton in Boston in October 1846, and moving forward into the information age of today, which includes information access through the World Wide Web. One of the highlights of this year's booth will be a computer-generated "virtual tour" of exhibits and artifacts in the WLM in Park Ridge, Illinois, without having to leave the confines of the Exhibit Hall!



*George J. Sheplock, M.D., is
Assistant Professor of Anesthesia
at Indiana University School of
Medicine, Indianapolis, Indiana.*

Figure 1



ASA's Web site contains several links to other anesthesia-related organizations. The address is <<http://www.ASAhq.org>>.

The EMIT committee, chaired by N. Ty Smith, M.D., is assisting with the planning and development of the overall exhibit. This ad hoc committee was established in 1994 as a task force by Wilson C. Wilhite, Jr., M.D., then ASA President. The task force was charged with evaluating and making recommendations regarding electronic media and related information technologies for our national Society, including electronic mail, CD-ROM, interactive hypermedia software and Internet technology for the distribution of information to ASA members. Since its beginning, the EMIT committee has provided information, advice and resources to the ASA's leadership, committees and membership.

ASA's Web site and the GASNet Web site contain links to many other anesthesia-related home pages for ASA members to visit. These home pages with links to other

subspecialty home pages demonstrate how the Internet is bringing together many knowledgeable practitioners who can benefit from ASA membership and from each other.

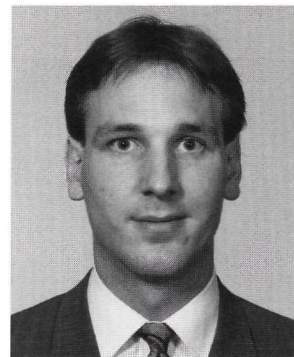
All individuals, regardless of computer skill level, are encouraged to participate in the display at the Annual Meeting. Members of ASA, the ASA Resident Component and subspecialty societies will be serving as "Internet ambassadors." These "ambassadors to cyberspace" will facilitate the interaction of meeting attendees with the computerized workstations by serving in two-and-one-half-hour increments.

The subspecialty leadership should find this to be an excellent chance to obtain ideas and hear about successful endeavors on the Internet with regard to implementation for their membership.

If you would like to have your subspecialty society listed on the GASNet or ASA Web sites, or if you would like to assist in the booth, please contact Michael P. Smith, M.D., by e-mail at <mikesmith@anesthesia.ccf.org> or by fax at (216) 444-9247.

This year's ASA exhibit looks to be an exciting, high-tech multimedia extravaganza. We look forward to seeing you there!

Michael P. Smith, M.D., is Staff Anesthesiologist at the Cleveland Clinic Foundation, Cleveland, Ohio.



Rovenstine Lecture to Be Broadcast Over the Internet

Keith J. Ruskin, M.D.

Ad Hoc Committee on Electronic Media and Information Technology

Recently introduced software has made broadcasting live audio and video transmissions across the Internet not only practical but relatively inexpensive. A recent example of an application of this technology is the recent broadcast of the plenary sessions of the World Congress of Anaesthesiologists in Sydney, Australia. These broadcasts, which were viewed by several hundred people worldwide, were made possible with a low-cost software package called CUSeeMe and an IBM PC-compatible or Macintosh computer.

ASA is pleased to announce that the Emery A. Rovenstine Memorial Lecture at the 1996 ASA Annual Meeting will be broadcast worldwide over the Internet. This important lecture is always given by an acknowledged leader in the specialty and is well-known around the world. This year's lecturer is David E. Longnecker, M.D., who is speaking on "Navigation in Uncharted Waters: Is Anesthesiology on Course for the 21st Century?"

The broadcast will bring this lecture to all members regardless of location, help to publicize the goals of the Society and firmly establish the Internet as an integral means of communication between the Society and its members.

Keith J. Ruskin, M.D., is Assistant Professor, Department of Anesthesiology, Yale University School of Medicine, New Haven, Connecticut.

All that is needed to receive the lecture is an IBM PC-compatible or Macintosh computer with a connection to the Internet and the CUSeeMe software. In addition, White Pine Software, the maker of CUSeeMe, will provide a time-limited, demonstration version of the software free of charge for those who wish to receive the broadcast. Detailed instructions as well as links to the demonstration versions of the software are available on the World Wide Web at <<http://gasnet.med.yale.edu/rovenstine>> or at <<http://www.ASAhq.org>>.

The lecture will be broadcast over a network of CUSeeMe reflectors. A reflector is a server-based application that allows CUSeeMe clients to have group conferences. It accepts multiple CUSeeMe connections and reflects the video, audio and additional data to all participants concurrently. Multiple reflector sites can be linked to create a network for larger group conferences or video broadcasts. The master reflector is on the GASNet computer <<http://gasnet.med.yale.edu>>; a list of additional reflectors will be placed on the Broadcast Information Page on GASNet.

We hope that through this effort, ASA members who are unable to attend the Annual Meeting will benefit from this important event.

For further information, contact Keith J. Ruskin, M.D., by e-mail at <ruskin@gasnet.med.yale.edu> or by telephone at (203) 785-2802.

Anesthesiology Journal Sponsors Symposium at Annual Meeting

Dennis T. Mangano, M.D., Ph.D.
Anesthesiology Editorial Board

The fifth symposium sponsored by the journal *Anesthesiology* for the ASA Annual Meeting will be held on Tuesday, October 22, 1996, from 9 a.m. to 12:30 p.m. at the Morial Convention Center, Room 13-17, in New Orleans. The symposium will address a critically important subject, namely the epidemiology, mechanism and clinical therapeutic trials for therapy for stroke, encephalopathy and cognitive dysfunction in high-risk surgical patients.

Included in this session will be a series of lectures by experts in the area and abstract discussions of recent findings. The agenda will be as follows:

9 - 9:30 a.m. Poster Viewing

9:30 - 11 a.m. Lectures

- *Epidemiology and Costs Associated With Ambulatory and Perioperative Stroke*
Dennis T. Mangano, M.D., Ph.D.
University of California-San Francisco
- *Current Stroke Mechanisms/New Approaches to Stroke Therapy*
Justin Zivin, M.D.
University of California-San Diego

- *Review of Clinical Trials in Stroke*
Dennis T. Mangano, M.D., Ph.D.
University of California-San Francisco
- *The Recent Nimopidine Trial Results*
Anne T. Rogers, M.B.
Bowman Gray School of Medicine

11 a.m. - 12:30 p.m. Panel Abstract Discussions

Moderator: Michael M. Todd, M.D.

Editor, *Anesthesiology*
University of Iowa

Panelists: Philip E. Bickler, M.D.
University of California-San Francisco
Bradley J. Hindman, M.D.
University of Iowa
Anne T. Rogers, M.B.
Bowman Gray School of Medicine
Richard J. Traytsman, Ph.D.
The Johns Hopkins University
Justin Zivin, M.D.
University of California-San Diego

New CD-ROM Holds 5 Years of Leading Anesthesiology Journals

ASA joins with leading health science publishers in announcing the availability of The Electronic Anesthesiology Library (TEAL) 1991-1995 on CD-ROM. TEAL combines five years of content from the four leading anesthesiology journals — *Anesthesiology*, *Anesthesia & Analgesia*, the *British Journal of Anaesthesia* and the *Canadian Journal of Anaesthesia* — on one easy-to-use disk. With a keystroke, users can access and simultaneously cross-search through full text and graphics of these four journals. References in all articles on TEAL are linked to MEDLINE abstracts, so important information can be accessed without the need for a separate search.

Technological features of the CD-ROM include full-text, fuzzy-logic searching; a hot-text link to cited MEDLINE abstracts; high-quality image presentation;

100-percent enlargement of images with preserved image detail; a thumbnail image panel that provides a visual overview of articles' contents; and a hot-text link between in-text figures and table references to corresponding images.

The initial disk is being offered at a special price of \$395 to ASA members. The disk is available for both Macintosh and Windows platforms. Annual updates will be available starting in April 1997 with TEAL 1992-1996. Updates will be available for \$95 to ASA members who purchase TEAL 1991-1995 (TEAL 1992-1996 will cost \$395 for first-time purchasers).

For further information or to order the new CD-ROM, contact Lippincott-Raven Publishers, 227 E. Washington Square, Philadelphia, PA 19106-3780; telephone: (800) 638-6423.

Medicare payments for physician services are adjusted to reflect different practice costs among 210 "payment localities," or distinct geographic areas. A proposal by the Health Care Financing Administration (HCFA), as published in the July 2 *Federal Register*, calls for a consolidation that would reduce the number of localities to 89. Under the HCFA proposal, 78 of the current localities would see an increase in reimbursement for anesthesia services. Sixty-four would see a decrease, and there would be either no change or a negligible (less than 1 cent) change in 63 localities. Five would experience mixed results. The numbers are similar for medicine in general.

How large will the changes be? The biggest cut, both for anesthesia services and for the rest of medicine, will occur in part of Pittsburgh, where ASA's consultant has estimated the potential decrease in the anesthesia conversion factor at \$1.33. Parts of the St. Louis, Missouri, locality (Columbia, Springfield and Jefferson City) would experience the next largest decrease, currently estimated at \$0.72. These cuts are attributable to the structure of the current locality system, where high- and low-cost areas have fortuitously been grouped together and are now being realigned. The affected part of Pittsburgh, for example, is now paid on the same basis as the much higher-cost Philadelphia. At the other end of the spectrum, there will be significant increases in the anesthesia conversion factor in Philadelphia (\$0.93), in the Boston metropolitan area (\$0.66) and in certain rural parts of California (\$0.66). Table 1 lists all of the localities in which the change, up or down, is projected to exceed 5 cents.

Why is HCFA proposing this restructuring? In the *Federal Register* notice, the agency is explicit about its "belief that statewide localities generally are preferable to the present Medicare localities because they simplify program administration and encourage physicians to practice in rural areas by reducing urban/rural payment differentials."

HCFA considered four restructuring options developed by its contractor, Health Economics Research, Inc., of Waltham, Massachusetts. Three of the options were based on metropolitan statistical areas and would have involved either too

Shift in Medicare Localities Will Affect Conversion Factors

Karin Bierstein,
Practice Management Coordinator

few or too many new payment localities or "fee schedule areas."

The option selected builds on the current localities. As it happens, there are already statewide localities in 22 states as well as in the District of Columbia, Puerto Rico and the Virgin Islands. These areas will experience no change. In the other 28 states, the localities are ranked from the highest to the lowest geographic adjustment factor (GAF) currently in use. The GAF of the highest-cost locality is compared to the weighted average GAF of all

lower-cost localities. If the difference is 5 percent or less, the state becomes a single statewide locality. If the difference exceeds 5 percent, the highest-cost locality remains a distinct area. The process is repeated for the second-highest-cost locality and on down the list, until the difference between the highest-cost locality and the weighted average GAF for all lower-cost localities does not exceed 5 percent.

Are these changes written in stone? What is ASA doing about them? It is important to note that the projected increases and decreases for anesthesia services are estimates only. Several factors will probably cause them to change, if only by a few cents:

1. The changes are intended to be budget-neutral within each state. An adjustment would be made to them late in the year, incorporating the most recent data, to yield the same total physician fee schedule payments within each state as if the payment localities not been changed. The budget neutrality adjustment will likely limit the amount of decrease for most anesthesiologists, since there will be disproportionately more services cut initially (the volume of services is higher in cities, which are generally seeing reductions in reimbursement).
2. HCFA is proposing a two-year phase-in for areas predicted to lose more than 4 percent. For most of medicine and surgery, only two states would experience cuts of this magnitude: Pennsylvania (8.6 percent for Pittsburgh, 5.0 percent for other non-Philadelphia cities) and Missouri (5.9 percent). The anesthesia conversion factor in Pittsburgh

Continued on page 30

Table 1

Part B Localities in Which Anesthesia Conversion Factors (CFs) Are Projected to Change by More Than \$0.05[†]

| Estimated | | | | Estimated | | | |
|--|---------|--------|--------|--|---------|--------|--------|
| State Locality Name | 1996 CF | New CF | Change | State Locality Name | 1996 CF | New CF | Change |
| AL Birmingham, AL | 14.82 | 14.51 | -0.31 | IN Metropolitan IN | 14.23 | 13.86 | -0.37 |
| AL Mobile, AL | 14.43 | 14.51 | 0.08 | IN Rest of IN | 13.81 | 13.86 | 0.05 |
| AL North Central AL | 14.38 | 14.51 | 0.13 | KS Kansas City, KS | 15.19 | 14.72 | -0.47 |
| AL Northwestern AL | 14.64 | 14.51 | -0.13 | KS Rest of KS | 14.61 | 14.72 | 0.11 |
| AL Rest of AL | 14.17 | 14.51 | 0.34 | KS Suburban Kansas City, KS | 15.19 | 14.72 | -0.47 |
| AL Southeastern AL | 14.37 | 14.51 | 0.14 | KY Lexington and Louisville, KY | 14.62 | 14.30 | -0.32 |
| AZ Flagstaff, AZ | 15.10 | 15.43 | 0.33 | KY Rest of KY | 13.98 | 14.30 | 0.32 |
| AZ Phoenix, AZ | 15.55 | 15.43 | -0.12 | KY Small Cities (City Limits), KY | 14.12 | 14.30 | 0.18 |
| AZ Prescott, AZ | 15.01 | 15.43 | 0.42 | LA Alexandria, LA | 14.25 | 14.39 | 0.14 |
| AZ Rest of AZ | 15.33 | 15.43 | 0.10 | LA Baton Rouge, LA | 14.63 | 14.39 | -0.24 |
| AZ Tucson, AZ | 15.19 | 15.43 | 0.24 | LA Lake Charles, LA | 14.55 | 14.39 | -0.16 |
| AZ Yuma, AZ | 15.20 | 15.43 | 0.23 | LA Monroe, LA | 14.26 | 14.39 | 0.13 |
| CA Fresno/Madera, CA | 14.74 | 15.13 | 0.39 | LA Rest of LA | 14.28 | 14.39 | 0.11 |
| CA Kings/Tulare, CA | 14.52 | 15.13 | 0.61 | LA Shreveport, LA | 14.48 | 14.39 | -0.09 |
| CA Merced/Surrounding Counties, CA | 14.80 | 15.13 | 0.33 | MD Southern and Eastern Shore, MD | 14.86 | 14.77 | -0.09 |
| CA Monterey/Santa Cruz, CA | 15.42 | 15.13 | -0.29 | MD Western MD | 14.68 | 14.77 | 0.09 |
| CA Northeast Rural CA | 14.47 | 15.13 | 0.66 | MA Suburbs/Rural Cities, MA* | 15.77 | 15.68 | -0.09 |
| CA Riverside, CA | 15.23 | 15.13 | -0.10 | MA Suburbs/Rural Cities, MA* | 15.77 | 16.43 | 0.66 |
| CA Sacramento/Surrounding Counties, CA | 15.28 | 15.13 | -0.15 | MA Urban MA* | 16.16 | 16.43 | 0.27 |
| CA San Bernadino/East Central Counties, CA | 15.35 | 15.13 | -0.22 | MA Urban MA* | 16.16 | 15.68 | -0.48 |
| CA San Diego/Imperial, CA | 15.30 | 15.13 | -0.17 | MS Rest of MS | 13.78 | 13.96 | 0.18 |
| CA Santa Barbara, CA | 15.52 | 15.13 | -0.39 | MS Urban MS | 14.12 | 13.96 | -0.16 |
| CA Stockton/Surrounding Counties, CA | 14.98 | 15.13 | 0.15 | MO Rest of MO | 14.19 | 14.31 | 0.12 |
| CA Ventura, CA | 15.90 | 16.33 | 0.43 | MO Small Eastern Cities, MO | 14.14 | 14.31 | 0.17 |
| CT Eastern CT | 16.10 | 16.49 | 0.39 | MO St. Joseph, MO | 14.41 | 14.31 | -0.10 |
| CT Northwestern and North Central CT | 16.36 | 16.49 | 0.13 | MO St. Louis/Large Eastern Cities, MO* | 15.03 | 14.31 | -0.72 |
| CT South Central CT | 16.67 | 16.49 | -0.18 | MO St. Louis/Large Eastern Cities, MO* | 15.03 | 15.24 | 0.21 |
| CT Southwestern CT | 16.84 | 16.49 | -0.35 | NV Elko and Ely (Cities), NV | 14.93 | 15.32 | 0.39 |
| FL Rest of FL | 15.13 | 15.29 | 0.16 | NV Rest of NV | 15.16 | 15.32 | 0.16 |
| GA Rest of GA | 14.28 | 14.48 | 0.20 | NJ Middle NJ | 15.84 | 15.72 | -0.12 |
| GA Small Cities 02, GA | 14.67 | 14.48 | -0.19 | NJ Southern NJ | 15.56 | 15.72 | 0.16 |
| GA Small Cities 03, GA | 14.39 | 14.48 | 0.09 | NY North Central Cities, NY | 15.01 | 14.92 | -0.09 |
| ID Northern ID | 13.88 | 13.98 | 0.10 | NY Rest of NY | 14.74 | 14.92 | 0.18 |
| IL Champaign-Urbana, IL | 14.36 | 14.28 | -0.08 | NY Rochester/Surrounding Counties, NY | 15.18 | 14.92 | -0.26 |
| IL De Kalb, IL | 14.08 | 14.28 | 0.20 | OR Rest of OR* | 14.14 | 14.84 | 0.70 |
| IL Northwestern IL | 13.90 | 14.28 | 0.38 | OR Rest of OR* | 14.14 | 14.22 | 0.08 |
| IL Peoria, IL | 14.43 | 14.28 | -0.15 | OR Southwest Cities (City Limits), OR | 14.36 | 14.22 | -0.14 |
| IL Quincy, IL | 13.78 | 14.28 | 0.50 | PA Large Cities, PA* | 15.28 | 14.61 | -0.67 |
| IL Rock Island, IL | 14.18 | 14.28 | 0.10 | PA Large Cities, PA* | 15.28 | 16.21 | 0.93 |
| IL Rockford, IL | 14.62 | 14.28 | -0.34 | PA Philadelphia/Pittsburgh Medical Schools/Hospitals, PA* | 15.94 | 14.61 | -1.33 |
| IL Southeastern IL | 13.74 | 14.28 | 0.54 | | | | |
| IL Southern IL | 13.87 | 14.28 | 0.41 | | | | |
| IL Springfield, IL | 14.79 | 14.28 | -0.51 | | | | |

Table continued on next page

[†]Figures are a consultant's projected estimates, *not* approved conversion factors. *Current locality to be split between two new localities.

Table 1 (continued)

Part B Localities in Which Anesthesia Conversion Factors (CFs) Are Projected to Change by More Than \$0.05

| Estimated | | | | Estimated | | | |
|---|---------|--------|--------|--|---------|--------|--------|
| State Locality Name | 1996 CF | New CF | Change | State Locality Name | 1996 CF | New CF | Change |
| PA Philadelphia/Pittsburgh Medical Schools/Hospitals, PA* | 15.94 | 16.21 | 0.27 | TX Wichita Falls, TX | 14.05 | 14.30 | 0.25 |
| PA Rest of PA | 14.32 | 14.61 | 0.29 | VA Rest of VA | 14.03 | 14.37 | 0.34 |
| PA Small Cities, PA | 14.51 | 14.61 | 0.10 | VA Richmond and Charlottesville, VA | 14.74 | 14.37 | -0.37 |
| TX Abilene, TX | 14.13 | 14.30 | 0.17 | VA Small Town/Industrial VA | 14.10 | 14.37 | 0.27 |
| TX Amarillo, TX | 14.40 | 14.30 | -0.10 | VA Tidewater and Northern Counties, VA | 14.52 | 14.37 | -0.15 |
| TX Brownsville, TX | 14.07 | 14.30 | 0.23 | WV Charleston, WV | 14.65 | 14.37 | -0.28 |
| TX Corpus Christi, TX | 14.54 | 14.30 | -0.24 | WV Eastern Valley, WV | 14.50 | 14.37 | -0.13 |
| TX Denton, TX | 14.57 | 14.30 | -0.27 | WV Ohio River Valley, WV | 14.25 | 14.37 | 0.12 |
| TX El Paso, TX | 14.49 | 14.30 | -0.19 | WV Southern Valley, WV | 14.12 | 14.37 | 0.25 |
| TX Grayson, TX | 14.20 | 14.30 | 0.10 | WV Wheeling, WV | 14.26 | 14.37 | 0.11 |
| TX Laredo, TX | 14.10 | 14.30 | 0.20 | WI Central WI | 14.48 | 15.00 | 0.52 |
| TX Lubbock, TX | 14.23 | 14.30 | 0.07 | WI Green Bay (Northeast), WI | 14.82 | 15.00 | 0.18 |
| TX McAllen, TX | 14.09 | 14.30 | 0.21 | WI Janesville (South Central), WI | 14.72 | 15.00 | 0.28 |
| TX Midland, TX | 14.63 | 14.30 | -0.33 | WI La Crosse (West Central), WI | 14.73 | 15.00 | 0.27 |
| TX Northeast Rural TX | 14.15 | 14.30 | 0.15 | WI Madison (Dane County), WI | 15.35 | 15.00 | -0.35 |
| TX Odessa, TX | 14.63 | 14.30 | -0.33 | WI Milwaukee Surburbs (Southeast), WI | 15.20 | 15.00 | -0.20 |
| TX Orange, TX | 14.63 | 14.30 | -0.33 | WI Milwaukee, WI | 15.39 | 15.00 | -0.39 |
| TX San Angelo, TX | 13.98 | 14.30 | 0.32 | WI Northwestern WI | 14.51 | 15.00 | 0.49 |
| TX San Antonio, TX | 14.59 | 14.30 | -0.29 | WI Oshkosh (East Central), WI | 14.76 | 15.00 | 0.24 |
| TX Texarkana, TX | 14.15 | 14.30 | 0.15 | WI Southwestern WI | 14.49 | 15.00 | 0.51 |
| TX Tyler, TX | 14.40 | 14.30 | -0.10 | WI Wausau (North Central), WI | 14.58 | 15.00 | 0.42 |
| TX Victoria, TX | 14.43 | 14.30 | -0.13 | | | | |
| TX Western TX | 13.97 | 14.30 | 0.33 | | | | |

*Current locality to be split between two new localities.

Continued from page 28

and non-Philadelphia cities and in St. Louis would be reduced by 8.4 percent, 4.4 percent and 4.7 percent, respectively. Reimbursement reductions would be limited to 4 percent in the first year (1997).

ASA will have filed its comments on the proposed rule by the time this issue of the *NEWSLETTER* is in print. Preliminarily, ASA is considering questioning HCFA's assumptions about administrative simplification and is urging, at a minimum, a longer phase-in. Component societies in states facing larger cuts are being alerted to the issue and to the opportunity to comment. ASA leadership, including the Committee on Economics, is reviewing the possibilities.

Aetna Is Pulling Out of Medicare

Aetna Health Plans has announced that as of October 1, 1997, it will terminate its service as a Medicare carrier. Currently, Aetna constitutes one-fifth of the Part B carriers and one-fourth of the Part A (hospital) intermediaries. The locations in which it is a carrier are Alaska, Arizona, Georgia, Nevada, Oklahoma, Oregon, Hawaii, New Mexico, Washington, Guam, and the Northern and Mariana Islands. HCFA will need to enter into multiple contracts with successor carriers in time to prevent disruptions in payment processing.

Aetna recently completed its \$8.9 billion purchase of U.S. Healthcare Inc., creating the third-largest health care maintenance organization chain in the country.

HCFA Agrees to Amend Teaching Instructions

In the "Washington Report" of the May 1996 *NEWSLETTER*, Michael Scott drew attention to the fact that HCFA had changed the instructions to carriers under the new teaching regulations to require that the teaching anesthesiologist working with a single resident be present in the operating room for the entire period in which time units were charged. The draft instructions had required physical presence in the operating room only during the key portions of the anesthesia procedure, e.g., induction and emergence.

Upon reviewing the revised instructions, ASA promptly filed vigorous objection with HCFA, noting that the new instructions were impermissibly at variance with the teaching regulations themselves, which required presence only during key portions of the procedure. In due course, HCFA advised ASA in writing that HCFA would again revise the instructions to bring them into conformity with the regulations [Figure 1]. On June 24, ASA President Norig Ellison, M.D., advised all program directors of the HCFA change.

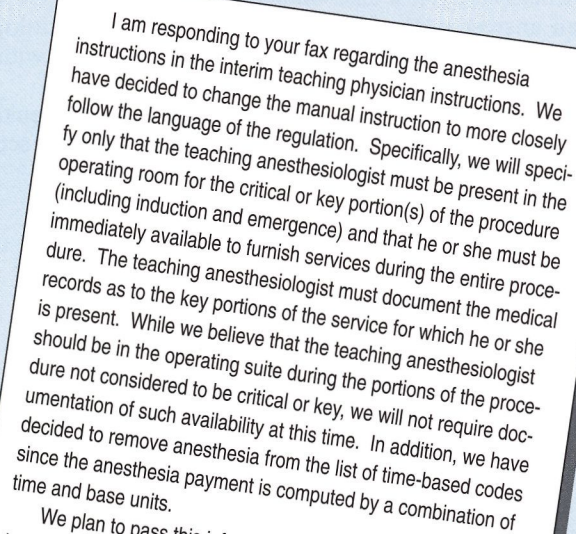
Applying the new teaching rules: The new teaching rules, together with the widely publicized Medicare audit of the University of Pennsylvania, have raised questions as to the appropriate documentation of the teaching physician's participation in the procedure. HCFA's letter merely says that the teaching anesthesiologist must document in the medical record the key portions of the procedure for which he or she is present and that, at least for the present, no documentation of availability during the nonkey portions of the procedure will be required. Amplifying on these requirements, Dr. Ellison suggested the conservative course outlined in Figure 2 (next page) in his June 24 advisory to program directors.

Do the teaching rules have any impact on medical direction rules? What is not clear is whether HCFA's teaching documentation advice has any application in the medical direction context. At present, there are absolutely no HCFA instructions as to how an anesthesiologist appropriately documents the steps involved in medical direction. Logic would suggest that, at the least, the anesthesiologist must document those "most demanding portions" of the procedure for which he or she was present in the medical records, but there is no guidance as to what further documentation is required.

ASA has written HCFA, seeking clarification of HCFA's requirements, and when the matter is resolved, advice will appear in this column.

There appears to be some confusion in anesthesiology teaching programs as to whether the anesthesiologist who is medically directing residents must participate in the pre- and postoperative visits. HCFA's proposal to require such participation for anesthesiologists involved with a single resident was withdrawn, as readers of the *NEWSLETTER* know. The teaching instructions do not supplant the medical direction rules, however. Thus, if the anesthesiologist is medically directing two, three or four residents (or a

Figure 1



I am responding to your fax regarding the anesthesia instructions in the interim teaching physician instructions. We have decided to change the manual instruction to more closely follow the language of the regulation. Specifically, we will specify only that the teaching anesthesiologist must be present in the operating room for the critical or key portion(s) of the procedure (including induction and emergence) and that he or she must be immediately available to furnish services during the entire procedure. The teaching anesthesiologist must document the medical records as to the key portions of the service for which he or she is present. While we believe that the teaching anesthesiologist should be in the operating suite during the portions of the procedure not considered to be critical or key, we will not require documentation of such availability at this time. In addition, we have decided to remove anesthesia from the list of time-based codes since the anesthesia payment is computed by a combination of time and base units.

We plan to pass this information on to the regional offices for transmission to the carriers prior to the July 1, 1996, implementation date.

Terrance L. Kay, Director
Division of Physician Services
Office of Physician and Ambulatory Care Policy
HCFA Bureau of Policy Development

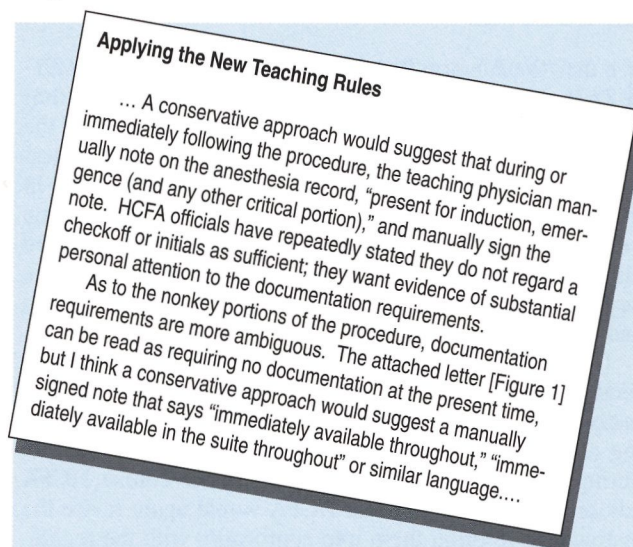
combination of residents and nurse anesthetists), he or she must still "perform a preanesthesia examination and evaluation" and "provide indicated postanesthesia care."

One-on-one ("personally performed") anesthesia: Must the anesthesiologist remain in the operating room? The debate continues: The question as to whether an anesthesiologist working with a single nurse anesthetist must remain in the operating room, or whether immediate availability in the operating suite suffices, continues to confound ASA members and also, apparently, Medicare carriers. Radically different interpretations from various carriers have been brought to the attention of the ASA Washington Office.

In 15 months, new rules will take effect that will recognize medical direction of a single case involving a nurse anesthetist. Until then, anesthesiologists can best protect themselves against false-billing claims by obtaining a written answer to the question "Must the anesthesiologist remain in the operating room throughout the case, without any breaks?" from their own carriers.

If you write to your carrier to request an interpretation, it may be helpful to include examples of the types of activities that would take you out of the operating room.

Figure 2



Excerpted from a letter from ASA President Norig Ellison, M.D., to members of the Society of Academic Anesthesiology Chairs and the Association of Anesthesiology Program Directors, June 24, 1996.

Washington Report

Continued from page 4

processes such as gene therapy. Although somewhat appeased by last-minute revisions to the amendment designed to protect the industry, biotechnological company spokespeople still objected to the form of the bill, expressing preference for the concept of a similar bill (S. 1334) introduced last year in the Senate by Sen. Bill Frist (R-TN). Negotiations concerning the terms of the Frist bill had stalled in recent weeks, and it is hoped that House passage of the Ganske version would give impetus to further discussions.

Both Sen. Frist and Rep. Ganske practiced surgery prior to their election in late 1994.

Commerce Committee Reports Gag Clause Ban

On the same day the House adopted his patent bill, Rep. Ganske succeeded in gaining unanimous House Commerce Committee approval of his bill (H.R. 2976) prohibiting managed care organizations from placing limits on communications (so-called "gag rules") between providers and their patients. The bill, expected to be brought to the House floor in September, received strong support from the Patient Access to Specialty Care Coalition, in which ASA is an active participant.

Resident Component 1996 Review and Annual Meeting Preview

Janet D. Pearl, M.D., Alternate Delegate
ASA Resident Component Governing Council

Resident involvement in ASA is needed more than ever in these "interesting times." Funding for graduate medical education is at risk for dramatic cuts as Congress scrutinizes the Medicare program for potential sources of "savings." Will fellowship opportunities be available to us? We are already seeing the results of this scrutiny in the new Medicare regulations pertaining to resident supervision. Moreover, the nature of graduate medical education is changing as managed care alters patient referral patterns. Managed care has initiated the concept of "scope of practice," which is now the "in" topic in health care discussions on Capitol Hill. Will nonphysicians be replacing us?

The 1996 National Residency Match Program was best described as a "drought" for anesthesiology. Will we be able to depend on the quality of our peers?

ASA provides a forum in which to discuss these issues and to develop a strategy for action as a profession. The ASA Resident Component provides a starting block from which residents can start to become involved in the process, to learn the organization and issues, and to develop the skills to become an effective leader for anesthesiology.

The ASA Resident Component Governing Council has planned the first Resident Leadership Training/Grassroots Advocacy Workshop, which will be held at this year's ASA Annual Meeting. The objectives of the workshop are to learn how distinguished members of ASA became involved in organized medicine and national politics, what the ASA leadership is doing in Washington, D.C., and how to lobby our senators and representatives effectively.

Five formal ASA meetings and one American Board of Anesthesiology (ABA) meeting are scheduled for resident participation at the ASA Annual Meeting in New Orleans:

1. **Resident Reception:** Friday, October 18, from 8 to 10 p.m. in the Elmwood Room, New Orleans Hilton.
2. **Resident Component House of Delegates:** Saturday, October 19, from 4 to 8 p.m. in the Carondelet Room, New Orleans Marriott.
3. **Resident Forum:** Sunday, October 20, from 11 a.m. to 1 p.m. in Balcony I, J and K, New Orleans Marriott.
4. **ASA House of Delegates Opening Session:** Sunday, October 20, at 9 a.m. in the Acadia and Bissonet rooms, New Orleans Marriott.
5. **ASA House of Delegates Closing Session:** Wednesday, October 23, at 8 a.m. in the Acadia and Bissonet rooms, New Orleans Marriott.

6. **ABA Information Session:** Saturday, October 19, from 5:30 to 6:30 p.m. in Ballroom I A-B (La Louisiane), Morial Convention Center.

Four special meetings that may be of interest to residents also will be held:

1. **Resident Leadership Training/Grassroots Advocacy Workshop:** Friday, October 18, from 4 to 7 p.m. in the Belle Chasse Room, New Orleans Hilton.
2. **Panel on Physician Advocacy: The Importance of Being Involved:** Monday, October 21, from 9 to 11 a.m., in Room 103-104, Morial Convention Center.
3. **Panel on Communicating With the Media, the Public and Our Peers:** Monday, October 21, from 2 to 5 p.m., in Room 103-104, Morial Convention Center.
4. **Panel on Job Opportunities as Anesthesiology Practices Change Rapidly:** Tuesday, October 22, from 2 to 5 p.m., in Room 100-102, Morial Convention Center.

Other Resident Component activities include a revival of the Anesthesiology Resident Key Contact Program. We will be asking for your e-mail address and fax number to improve communications and establish an expeditious method of disseminating information. We are also working on a guide to encourage medical students to choose a career in anesthesiology. This idea was suggested by residents at last year's Resident Forum.

The Resident Component extends its sincere thanks to

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Janet D. Pearl, M.D., is a CA-2 anesthesiology resident at Massachusetts General Hospital, Boston, Massachusetts.

Candidates Announce for Elected Office

Even ASA members recently have announced their candidacies for elected office. The anesthesiologists and the offices they seek are:

- **President-Elect**
William D. Owens, M.D.
- **First Vice-President**
John B. Neeld, Jr., M.D.
- **Vice-President for Scientific Affairs**
Robert K. Stoelting, M.D.
- **Assistant Secretary**
Joanne Jene, M.D.
- **Assistant Treasurer**
Neil Swissman, M.D.
- **Speaker, House of Delegates**
Barry M. Glazer, M.D.
- **Vice-Speaker, House of Delegates**
Eugene P. Sinclair, M.D.

The ASA Board of Directors on March 6, 1982, approved the following regulations for the announcement of candidacies for elected office:

1. On or before August 1, any candidate for ASA office may send to the Executive Office a notice of intent to run for a specific office;
2. The Executive Office shall prepare a list of candidates submitted to be published in the September issue of the *ASA NEWSLETTER* and the Handbook for Delegates;
3. The announcement for candidacy does not constitute a formal nomination to an office nor is it a prerequisite

for being nominated; and
4. Nominations shall be made at the Annual Meeting of the House of Delegates for all candidates as prescribed by the ASA Bylaws.

Workshop Set in St. Louis in November

Practitioners who evaluate and care for surgical patients during the pre-, intra- and postoperative periods should find the ASA Workshop on Perioperative Assessment and Management of interest. The program will be held on November 16-17, 1996, at the Marriott Pavilion Hotel in St. Louis, Missouri.

Sessions will be devoted to preoperative risk assessment, focusing on specific disease entities and selection of appropriate laboratory testing, primarily on noncritical care patients. The impact of value-based anesthesia care on the intraoperative and post-anesthesia periods will be discussed.

Sessions will also highlight the skills needed for operating room leadership and for the development of administrative and managerial expertise necessary to promote the anesthesiologist's role as a perioperative physician.

After completing this workshop, participants should be familiar with current cost-effective preoperative testing in ambulatory and hospitalized patients; be able to identify perioperative risk factors as they relate to the pathophysiology of common diseases; be knowledgeable of the impact that anesthetic choice has on patient recovery and outcomes; and understand the skills needed to participate in leadership, administrative and managerial roles as a perioperative physician.

Rebecca S. Twersky, M.D., is the program chair. She will speak on "Medical-Legal Implications of Perioperative Assessment" and "Perioperative Management: The PACU." Other faculty members and their topics are:

- Stephen P. Fischer, M.D., "Practical Approaches to Preoperative Evaluation" and "Pitfalls in Managing a Preoperative Anesthesia Clinic";

ABA Announces...

ABA to Conduct Critical Care Exam

The American Board of Anesthesiology (ABA) will administer its written examination in Critical Care Medicine on Saturday, September 6, 1997.

Diplomates of the ABA who apply and are judged to be qualified by virtue of their additional training in the subspecialty will be

accepted for examination. An application may be requested by writing to the Secretary, American Board of Anesthesiology, 4101 Lake Boone Trail, The Summit-Suite 510, Raleigh, NC 27607-7506.

The deadline for receipt of completed applications in the ABA office is **March 1, 1997**.

- Barbara S. Gold, M.D., "Preoperative Cardiac Risk Assessment and Testing" and "Abnormal Preoperative Coagulation Tests";
- L. Reuven Pasternak, M.D., "Practice Guidelines for Preanesthesia Assessment" and "Choices in Routine Preoperative Testing: Medical and Fiscal Realities";
- Peter Rock, M.D., "Perioperative Management of the Patient With Lung Disease" and "Patient With a New Left Bundle Branch Block"; and
- Denham S. Ward, M.D., Ph.D., "Budget Cuts in an Anesthesia Department," "Value-Based Anesthesia Care" and "Taking the Leadership Role in Operative Services Management."

ASA is approved by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor

continuing medical education programs for physicians.

ASA designates this continuing medical education program for 11 credit hours in category 1 of the Physician's Recognition Award of the American Medical Association.

Registration is suggested by October 16, 1996. 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 St. Louis Marriott Pavilion Hotel until October 24, 1996. A room reservation form will be sent to registrants upon enrollment. The form should be returned to the hotel by the above date.

The hotel is two blocks from the Gateway Arch and a short walk from Laclede's Landing, where restaurants and music can be found.

Address Changes for *Anesthesiology* Editorial Office

The editorial office for the journal *Anesthesiology* has moved. All correspondence should be directed to:

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Residents' Review

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ASA President Norig Ellison, M.D., for his support and to the other past and present ASA leaders who have encouraged further resident involvement in ASA's governance. A special thanks is also extended to Ronald A. Bruns, ASA Director of Administrative Affairs, for all of his assistance. We would like to express our gratitude to the state anesthesiology societies who

have sent resident delegates to the ASA Resident Component annual meeting.

To those members of the ASA Resident Component Governing Council who will be completing their terms as officers — John L. Jimenez, M.D., Chair; Steven J. Hattamer, M.D., Delegate; Anne C. Still, M.D., Secretary; and Michael L. Ault, M.D., "Residents' Review"

Editor — we express much appreciation for your leadership, vision and effort.

Finally, thank you to the many residents who have contributed to the ASA Resident Component. Scott E. Metzger, M.D., Resident Component Governing Council Chair-Elect, and I look forward to an exciting and interesting year ahead. See you in "N'Awlins"!

FAER REPORT



FOUNDATION FOR ANESTHESIA

EDUCATION ■ RESEARCH

Thanks to the Anesthesiology Community

The April 1996 "FAER Report" focused on the monetary contributions of corporations for the four Foundation for Anesthesia Education and Research (FAER) research programs. In this "FAER Report," the FAER Board of Directors would like to thank the anesthesiology community for its generous support. As FAER's founding organization, ASA continues to be the major donor to FAER programs, and ASA plans to give \$1,050,000 to FAER annually through the year 2000. Of that \$1,050,000, the FAER Board of Directors has designated \$600,000 to be transferred annually to the FAER Endowment Fund. The remaining \$450,000 will be used to help fund operating expenses and the four research programs.

Like the Corporate Grand Sponsors described in the April "FAER Report," subspecialty societies have co-sponsored FAER awards for several years. At the May 1996 Annual Meeting of the **Association of University Anesthesiologists** (AUA), AUA's membership approved a three-year commitment to raise its annual contribution to \$50,000. The AUA has co-sponsored Anesthesiology Research Fellowships since 1988. The most recent recipient is Laura E. Niklason, M.D., Ph.D., Massachusetts General Hospital, Boston, Massachusetts.

The **Society for Pediatric Anesthesia** (SPA) also decided to increase its level of contribution to FAER this year. SPA will give \$25,000 toward co-sponsoring up to two Research Starter Grants for anesthesiologists whose research proposals focus on the anesthesiologist's care of children. SPA has co-sponsored FAER grants since 1993. The most recent recipient of a SPA/FAER Research Starter Grant is Robert T. Wilder, M.D., Ph.D., Children's Hospital, Boston, Massachusetts.

Long-term support has been received from the **Society of Cardiovascular Anesthesiologists** (SCA) since 1991, when the first two-year SCA/FAER Young Investigator was named. The two current recipients are Judy R. Kersten, M.D., Medical College of Wisconsin, Milwaukee, Wisconsin, and Paul M. Chetham, M.D., University of Colorado Health Sciences Center, Denver, Colorado.

In 1993, the **Society for Ambulatory Anesthesia** (SAMBA) donated \$17,500 to co-sponsor a Young Investigator Award for research in anesthesia specific to the ambulatory setting. The funds continue to be held until a high-quality proposal in this field is approved for funding

by the review committee (ASA Committee on Research). Persons interested in pursuing this funding are encouraged to request application materials for the December 2, 1996, deadline from the FAER Office by contacting Cynthia King, FAER Assistant Director, at (507) 266-6866, or by e-mail: <king.cynthia@mayo.edu>.

A recent decision by the **American Society of Regional Anesthesia** (ASRA) to co-sponsor a FAER Young Investigator Award has been gratefully received by the FAER Board of Directors. We are pleased to announce that the second year of a project by Timothy J. Brennan, M.D., University of Iowa, Iowa City, Iowa, will be designated the ASRA/FAER Young Investigator Award. (Dr. Brennan's first year was supported by FAER from general funds.) The proposal is titled "Central Neuronal Hyperexcitability in Postoperative Pain" and was described in the May 1995 "FAER Report."

In addition to this program support, anesthesiologists have contributed to the FAER Endowment Fund through individual and component society donations. In 1995, 18 state societies contributed \$36,800 to the FAER Endowment Fund. Thus far in 1996, 15 state societies have donated \$29,480. Individual anesthesiologists contributed \$57,770 to FAER in 1995, and thus far they have donated \$31,555 in 1996. All gifts from individuals are deposited in the Endowment Fund.

The Endowment Fund is being accumulated to provide funding for the long-term future of FAER. The FAER Board of Directors appreciates the strong support from the entire anesthesia community and hopes to continue to work with all of you for the career development of new investigators in the specialty. *Thank you!*



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New Orleans

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**1996 Annual Meeting
October 19-23**

*Registration opens at 3 p.m. Friday, October 18,
1996, at the Morial Convention Center.*