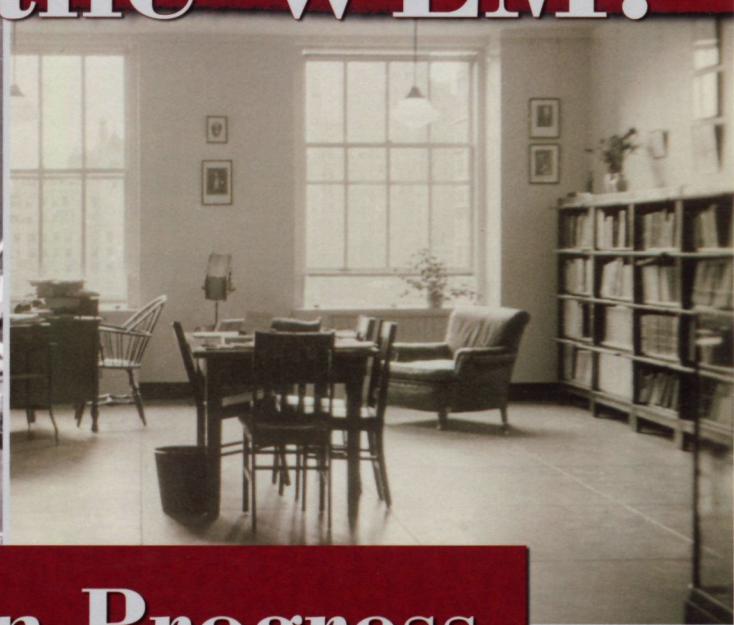
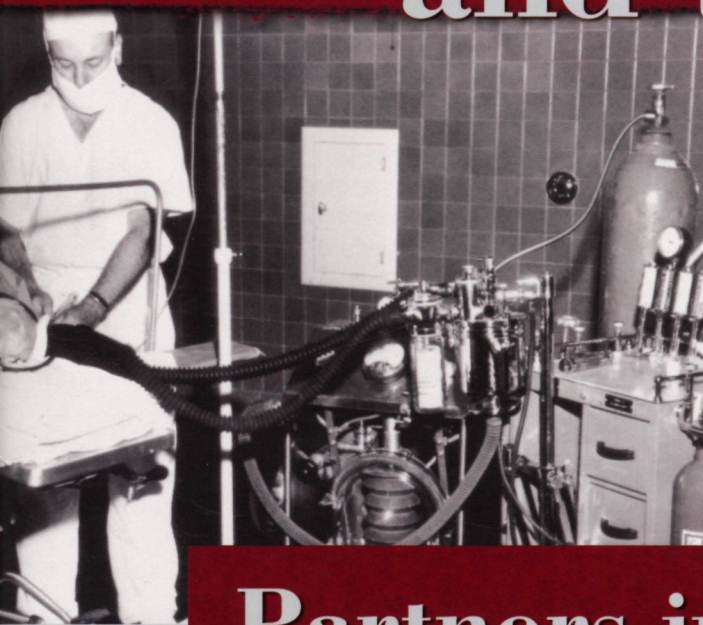
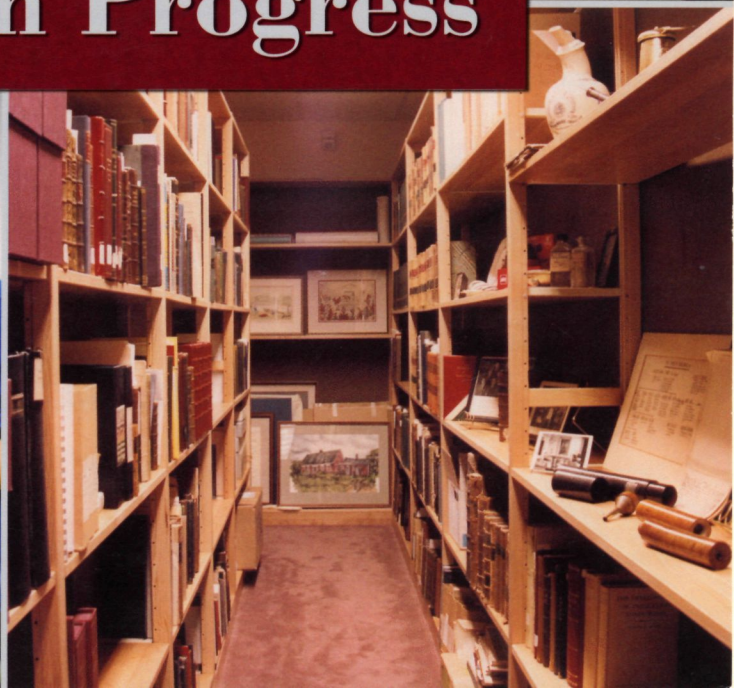
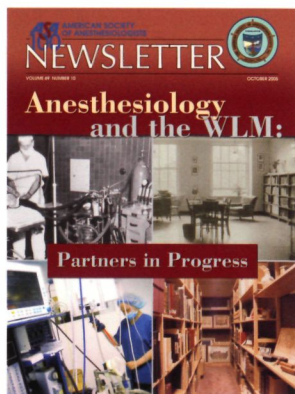


Anesthesiology and the WLM:



Partners in Progress





The essence of ASA and anesthesia history has been captured in the rooms of the Wood Library-Museum. Many ASA mentors and leaders have spoken profound words while sitting among the treasures now found here. We regard the WLM with particular appreciation in ASA's centennial year.

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SUBSTANCE ABUSE HOTLINE:

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

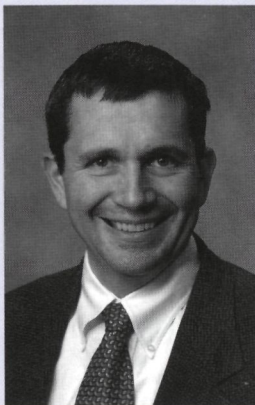
Who We Are at 100 — Reflections of a Historian

It begins somewhere deep in the soul, welling up through the mind until it comes out with the loudest possible sound and a force that reveals its origin. Moments before this gut-wrenching clamor is heard, a surgeon has put knife to skin in an effort to cure the patient. No matter how or when we have encountered this cry, and perhaps witnessed the events of surgery without anesthesia, most likely in the movies, but rarely, and under extreme conditions in real life, it tears the very fabric of our being. For we are anesthesiologists; we have dedicated our lives to stopping this horror and allowing the surgeon's knife to be an instrument of healing rather than an instrument of torture. And this is why the "awareness crisis" of the last several years, in all of its manifestations, evokes such a personal response in all anesthesiologists.

The decade of the 1840s in the United States was the time when the scream was first stilled. The best extant account of that "first" administration, in January 1842, was in Rochester, New York, a scant 60 miles from my hometown. A medical student, William E. Clark, gave ether to the sister of a classmate from medical school in order that a molar might be painlessly extracted. Two months later, Crawford W. Long, in rural Jefferson, Georgia, gave ether to his friend, James Venable, so that masses could be removed

from his neck. In 1844, Horace Wells used nitrous oxide to eliminate pain from dental practice. On October 16, 1846, a brash young man, William Thomas Green Morton, stood in front of the American surgical establishment in a room that would come to be known as the "Ether Dome" and silenced the sound for the first time publicly. Word spread around the world from that day in Boston, Massachusetts, and people across the world, regardless of nationality, race, creed, politics or religion, benefited from the first great medical advance from the fledgling United States.

Flash forward almost 60 years. A small group of eight physicians and a medical student gather in an auditorium at the Long Island College of Medicine in Brooklyn, New York. October 6, 1905, almost 59 years to the day after



Douglas R. Bacon, M.D.,
Editor

Morton's demonstration, these men hope to form a society that is dedicated to the "art and science" of anesthesia. It was felt that a forum was needed, a place to discuss who could best care for surgical patients and advance the specialty, to continue to silence that awful sound. They succeeded in a way that Adolph Frederick Erdmann, M.D., could not even begin to envision. Consider for a moment how the Society and the specialty have changed. No longer meeting quarterly, for an evening, to do both business and education, the Society works year-round to produce our Annual Meeting, and our dedication to education is such that the Society has moved, on very short notice, the 2005 Annual Meeting from devastated New Orleans to

Atlanta to ensure that all anesthesiologists have the opportunity to continue their education in the specialty. Our meeting this year will be historic, and while we concentrate on education and to some extent the business of anesthesiology, our thoughts will remain on those whose lives have been forever changed.

On that October day, I wonder if "Fred" Erdmann and his colleagues had a vision of what they were creating. ASA is the oldest independent society devoted to the specialty in the world.¹ Fred and several of the founders did live long enough to see the birth of the American Society of Anesthesiologists on April 12, 1945.² They watched as the Society struggled for recognition of anesthesia as a specialty within the house of medicine in the 1930s and understood the gargantuan efforts by ASA members and officers that made the American Board of Anesthesiology possible, catapulting ASA into national leadership. The Long Island Society, as it came of age, created an offshoot that defined, and to a large extent continues to define, what it means to be an anesthesiologist through the knowledge

Continued on page 4

1. The London Society of Anaesthetists was organized in 1893. In 1907 it merged with the British Medical Association to become the Section on Anaesthetics of that organization. Despite the protests of my English colleagues, ASA is the oldest independent anesthesia organization in the world!
2. The Long Island Society of Anesthetists became the New York Society of Anesthetists in 1912, and further changed its name to the American Society of Anesthetists (ASA) in 1936, with a final name change in 1945 to the American Society of Anesthesiologists.

ASA
100
A Century of Advancing
PATIENT SAFETY

Honoring the Heroes Who Weathered the Storm

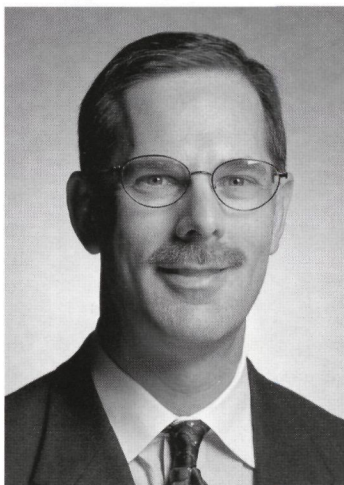
Gregory K. Unruh, M.D., Assistant Secretary

I had an article all set to go for the October *NEWSLETTER* about the Committee on Credentials for the Annual Meeting House of Delegates and activities just completed at the August Board of Directors Meeting. As most of you know, the *NEWSLETTER* deadline is about a month before publication date. I thought (modestly) that my article was newsy and informative. As I watch the coverage of Hurricane Katrina and New Orleans and surrounding areas unfold, however, I thought it better to discuss other things, and I scrapped the original article.

I, like most of us, watched in quiet dismay as the images rolled by — water and wind-wrecked destruction that I can only try to imagine. The toll in lives makes me unbelievably sad, and the thoughts of the injuries and the families torn apart further compound these feelings. On top of that, I can do nothing. I read about the devastation. I listen to the radio descriptions, but my life goes on; working, running the kids to their activities and making sure their homework is done. I made a donation to the American Red Cross, but I can still personally do nothing right now except worry.

I worried about our President-Elect, Orin F. Guidry, M.D., and his wife, Nancy, until I heard that they were safe. I worried about all the other anesthesiology friends from Louisiana, Mississippi and Alabama, many of whom I have come to know over years of ASA activities. My family and I prayed for their safety and the safety of their families.

I wondered what I would do in that type of situation and started to ponder where I would be. Would I have sent my family away with a few of life's precious possessions? Would I have gone with them? Would I be at the hospital waiting and anesthetizing our usual patients, or would victims of the disaster need my help? Would it be dark? Wet? Would we have supplies? Could we get more? Would our disaster plan (so grudgingly practiced) work? What would I eat? Would there be plumbing for toilets? How would I get there? Where would I sleep? Could you sleep in the face of so much difficulty and suffering? Would I be able to



Gregory K. Unruh, M.D.

communicate with my family? Would I know they were safe? Would they know how I was doing?

I came to the conclusion that in the dark, heat and humidity of New Orleans, the anesthesiologists were selflessly working hard. They were there for their patients. They are professionals. If patients need them, they are there. I suspect that not only were the anesthesiologists carrying on, but nurse anesthetists, anesthesiologist assistants, O.R. personnel, surgeons and other physicians, nurses and allied health professionals also were there answering the call. Our profession does not define us, but in this case, it is who we are. We care. If the patient needs an anesthesiologist, we will relieve his/her pain and make sure he/she safely

transitions the O.R. period and beyond. We have the skills and the intellectual gifts to make this happen. We use them for good when the time arrives.

I imagine that by the time you read this, many of the major problems will be overcome. I know we will hear story after story of personal and professional sacrifice. But for now, I continue to worry about the health and safety of our colleagues who are there helping out. I know conditions will only worsen in the next many days, and I think they are heroes on behalf of their patients for working in what must be awful conditions without regard for their personal health and safety. I wish them the very best and pray for their safety. I hope they, in retrospect, will recognize that we were there with them in spirit and are so very proud of them.

Note: The November issue will contain an article about Hurricane Katrina. Many ASA members treated victims and evacuees in the first hours and days after the disaster, served on disaster medical assistance teams in grueling conditions, assisted in evacuations and much more. Others stayed on in New Orleans to keep their hospital going under very difficult conditions. Their stories provide a backdrop for ASA's ongoing efforts to provide assistance in the aftermath of this event and to prepare for future situations.

The Medicare Teaching Rule —The Battle Has Been Joined

Ronald Szabat, J.D., LL.M., Director
Governmental Affairs and General Counsel



In a dramatic response to ASA's late-summer "call to action," hundreds of academic anesthesiology departments, program directors, resident physicians and many, many members at large have answered forcefully in support of ending the discrimination in Medicare reimbursement for teaching anesthesiologists. With the Centers for Medicare & Medicaid Services (CMS) comment period that ended September 30, 2005, ASA collectively made a very strong point: Medicare's irrational payment policy has had a significant adverse impact on the ability of academic programs to train the anesthesiologists necessary to help alleviate the widely acknowledged shortage of anesthesia professionals — a shortage that will be exacerbated in coming years by the aging of the baby boom generation and their need for surgical services.

With this combined action, ASA, working closely with the Society of Academic Anesthesiology Chairs/American Association of Anesthesiology Program Directors and many others in the academic community and beyond, is firmly on record with the

federal government in opposition to the 1995 CMS policy change that has shortchanged academic programs by millions of dollars over the last decade and threatened the very future of anesthesiology. ASA is particularly grateful for the strong support it has received from across medicine in similar comments from the American Medical Association, the American Osteopathic Association, the Association of American Medical Colleges and a large cross-section of the surgical and surgical subspecialty community, most notably from the American College of Surgeons, the American Association of Neurological Surgeons, the American Academy of Otolaryngology-Head and Neck Surgery and the Medical Group Management Association.

As with all academic physician training programs, teaching anesthesiologists are supposed to be paid under the Medicare Physician Fee Schedule for their hands-on training and supervision of medical residents. For other specialties, particularly surgeons, teaching physicians frequently work with resident physicians in overlapping cases and are usually paid a full fee for each case. For example, a surgeon may supervise residents in two overlapping operations and collect a full fee for each case from Medicare. An internal medicine physician may supervise residents in four overlapping office visits and collect full fees for each.

For many years, teaching anesthesiologists were paid a full fee when working with two residents on overlapping cases. CMS decided in 1995, as part of a new Part B teaching payment rule, to revise the teaching payment policy only as it applied to anesthesiologists. The

resulting inflexible rule directed Medicare carriers to reduce Medicare payment by 50 percent per case if a teaching anesthesiologist works with two residents on overlapping cases. This CMS policy is simply unfair and has caused widespread hardship.

A recent survey found that the current Medicare policy is costing programs an average of \$400,000 annually. Some programs are losing in excess of \$1 million annually. Many programs are having difficulty filling faculty positions and are operating on negative revenue margins. The 50-percent payment reduction has become even more problematic as commercial insurers have begun to adopt the policy when their beneficiaries receive care in academic institutions.

Make no mistake about it, fixing the Medicare anesthesiology teaching rule is a defining issue for ASA and academic medicine. Those who oppose us are gambling with the safety of surgical patients, both in the Medicare program and beyond, today and for years to come.

As the recognized leaders in patient safety, anesthesiologists cannot sustain their remarkable record of ensuring safe surgical outcomes for Americans if the very teaching programs that train future physicians continue to be dramatically underfunded by Medicare. Far from our shores, anesthesiologists also have responded with unparalleled professionalism and patriotism on the battlefronts in Iraq, filling slots far beyond those expected to be filled by anesthesiologists and left vacant by other anesthesia professionals. It is vitally important that America's ability to treat its wounded soldiers in the

midst of battle, today and in the future, not be compromised by Medicare's unwillingness to properly fund and train our future generations of anesthesiologists. Aiding disaster preparedness on our own soil also will require a good future supply of physicians, including anesthesiologists.

In the August 8, 2005, proposed rule for the FY 2006 Medicare Physician Fee Schedule, CMS agreed to review the anesthesiology teaching

rule and accept comments on revisions that would make the rule "more flexible for teaching anesthesia programs." The time for action is now, and all eyes are on CMS as it moves toward a final Medicare payment rule for 2006, to be published shortly, where resolution of this issue is imperative.

ASA has emphatically asked CMS to support academic anesthesiology programs by applying the policy of payments for overlapping services

consistently across medical specialties and by eliminating the 50-percent payment reduction for anesthesiology teaching programs. This same message has been forcefully delivered to Capitol Hill and the Bush Administration. On behalf of your dedicated governmental affairs staff, our fine ASA officers, committee members and all those who have worked to bring this issue to the forefront, "thank you!" We will not relent, and we will prevail!

From the Crow's Nest: Who We Are at 100

Continued from page 1

required to become a board-certified specialist. Furthermore ASA worked with the American Medical Association (AMA) to ensure that this certification process would be recognized in the United States and that anesthesiology would have a seat at the table in any further decisions concerning specialized practice in the United States.

As I write these words, I am 2,000 miles from home, at 33,000 feet, returning from the Sixth International Symposium on the History of Anesthesia, which was held at Queen's College, Cambridge, England. At this meeting, ASA's birthday was of such import that one-sixth of the meeting was devoted to our anniversary. Walking the grounds at Queen's — 100 years is of less significance when compared to buildings and traditions four or more times that age — I was gratified as an American that our anniversary was so important to the worldwide anesthesia history community. I also was struck by how similar our histories are: the struggle for recognition in the 1930s, sending in a qualifying examination for specialist practice, a post-World War II boom and a current set of circumstances that does not seem to resemble anything in the past 100 years was commonly heard throughout the symposium.

Yet perhaps the coming days most resemble the days of our founding. As an eminent British historian of anesthesiology, Dr. Jean Horton described her research into the techniques employed at the hospital in which she had spent her entire career, and the two physicians who were appointed as specialists in anesthetics, it became clear that the effort and dedication of a few

people changed the face of surgical practice at the hospital. Today we continue to face issues about how we define ourselves. Are we chained to the operating room and the anesthesia machine, or are we evolving into a new type of specialist? What is our proper role in the critical care unit? Should we be the invasive pain specialist, as we have the greatest experience in this area? Are anesthesiologists the natural hospitalist — taking a patient from admission through the surgical experience to discharge, however long that takes?

The past 100 years have been filled with triumphs and, to a lesser extent, tragedies. Our history is full of physicians willing to take a chance, to stand up and be counted as believing in something. In creating our specialty, they made it possible for us to have a proper place within the house of medicine. There are many challenges ahead of us in the coming years. How we respond to those trials is what is important. Our history is replete with examples of leadership — and dogged determination. Now more than ever, it is time to follow those examples and to give the anesthesia historians of the 22nd century something to write about and to recognize our contribution to patient care.

We stand on the shoulders of physicians whose grasp exceeded all expectations. To honor them, we must mold our future, centering as they did on the most important facet of anesthesiology — the patient. To do any less would be an abdication of our professional responsibilities.

— D.R.B.

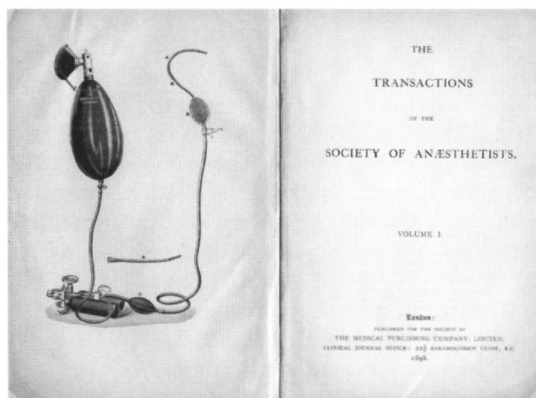
It appears that 1905 was a propitious year for Adolph Frederick Erdmann, M.D., to begin to organize what later turned out to be ASA, if alone for the fact that 1905 was the *ANNUS MIRABILIS* of Albert Einstein. He not only received his Ph.D. degree, but also published four extraordinary papers on light, including the Theory of Relativity. 1905 also heralded the first Russian Revolution, the complete defeat of the Russian Navy in the Battle of the Straits of Tushima by the Japanese and a peace treaty between Russia and Japan brokered by U.S. President Theodore Roosevelt. Robert Koch garnered the Nobel Prize in Medicine for his work on tuberculosis, and Alfred Einhorn synthesized procaine.

In the United States during 1905, the five leading causes of death were pneumonia and influenza, tuberculosis, diarrhea, heart disease and stroke; the average life expectancy was 47 years; only 14 percent of homes had a bathtub; there were only 8,000 automobiles and only 144 miles of paved roads; more than 95 percent of the births in the United States took place at home; sugar cost 4 cents a pound and eggs 14 cents a pound.

By 1905 the anesthesia cupboard included sulfuric ether, nitrous oxide and chloroform as the mainstays of the inhalational agents; cocaine, stovaine and procaine being available for regional anesthesia, and barbitol just recently synthesized. Numerous inhalers and vaporizers had been developed as well as devices that proportioned and delivered the inhalational agents. Oral intratracheal intubation was known, and the introduction of intratracheal tubes through a direct vision laryngoscope was a reality, as well as the use of intravenous fluids. Educationally a significant number of anesthesia texts existed, and established medical journals contained reports on anesthetic uses. The landmark six-volume *Medical and Surgical History of the War of the Rebellion* had been finalized in 1888, containing an important chapter on anesthesia morbidity and mortality using statistical methods.

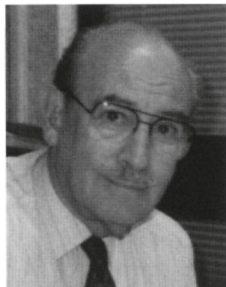
From There to Modernity: A Millennium of Progress in a Century

Maurice S. Albin, M.D., M.Sc. (Anes.)



The cover of the first issue of the British Society of Anaesthetists Proceedings, 1898.

Maurice S. Albin, M.D., M.Sc. (Anes.), is Professor of Anesthesiology in the David Hill Chestnut Section on the History of Anesthesia, University of Alabama School of Medicine in Birmingham.





The Bowles Stethoscope, from 1901. Image courtesy of the Wood Library-Museum of Anesthesiology.

The British Society of Anaesthetists (London) was formed in 1893. Extensive work had been done in the areas of regional, subarachnoid, epidural, infiltration and nerve block anesthesia. Clinical monitoring was very primitive with the emphasis on pulse rate and respiration. On January 19, 1903, Harvey Cushing, M.D., and George Crile, M.D., presented their findings on the use of blood pressure measurements during surgical procedures to a committee from the Department of Surgery at Harvard Medical School, with the verdict being that *"the palpation of the pulse was a much better indicator of the circulatory status clinically than a pneumatic device!"* Dr. Cushing measured blood pressure with the Riva-Rocci sphygmomanometer, and Dr. Crile with a Gaertner apparatus. Unfortunately, even like today, valid estimates of anesthesia-related mortality and morbidity were not readily available prior to 1905, although deaths from the use of chloroform were an important issue.

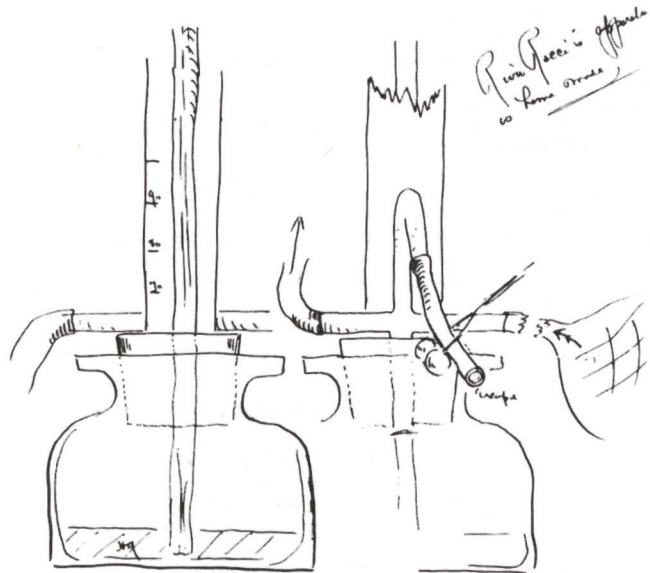
The dawn of a new century and the formation of ASA found that the practice of anesthesia in the United States was mostly performed by surgeons, nurses and general practitioners, with scientific enterprise limited to those working in but a few academic institutions and hospital centers. Formal training and certification were virtually nonexistent. With these characteristics, how do we account for the

advanced state of anesthesiology as we know it today in the United States, with our research on molecular mechanisms underlying anesthesia, our ever-upgrading technology, numerous pharmacological adjuncts, disciplined educational programs and an institutional membership in the area of 40,000?

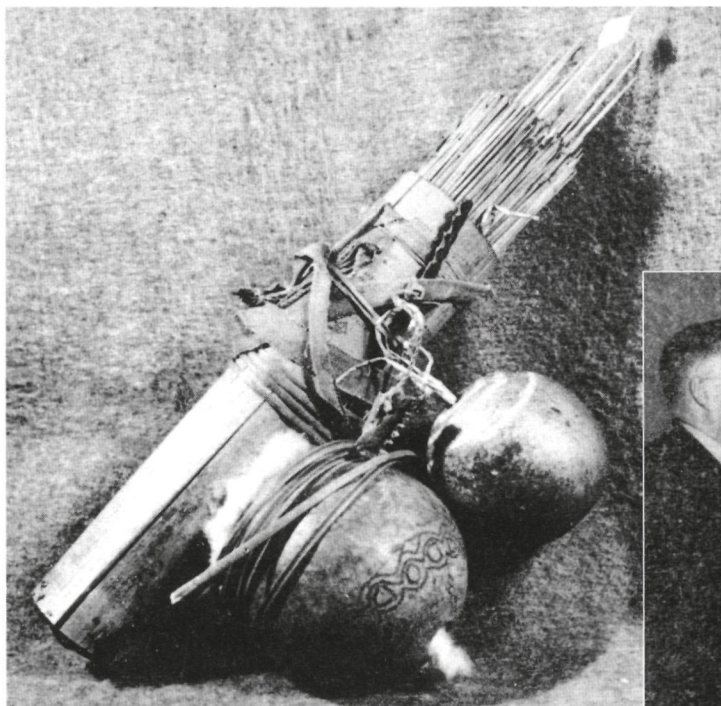
Seminal Events

During the course of the century following 1905, there were significant epochs and seminal events that influenced the development of anesthesiology in general and the American experience in particular. Finite achievements are often the result of the infinite contributions of others, and the naming of an individual for a specific accomplishment in no way detracts from those whose work supplied the building blocks of an idea, theory, experience or philosophy.

The "guts" of medical education reside in the medical school; and in 1910, a committee headed by American educator Abraham Flexner changed the whole face of American medical education by setting standards for the organization and curriculum of North American medical schools. This, of course, impacted on the quality of those physicians entering the anesthesia arena. Anesthesiology often is driven by advances in the basic sciences and the medical, surgical, pediatric and obstetrical specialties, and because of the nature of our specialty, we find ourselves to be the



A rough sketch of Riva-Rocci's "sphygmomanometer." Image courtesy of George S. Bause, M.D.



▲ Curare and darts used by hunters in the Amazon jungle. These items were brought back from Ecuador by Richard Gill.

1952 commemoration of the first clinical application of curare for surgical operation by Harold R. Griffith, M.D., and Enid Johnson, M.D., in January 1942. Dr. Griffith appears in the middle with his resident, Dr. Johnson, to his left. Lewis H. Wright, M.D., then Medical Director of E. R. Squibb Pharmaceuticals, is on the left. Squibb manufactured Intocostrin, which Dr. Wright provided to the Montreal team. ▼



consummate clinical synthesizers. Thus the advances in physiology, chemistry and physics throughout the 20th century elicited an important feedback response, allowing anesthesiologists to incorporate these findings into their practices. World War I and World War II were important epochs and had far-reaching effects on the development of anesthetic progress. Some important moments that had a major impact on anesthesiology involved the discovery of blood types in 1901 and 1925, allowing for the use of blood products; the introduction of a gas machine in 1911; the

development of a carbon dioxide absorber in 1915; the entrance of intravenous thiopental into the anesthesia armamentarium; the use of curare for muscle relaxation in 1941; and the perfection of the PO_2 and PCO_2 electrodes in 1956 and 1958 to open up the vista of perioperative rapid acid-base determinations and critical care.

The end of World War II heralded a new era in technology with the discovery of the transistor, then followed by remarkable advances leading to the computer, which has changed the face of medicine. With this progress, we must not forget the advances in patient care monitoring ranging from automatic blood pressure measurement to echocardiography. Other monumental changes that were taking place included the development of modern immunology that made transplantation possible. The delineation of the molecular structure of DNA began our understanding of the genetic code in the 1950s and has had repercussions affecting the fundamental basis of many of our anesthesia concepts.

With the profound realization of the role of anesthesia in making the progress of surgery possible, this milieu mandated the separation and independence of anesthesiology with the establishment of independent departments. We

Anesthesia record of the first application of curare by Drs. Griffith and Johnson in Montreal. E. M. Papper, M.D., considered this event the second revolution in surgical anesthesia, the first being the discovery of ether and chloroform.

Continued on page 11

Then and Now: The Women of ASA

Selma Harrison Calmes, M.D.



Physician Anesthetist Mary Botsford, M.D., 1923.



Physician anesthetist Alma Vedin, M.D., 1922. She was the first woman ASA officer.

Based in part on a chapter for the upcoming book *The American Society of Anesthesiologists: A Century of Challenges and Progress*, this article looks back at the situation for women physicians when ASA began and then leaps forward 100 years to the present, to 2005.

Then (1905):

There were few women physicians when ASA began in 1905 as what was then the Long Island Society of Anesthetists (LISA). There had been progress, however, from a lone woman doctor in 1849 (Elizabeth Blackwell, M.D.) to 8,201 women doctors in 1905. Because they had usually trained at a women's medical college (few regular medical schools accepted women students), did their hospital work at a women's hospital, usually cared for only women and children and were often not accepted by local medical societies, women doctors of that time were usually isolated from mainstream medicine.

Only a few physicians were interested in anesthesia as a specialty in 1905. Several hospitals had appointed physician anesthetists to try to solve the problem of excessive anesthesia mortality. At least two women physicians were known to be practicing anesthesia in 1905: Mary Botsford, M.D., of San Francisco, California, and Emilie Schirmer, M.D., of Brooklyn, New York. (Isabella Herb, M.D., of Chicago, Illinois, had started her anesthesia practice in 1894 but left in 1904 for pathology, where she stayed for five years.) Dr. Botsford (M.D. in 1896 from the University of California) had been appointed anesthetist at the Children's Hospital of San Francisco (a hospital founded by and for women physicians) in 1898; it was not possible to learn where Dr. Schirmer (M.D. in 1899 from Cornell University; this was the first Cornell class that included women) did



Selma Harrison Calmes, M.D., is Chief of Special Projects, Medical Administration, Olive View-UCLA Medical Center, and Clinical Professor of Anesthesiology, UCLA Medical Center, Sylmar, California.

Emilie C. Schirmer M.D.
596 St Marks av. Bklyn

No photo of Dr. Schirmer could be found. She was the first woman ASA member. This is her signature on the list of Charter Members of LISA.

anesthesia. Because it was difficult to make a living doing only anesthesia then, physicians interested in anesthesia usually had other practices, and this was the case with these two. Dr. Botsford had a general office practice in addition to her anesthesia work, and Dr. Schirmer did pathology along with her anesthesia practice. The image of a woman doctor in 1905 was as an unattractive, unmarried spinster. The true picture was very different. Dr. Botsford had been married to another physician and had no children but lived with and supported a niece and the niece's child. Dr. Schirmer was married to another physician and had two children. A live-in servant was her support at home.

Dr. Botsford never joined the LISA-ASA organizations due to, first, geographic issues (it was hard then to travel across the country to meetings) and second, she was committed to the anesthesia organizations of Francis H. McMechan, M.D., which competed with the East Coast-based LISA. Dr. Schirmer was located in Brooklyn and was the only woman present at the first general meeting of LISA. So she should be considered the first woman member of ASA. She is listed as member 11 in the typed list of ASA members; no photograph of her could be found. Few medical societies allowed women members then, so LISA was unusual. Perhaps women were included because there were so few people practicing anesthesia.

It was about five more years until there was another woman applicant to the New York Society of Anesthetists (NYSA), the organization having changed its name in 1912. This was Alma Vedin, M.D., of New York City (M.D. in 1899 from Women's Medical College of the New York Infirmary, a women's medical college). She began anesthesia practice in 1907 and was the anesthetist for the New York Infirmary for Women and Children, a women's hospital. Dr. Vedin was elected to the LISA Executive Committee in 1918 and was vice-president in 1920-22. She can be considered the first female officer of ASA.

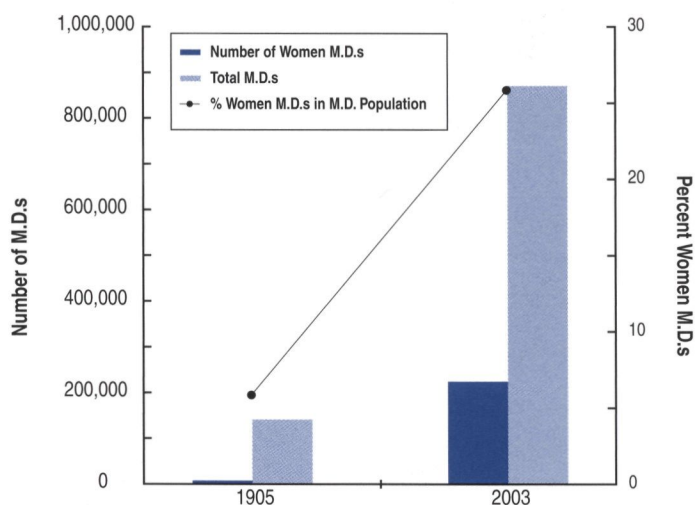
The situation for women physicians slowly improved after 1905, and by 1910, women physicians thought they were in a "golden age." A striking drop in opportunities for education and training and in the total number of women physicians and percent of women in the physician pop-

ulation began after 1910. This drop lasted for 50 years, until 1960. Surprisingly, during this time of even fewer women physicians, women physicians filled a need for manpower in anesthesia practice. Although they were only 4.4 percent to 5 percent of the physician population (1920-48), women were 11 percent to 13 percent of national anesthesia society members, a marker for being a professional anesthetist. This was most likely due to their lack of other practice opportunities and their acceptance by surgeons.

Now (2005):

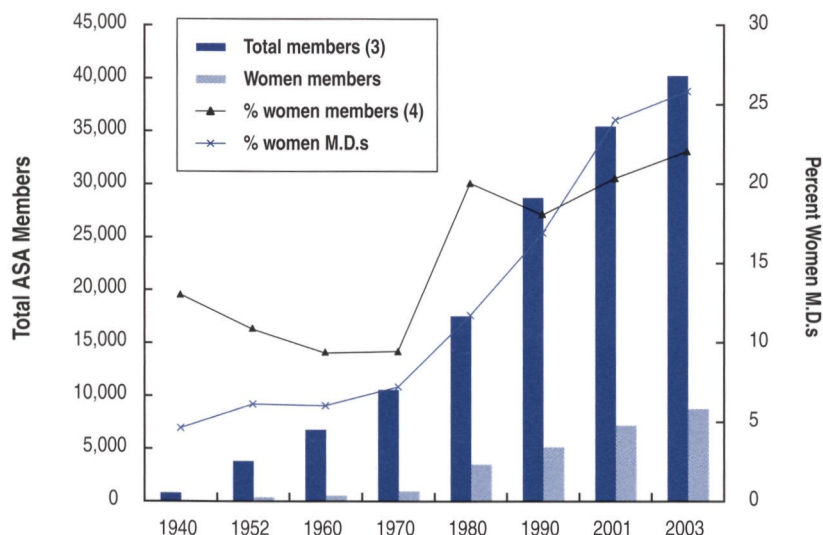
The presence of women in medicine and anesthesiology has changed dramatically! The number of women physicians increased strikingly after 1960, without the women's medical institutions needed at the turn of the century [Graph 1]. This increase means more women are available

Graph 1: Number and Percent of U.S. Physicians By Gender, 1905 and 2003



Data for 2005 are not yet available. Data sources: 1905 calculated from Walsh MR. *Doctors Wanted: No Women Need Apply*. 2003:186. 2003 data from AMA Physician Characteristics and Distribution in the U.S., 2005.

Graph 2: Total Number and Percent Women ASA Members and Women M.D.s



1940-90 data was hand-counted from membership directories by the author and ASA staff. 2001-03 ASA data are taken from the ASA membership database. Women M.D. data are taken from the AMA Physician Characteristics and Distribution for appropriate years.

to enter specialties. This increase is reflected in a numeric increase in women anesthesiologists. The percent of women physicians entering anesthesiology is actually falling, however [Graph 2]. Other specialties such as surgery are now available to women, and women doctors are choosing them in preference to anesthesiology. This could be important in the future manpower supply for anesthesiology. Anesthesiology remains, though, the sixth most popular specialty for women, a rank it has held since 1980.

More women also are entering medical societies. If opportunities to become leaders are indeed equal now, there should be an increase in women officers of societies. See Graph 3 for recent data on women in ASA leadership positions. One possible cause for lack of women leaders is women's family responsibilities, which give them less time to participate in medical societies. This effect

Table 1: Women Presidents of Other Medical Specialty Organizations, 2004

Organization	2004 Woman President?	Total Women Presidents
American College of Obstetricians and Gynecologists	Yes	3
Society of General Internal Medicine	Yes (also woman immediate past-president)	4
American Psychiatric Association	Yes (also woman immediate past-president)	2
American College of Surgeons	No	0
American Academy of Pediatrics	Yes (also woman president-elect)	3
American College of Radiology	No	2
American Society for Clinical Pathology	Yes	3

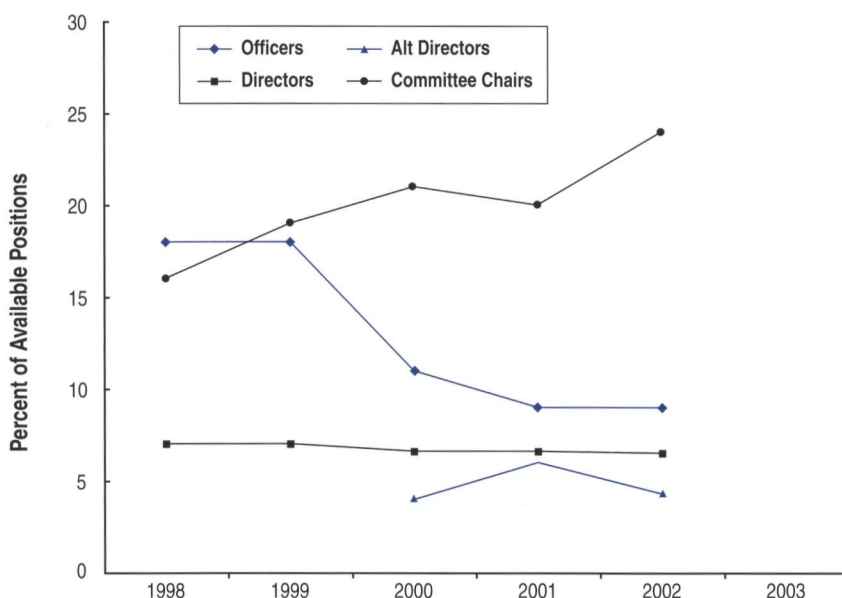
The author made telephone calls to each organization's headquarters in December 2004 to acquire these data.

would be equivalent for all women in all the various societies. An excellent measure of success in leadership would be achieving the presidency of an organization, so the major specialty organizations were surveyed about recent women presidents. It was surprising to learn that all the major specialty societies in 2004, except for surgeons, have either a woman president, a woman immediate past-president or an incoming woman president [Table 1]. ASA has had only one woman president, Betty P. Stephenson, M.D., in 1999.

The reasons for the “steady state” of women in ASA leadership positions, except for committee chairs, have not been explored, although they have been discussed informally. Remarkable changes have occurred for women in anesthesia since 1905, but there are still more issues to examine and discuss.



Graph 3: Recent Data on Women in ASA Leadership Positions



Data were hand-counted from membership directories by the author and ASA staff.

From There to Modernity: A Millennium of Progress in a Century

Continued from page 7

also must not forget that the incredible advancements in surgical specialties led to the formation of the subspecialties in anesthesiology and the reorientation of our educational system. Included in this response is the pioneering role that anesthesiology has played in critical care and pain management medicine.

Yes, we have come quite a distance since Dr. Erdmann and his colleagues met and formed the predecessor to ASA. In all humility, though, our tasks and responsibilities have become enormous. Our use of modern statistical techniques and evidence-based medicine have indicated that we still have a significant 24-

hour postoperative death rate. This is an added incentive to redouble our efforts in an area of medicine that we in anesthesiology have pioneered — the pursuit of patient safety. The bombardment of technological advances on our psyche appears to often dull our sensibilities to a point of desensitization so that we regard the target of our therapy, *the patient*, with a dangerous sense of depersonalization.

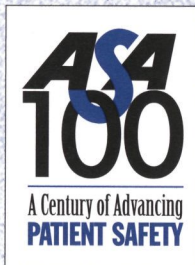
It is hoped that the next century of ASA activity will carry with it an even greater dedication to succor mankind.



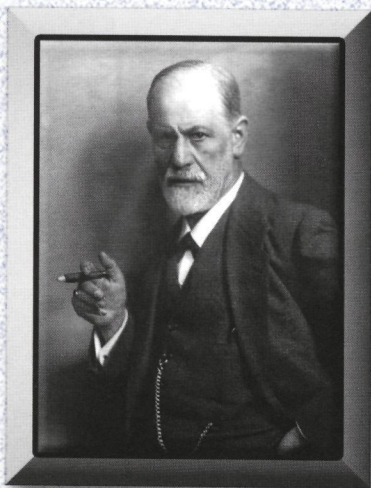
Freud, Erdmann and Einstein: Heroes of 1905, ASA's Founding Year

*George S. Bause, M.D., WLM Honorary Curator
James C. Erickson III, M.D.*

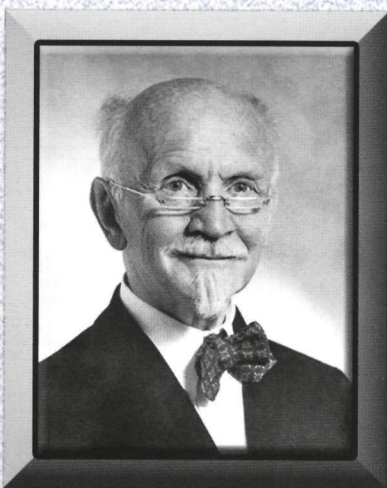
For Freud, Erdmann and Einstein, 1905 was a banner year. The Father of Psychoanalysis, Freud published his theory of psychosexual development. Eleven years Freud's junior, Erdmann founded the New World's first organized anesthesia society (now ASA). Eleven years Erdmann's junior, Einstein turned 1905 into his miracle year of publications on Brownian motion, specific relativity and the photoelectric effect.



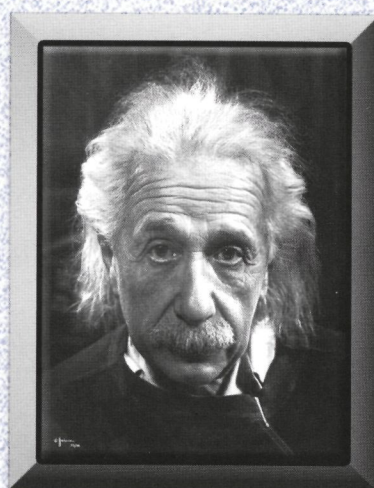
On self-analysis, Freud found himself an anal retentive who fearfully faced the world as a well-groomed, faithful husband. In contrast, his analysis of Einstein would characterize the latter as an anal expulsive who fearlessly defied convention as an unkempt philanderer. Erdmann held the moderate middle ground between Freud and Einstein.



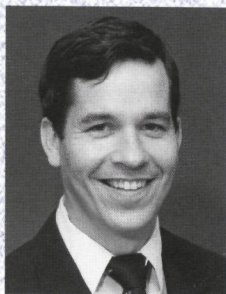
Sigmund Freud, M.D. (1856-1939), Psychoanalyst. 1920 photograph by Max Halberstadt.



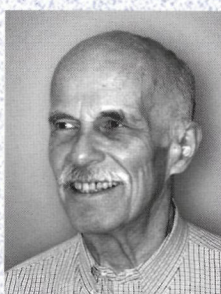
A. Frederick Erdmann, M.D. (1867-1953), Anesthesiologist and ASA's Founder. Photograph courtesy of the Wood Library-Museum of Anesthesiology.



Albert Einstein, Ph.D. (1879-1955), Physicist. 1947 photograph by Phillippe Halsman.



George S. Bause, M.D., is Clinical Associate Professor of Anesthesiology, Case Western Reserve University, Cleveland, Ohio, and is Honorary Curator of the Wood Library-Museum of Anesthesiology.



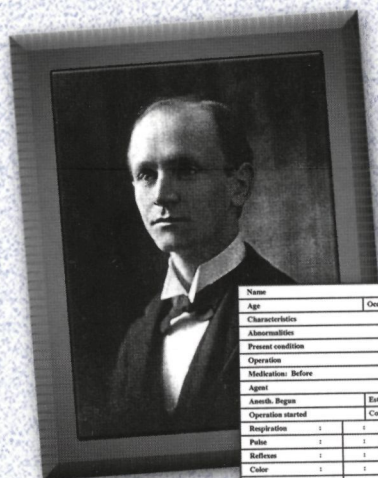
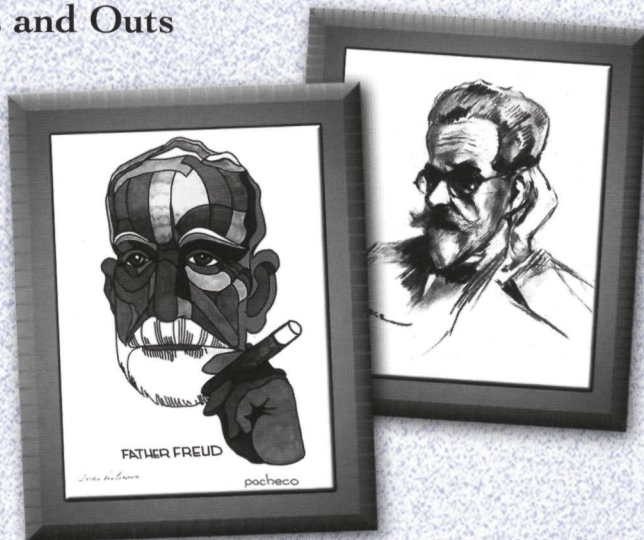
James C. Erickson III, M.D., is Professor Emeritus of Anesthesiology, Northwestern University, Chicago, Illinois, and a volunteer consultant to the Wood Library-Museum of Anesthesiology.

Freud, Erdmann and Einstein: Ins and Outs

Retentive Freud

By 1905 Freud theorized two early stages of development: oral and anal. His own oral habits centered around black coffee and smoking cigars. Compulsive about his daily schedule and rituals, Freud considered himself an anal retentive.

Father Freud and his oral habit: cigars (right). 1980 portrait by Ferdie Pacheco. Portrait of Sigmund Freud — the compulsive psychoanalyst (far right). 1940s sketch by Kurt Wiese.



Attentive Erdmann

In contrast to Freud, Erdmann was tighter orally. A teetotaling nonsmoker, "Fred" Erdmann was a deeply religious proponent of temperance. An anal attentive, Erdmann popularized a chart he devised for patients' anesthetic records.

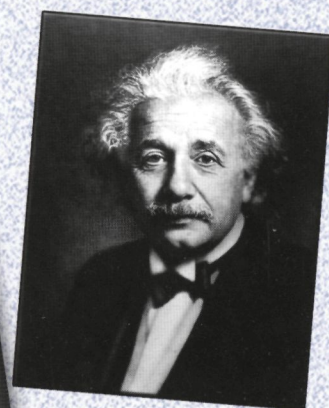
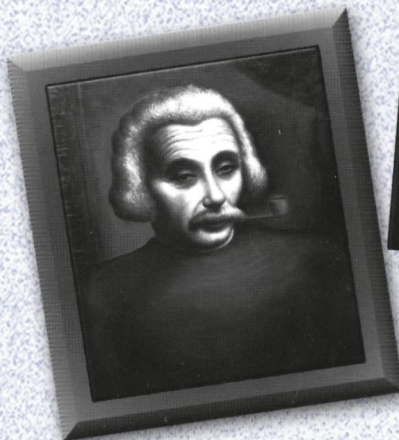
Name	Age	Occupation	Hospital No.
Characteristics			
Abnormalities			
Present condition			
Operation	Posture		
Medication: Before	During		
Agent	Anesthetic		
Amount: Before	Established	Stopped	Recovery
Operation started	Completed		
Respiration	1	2	3
Pulse	1	2	3
Reflexes	1	2	3
Color	1	2	3
Temperature	1	2	3
Remarks	Total		
Quantity: To Establish			
Date	Anesthetic conditions		
Operator	Anesthetist		

A.F. Erdmann, photographed circa 1898 (far left). Image courtesy of Colgate University. Erdmann's chart (left).

Expulsive Einstein

Unlike Freud, Einstein preferred his coffee white and his tobacco tamped in pipes. A Freudian anal expulsive, Einstein was wildly disorganized. The 1921 Nobel Physics Prize saluted Einstein's (photon in, electron out) explanation of the photoelectric effect.

Albert Einstein — and his oral habit: pipes (right). 1956 portrait by Paul Meltsner. Albert Einstein — his hair unstyled even for this formal 1940s photograph by L. Fabian Bachrach (far right).



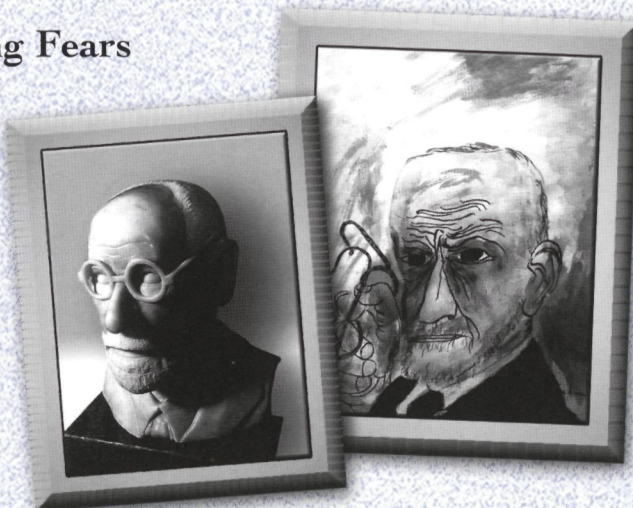
Continued on page 14

Freud, Erdmann and Einstein: Facing Fears

Freudian Fears

Freud postulated a phallic stage centered on one's public face and private fears. With every hair in place, Freud was compulsively vain. Freud nursed personal phobias about death, railways and even ferns (pteridophobia).

Sigmund Freud — resigned in old age to his fears ... and to his spectacles (right). 2002 sculpture by Philip Sustachek. Portrait of Sigmund Freud — vainly removing his glasses (far right). 1956 watercolor by Ben Shahn.



Erdmann the Fear-fighter

Not sharing Freud's vanity, Erdmann was just adequately groomed and dressed. He allayed surgical patients' fears by piping music to them through headphones. Erdmann fearlessly wrestled down men twice his size to etherize them.

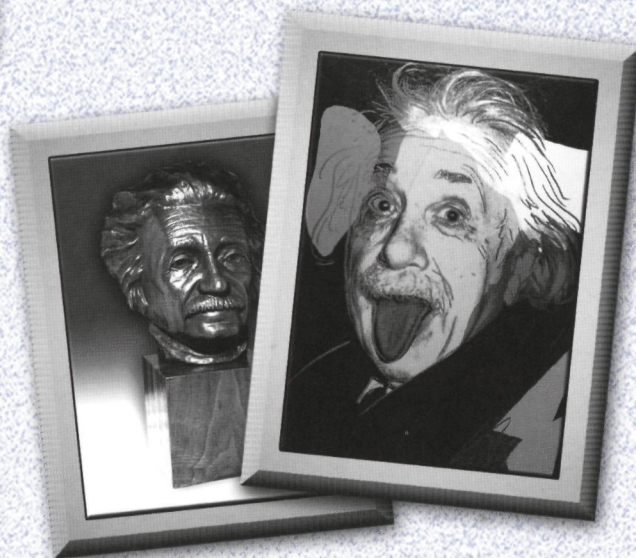


Erdmann, (unmasked and standing): "A patient under local anesthetic is calmed by music through ear-phones" (far left). Scientific American, 1933. Erdmann fearlessly wrestled down combative patients to etherize them (left). A 1930s sketch by "Myrtle's Ernest." Both images courtesy of the Wood Library-Museum of Anesthesiology.

Einstein the Fearless

Unlike Freud and Erdmann, Einstein was disheveled and unkempt. With $E = mc^2$, he navigated the heavens as he did the waters, fearlessly. A nonswimmer yet reckless sailor, Einstein shrugged off earthly fears, observing that "an equation is for eternity."

Albert Einstein — a young, fearless scientist (right). 1999 sculpture by Robert Toth. A 1951 photograph of Albert Einstein — older, but still fearlessly unkempt — as colorized years later by H. Juergen Kuhl (far right).

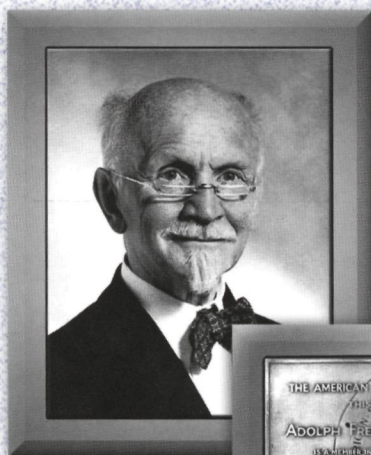


Freud, Erdmann and Einstein: Intimacy

Freud: The Faithful Romantic

A romantic and loyal husband, Freud honored his wife lifelong. His marital bliss ranged from early years as a “wild man” lover on cocaine to later ones as an impotent but tender husband. Even while racked by cancer pain, Freud cherished his wife as “magic that is never exhausted.”

Sigmund Freud — the colorfully romantic youth (far right). 1980 portrait by Andy Warhol. Sigmund Freud — the cancer-racked faithful husband (right). 1930 portrait by Ferdinand Schmutzer.



Erdmann's Mistress: ASA

A devout parishioner, Erdmann was a model husband and father. Apparently, Erdmann's only mistress was the Long Island Society of Anesthetists (the future ASA). Saluted in 1937 as the ASA's founding member, Erdmann was awarded a Silver Certificate by ASA.

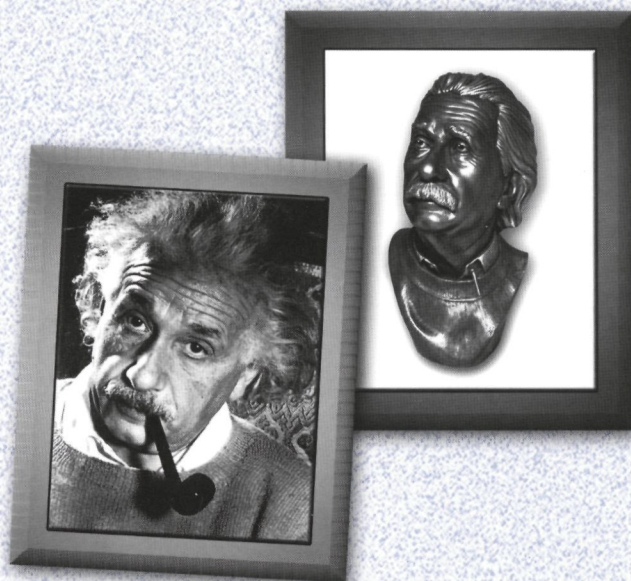


A. Frederick Erdmann, M.D., circa 1946 (far left). Photograph courtesy of the Wood Library-Museum of Anesthesiology. Silver Membership Certificate awarded to Erdmann in 1937 by ASA (left).

Einstein: Brownian Philanderer

Divorcing his first wife, then marrying his cousin, Einstein bounced from lover to lover. His social life paralleled his most cited paper, one on Brownian motion. Einstein lamented, “Lasting harmony with a woman [was] an undertaking in which I twice failed rather disgracefully.”

Albert Einstein, Princeton — acting “on women as a magnet acts on iron filings” (right). 1940 photograph by Lucien Aigner. Searching for Truth — Einstein, truer to physics than to his lovers (far right). 1999 sculpture by Peter Carsillo.



Special thanks to co-author Evan Bause, FAISES. 

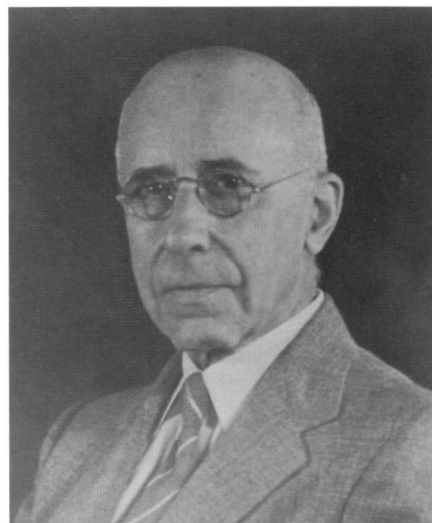
Albert Heircy Miller: *Anesthesiology Pioneer*

R. Dennis Bastron, M.D.

Albert Heircy Miller, M.D., a largely unsung pioneer of anesthesiology, was born in Lewiston, Maine, on April 3, 1872. Young Albert proved to be an excellent student and developed an early talent for drawing and photography, which helped finance his education and opened many important doors for him. After graduation from Bates College in Lewiston, he began his medical studies at the newly opened Bowdoin co-educational School of Science but, after one year, transferred to the College of Physicians and Surgeons at Columbia. While a student at "P. and S." (as Dr. Miller refers to it in his papers), Albert Miller was asked to do photographs of surgical procedures for Charles McBurney, M.D. Dr. McBurney was one of the leading surgeons of his time and was in the process of writing his surgical textbook. Albert devised a camera and tracking system that could make photographs at different stages of a procedure without interrupting or distracting Dr. McBurney.

After graduation from P. and S. in June 1898, Dr. Miller had several opportunities, including at the Central Maine General Hospital in Lewiston, Maine, and as an intern at the Rhode Island Hospital in Providence. In Dr. Miller's own words, "First, I took the appointment at the Lewiston Hospital. It was a wise choice, for the hospital was new. Dr. Oakes was the surgeon ... I got experience in anaesthetics and worked out a plan for sterilizing sutures. Later, I had two assistants, Dr. Barrows and Dr. Burrell, so I could safely leave to go on to my Rhode Island Hospital appointment in March 1899."

Dr. McBurney had offered Dr. Miller a position but had advised him that, if he went to Providence, he should take up anesthesia. He introduced the young Dr. Miller to Thomas L. Bennett, M.D., who gave him many pointers about the latter's successful method of anesthesia in New

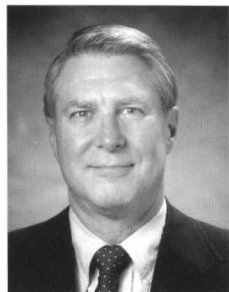


Albert H. Miller, M.D. Photograph courtesy of the Wood Library-Museum of Anesthesiology.

York. (Dr. Bennett is thought to be the first American physician to limit his practice to anesthesia.) During his tenure as an intern at the Rhode Island Hospital, Dr. Miller continued giving anesthetics, and he graduated from the hospital on January 1, 1901, with an appointment as anesthetist, which had been promised by the trustees a long time back. In those days, all operations in private practice were done in homes or small private hospitals. Dr. Miller was engaged to give an anesthetic for a spina bifida operation at a house in East Providence on his first day!

He soon had a busy and lucrative practice doing general medicine, obstetrics, orthopedics and anesthesia; however, after a life-threatening illness, he limited his practice to anesthesia. By this time, he had trained some assistants and soon established anesthesiology departments in several Rhode Island hospitals, perhaps the first departments of anesthesiology in the United States. In 1935, Leo V. Hand, M.D., was appointed as the first resident in anesthesia in the newly formalized department at Rhode Island Hospital. (Dr. Hand was ASA President in 1960. Later, Meyer Saklad, M.D., another very prominent ASA member, was one of Dr. Miller's residents.)

Dr. Miller put his incredible observational skills, meticulous attention to detail, compassion for patients, thirst for knowledge and love of the profession to good use. Early in



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Dr. Miller's mentor, Thomas Linwood Bennett, M.D., of Kansas (left), and the famous Bennett Inhaler (right). Photographs courtesy of the Wood Library-Museum of Anesthesiology.

his practice, he promoted the use of careful and detailed anesthesia records, and although not the first to use anesthesia records, it is likely that Rhode Island Hospital was the first hospital in the United States to routinely use such records and to use those records to improve patient outcomes. Dr. Miller studied the records of thousands of consecutive patients and developed a classification of operative risk. He recognized the importance of the anesthesiologist in performing a complete history and physical examination. He insisted it be done in spite of resistance from surgeons who resented what they perceived as an intrusion on their practices. He also recognized that patients with concomitant medical disease should be medically optimized to improve their outcomes from the surgical procedure. Dr. Miller was one of the first anesthesiologists to understand the importance of giving adequate oxygen to patients receiving nitrous oxide, and he made many contributions to the development of safer anesthesia delivery systems and machines (Elmer I. McKesson, M.D., was a frequent guest in the Miller house).

A surgeon, Philemon E. Truesdale, had devised a method to surgically correct diaphragmatic hernia, which was successful on animals, but he hesitated to try it on patients because of the difficulty of anesthesia and a published mortality rate of greater than 50 percent. At a meeting of the Providence "Friday Night Club," he suggested that Dr. Miller develop a method of anesthesia for intrathoracic sur-

gery. Dr. Miller called his method "Constant Pressure Nitrous Oxide Oxygen Anesthesia." It was so successful that he and Dr. Truesdale did a series of 12 operations for diaphragmatic hernia without a death. Dr. Miller also devised a technic of pharyngeal anesthesia for surgical procedures on the upper airway.

Dr. Miller early on recognized the effects of surgical position on the physiology of oxygen delivery. He may have been the first to use symbols for the patient's position on the anesthetic record. He also was one of the first to note the effects of surgical traction on the gall bladder on the cardiovascular system. A student of history, Dr. Miller was especially interested in the contributions of Horace Wells and William T.G. Morton and the work of British physician Thomas Beddoes.

Perhaps his greatest contribution to our specialty was his description of the ascending intercostal muscle paralysis that develops as the depth of anesthesia increases. Arthur E. Guedel, M.D., used this observation when he developed his classification of the planes and stages of anesthesia. Dr. Miller recognized that the abdominal movement so often complained about by surgeons was actually caused by deep anesthesia, intercostal muscle paralysis and diaphragmatic breathing, and should not be treated by deepening the anesthetic further but rather by lightening the depth.

Dr. Miller also recognized the importance of organizations in the development of a profession. He was present for



◀ Dr. Miller's other important mentor, surgeon Charles McBurney, M.D., around 1897 in New York. Dr. Miller described Dr. McBurney as a short but very proud man who always insisted on standing on a stool during surgery. This photo was taken during the first operation for appendicitis by Dr. McBurney with Dr. Miller as his anesthetist. The ether cone seen in the hand of the anesthetist was the forerunner of the first open-ether method developed by Dr. Miller. The Miller open-ether method was first used at the Rhode Island Hospital in 1900.

Dr. Miller at one of his Friday Night Club meetings in 1948, a forum for doctors which he had instituted to discuss clinical matters every week. Photograph courtesy of the Wood Library-Museum of Anesthesiology. ►



the founding of the Providence Society of Anesthetists and the Boston Society of Anesthetists. He also attended the founding of the American Association of Anesthetists (AAA) in Atlantic City in June 1912. AAA later amalgamated into the International Anesthesia Research Society. James T. Gwathmey, M.D., first president of AAA, also was a frequent guest in the Miller home. Dr. Miller was president of AAA from 1918-20 and was a frequent participant in the scientific sessions. He also was an early member of the American Society of Anesthetists, which later was renamed the American Society of Anesthesiologists (member number 81). His contributions to the specialty of anesthesiology include 74 publications.

All of the material used in developing this article is contained in the extensive Albert H. Miller collection in the Wood Library-Museum of Anesthesiology (WLM). This collection was made possible by the generosity of Dr. Miller, his widow the late Ada Miller, and his oldest daughter, Mrs. Jonathan B. Richards, of Red Oak, Iowa. Included in the collection are personal reminiscences, photographs and papers, including programs and notes from many of the early meetings of AAA. These materials are available for study at the WLM and make for fascinating reading. The programs give an insight into the development of our specialty and the genius of the giants on whose shoulders we stand.



Preservation of the WLM Living History Collection and Educational Films

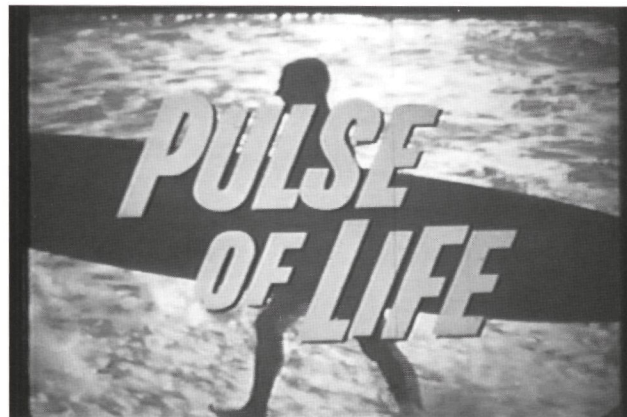
Mary Ellen Warner, M.D., Trustee
Wood Library-Museum of Anesthesiology

The Wood Library-Museum of Anesthesiology (WLM) houses a treasure trove of old 16 mm films and VHS tapes depicting the history of the specialty of anesthesiology over the last century, as told by the giants of our specialty. Examples of these classic films include "Signs and Stages of Anesthesia" from 1945 with I.W. Magill, "Ether Analgesia for Cardiac Surgery" with Joseph Artusio, M.D., and "Pulse of Life" from 1975, detailing the story of artificial respiration and artificial circulation by Peter Safar, M.D.

As is true with all media formats, however, these films and tapes will not last forever. With deterioration, two disastrous possibilities could occur. First is the loss of the images altogether, and second, as the celluloid deteriorates, it exposes the storage area to a combustion risk. The WLM Board of Trustees has long recognized the need to preserve these priceless films and convert them to a digital format.

After researching various companies dealing with digitization, WLM accepted a proposal from Digital Transfer, Inc., to begin the process of transferring a portion of some 145,000 feet of film in 185 titles to DVD. The cost of this project will be supported by WLM, by a generous donation from the Greater Atlanta Society of Anesthesiologists and the John W. Pender, M.D., Education Trust. Future plans for the preservation of our media format also include the transfer of 150 VHS tapes to DVD.

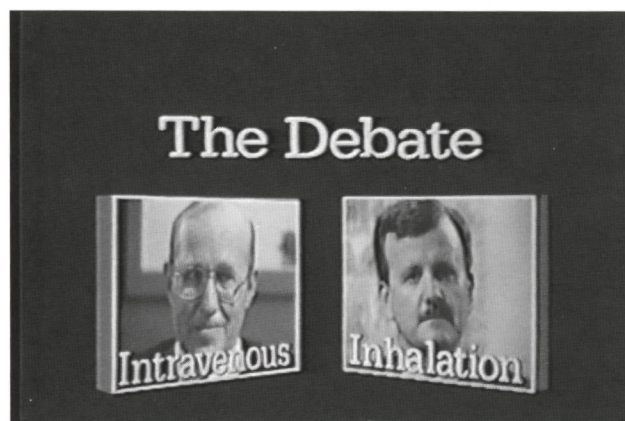
The WLM Board of Trustees recognizes the great value of this preservation project that will ensure the long-term security of our priceless collection.



Pulse of Life. Image courtesy of Wood Library-Museum Archival Film collection, 1975.



Joseph F. Artusio, M.D., (left), from film "Ether Analgesia for Cardiac Surgery." Image courtesy of Wood Library-Museum Archival Film collection, circa 1950s.



Left to right, Theodore H. Stanley, M.D., Ronald D. Miller, M.D. Image courtesy of Wood Library-Museum Archival Film collection, 1985.



Mary Ellen Warner, M.D., is Associate Professor of Anesthesiology, Mayo Clinic College of Medicine, Rochester, Minnesota.

What's in Store for Us in 2025?

Eugene P. Sinclair, M.D., President

At the beginning of my term as ASA President, I pointed out that the Administrative Council is the official planning body for ASA. It must look beyond the next year or two and have the vision and resolve to look over the horizon in charting the future direction of our specialty.

The accelerating rate of dynamic change in coming years will have profound effects on our practices and our patients. To assist the officers in studying the multiple issues that will influence and shape our profession and our future practices, I appointed a Task Force on Future Paradigms of Anesthesia Practice, chaired by Ronald D. Miller, M.D., of the University of California-San Francisco.

Dr. Miller has presented well-received summaries of the task force report to the August 2005 Board of Directors and the Administrative Council. He has prepared a written summary that follows this preface.

The full report will serve as a valuable resource to the Administrative Council in its work as the official planning body of the Society. Clearly future Administrative Councils will have to revisit and update this work from time to time to keep it current.

Eugene Sinclair



Eugene P. Sinclair, M.D.

Report From the Task Force on

Future Paradigms of Anesthesia Practice

Ronald D. Miller, M.D., Chair

Task Force on Future Paradigms of Anesthesia Practice

The following represents a talk given by Dr. Miller at the August 2005 Board of Directors Meeting, which took place in Chicago last August 20-21.

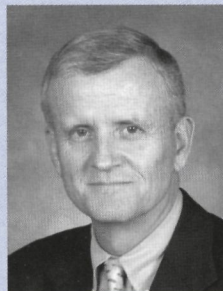
I. Introduction

In 2004, ASA formed a task force to identify possible anesthesia paradigms in 2025. Hopefully the findings of this task force may facilitate ASA's strategic planning. In planning the task force, several concomitant questions emerged.

For example:

- What are the factors that could influence our future practice?
- Is the specialty of anesthesiology ready for the future?
- What are the changes in American medicine and its hospital structure that may promulgate future anesthesia pathways?
- How will variables such as innovations, demographics and economics influence the specialty?
- How can anesthesiology be positioned as a specialty that is the best value for improved health care delivery systems?

Considerable thought and discussion preceded the development of this task force, including three Foundation for



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Anesthesia Education and Research retreats, academic anesthesiology committee discussions and many informal discussions. In addition, the task force analyzed the interviews of more than 20 leaders in American medicine outside the specialty of anesthesiology. Despite a diversity of responsibility in health care, these leaders often provided similar views regarding the future of medicine and the possible role anesthesiology may have. This consistency certainly added strength to our conclusions.

II. Current Trends and the Future

Tertiary care-oriented hospitals will persistently increase the percentage of critical care and monitored beds to as many as 50 percent of the total beds. Information technology is rapidly becoming installed in many of our nation's hospitals, creating more opportunities for national databases from which both quality and quantity of clinical care can be assessed. Operating rooms will increasingly have information-intensive layouts with more robotics and voice-activated technologies. Increasing numbers of invasive procedures will be delegated to nonphysicians or mid-level technicians. Credentialing will be based more on demonstrated competence rather than academic degree or board-certification. Turf wars will increasingly occur, with traditional boundaries for scope of practice being severely challenged. For example, at least four specialties are currently competing for control of the "carotid artery."

Traditional surgical approaches will be challenged by imaging and invasive catheters approaches. Furthermore, medical substitutes will be developed for some surgical interventions. For example, 50 percent to 70 percent of vascular surgery is by imaging and catheter approaches rather than traditional surgery. How is the risk of anesthesia influenced by sicker patients but less invasive procedures? In some cases, some surgical procedures will actually disappear or be markedly modified by genetic-molecular medicine and/or imaging.

The institution of genetic-molecular medicine has already started and will only continue to increase over the next 20 years. New drug development will be based on pharmacogenomics. Molecular studies for individualized analysis of drug responses, including our ability to project a patient's susceptibility to adverse events, will occur. And, lastly, drugs will be developed that will have little risk or will not require marked skill necessary to administer them.

Evaluation of our interviews inevitably created many questions.

For example:

- With the advances in technology and pharmacology, how qualified will the future intraoperative anesthesia provider need to be?
- What will the role of the anesthesiologist be with advanced technology and pharmacology (e.g., safer and more precise drugs)?
- How many anesthesia providers (e.g., technicians?) should an anesthesiologist supervise at once?

Even though many anesthesiologists think that compensation is currently inadequate, some of our interviews reflected that some day the "anesthesia-operating room economic bubble" may burst. Can the current economics be sustained in the long run, especially with the arrival of

"Most certainly science and technology are creating more ways to both use and not use the anesthesiologist's skills. No doubt, health care delivery systems, and hospitals in particular, will favor the specialty that provides more overall value and diversity of practice paradigms."

advanced technology and pharmacology requiring less skill for the delivery of intraoperative anesthesia? Because of perceived inadequate third-party reimbursement, many academic medical centers and even a few private practice situations are providing additional financial support to augment the financial package of anesthesia health care providers. Will such institutional support continue, especially in large academic anesthesia medical centers?

III. Opportunities of the Future

With the tertiary care hospital increasingly dominated by a combination of monitored and critical care beds (i.e., at the exclusion of general medical beds), in addition to procedural suites and operating rooms, opportunities for our specialty presently exist. Most inpatients will be procedurally oriented but of higher acuity than now exists.

- Who will perform the preoperative evaluation?
- Who will prepare patients for these procedures and surgery?
- Who will manage their intraoperative course, both

logistically and medically in the postanesthetic care units (i.e., many intensive care units)?

- Who will manage these?
- Who will take care of the patient's postoperative care (including pain)?
- Who will provide their critical care?
- On a broader scale, what type of physician should lead all of these areas of inpatient care in an organizationally and medically sound coordinated basis?

Increasingly this type of medical care must be based on systems analysis and measures of outcome. In fact, one of the leaders we interviewed suggested that this represents a medical specialty that currently does not exist.

“We must act immediately to create the intellectual environment that will actualize the profession's full and diverse potential by 2025 because change takes time.”

Although inpatient care has been emphasized, our specialty has the opportunity to be more involved with interventional pain management, including acute and chronic pain care and palliative care on an outpatient basis.

IV. Conclusions

Anesthesia could be the dominant leader in tertiary care hospitals, both clinically and administratively, with emphasis on “through-put” and “outcomes.” Furthermore the leaders we interviewed frequently stated that anesthesiology, in many respects, is the preferred specialty for this type of change. Yet they also questioned whether the specialty of anesthesiology would seek or accept broader perioperative responsibilities. Their perception is that the current comfortableness with operating room anesthesia and its economics (i.e., anesthesiologists are highly paid specialists) was the basis of this concern.

Will the specialty be able to adapt to the hospitals of the future? Even with substantial changes in training programs, new graduates with contemporary training will not manifest themselves for six to 10 years. For example, anesthesia's increased role in perioperative medicine probably requires additional involvement in critical care. Specifically, were a change in our residency to augment the amount of critical care training, the residency would not be changed until 2008, which means that graduates will not appear until 2012, seven years from now. Yet other specialties are ready

to act now. For example, medical hospitalists have been actively discussing and publishing a projected vision of their future role in perioperative medicine. Other specialties, including surgery, emergency room and trauma physicians, are discussing an augmented role in inpatient medicine. Some of these specialties (especially medicine) are ready to respond now, and even more so in the next two or three years.

Those who favor retaining the status quo may argue that our task force's vision of operating room anesthesia and perioperative care in 2025 could be wrong. They may even predict that because operating room anesthesia has been essentially the same for the last 30 years, it will remain similar for the next 20 years (i.e., until 2025). However, a widespread consensus among the interviewed leaders was that there would be more change in the next 10 years than in the last 30 years put together. Close examination of current economics and scope of practice indicates that this scene of rapid change is already taking place.

Should the future of our specialty be nearly entirely based on operating room anesthesia? If the status quo persists, the answer is possibly yes. If the predicted changes in technology and pharmacology allow a lesser-trained individual to deliver anesthesia, then the answer is no. If the later prediction is correct, then diversification of practice paradigms is a more fundamentally sound basis for the future of anesthesiology. Our traditional and current practices may be more assured if we complement them with future focused alternatives (e.g., perioperative medicine, critical care, pain). Most certainly science and technology are creating more ways to both use and not use the anesthesiologist's skills. No doubt, health care delivery systems, and hospitals in particular, will favor the specialty that provides more overall value and diversity of practice paradigms.

V. Recommendations

A. Our specialty should have a mechanism in place to automatically revise our vision of the future every one to two years. This disciplined approach will automatically force us to consider new clinical, scientific and administrative approaches in the overall framework of what our specialty should be. It was inspiring to hear that while the specialty of anesthesiology could and should have a major role in the future of American medicine, especially its hospitals, the opinion, however, is that most (but not all) anesthesiologists are relatively comfortable with their current role in operating room anesthesia and probably will not be willing to adapt themselves to the future.

B. Our specialty should initiate research programs to guide appropriate diversification, including the scientific

determination of best practices and clinical benchmarks, management studies to determine the approach to clinical excellence and the performance of high-quality research that contributes not only to the welfare of our specialty but also medicine overall.

C. Despite the considerable lag time between changing our training programs and the resultant contemporary graduates appearing on the clinical scene, there are some changes than can be made in the next two to four years.

1. Our vision for the future is severely hampered by a lack of substantial anesthesiology-trained critical care physicians. Even though our specialty has historically been the one that started and developed critical care medicine, it has gradually been given away to other specialties in the last 30 years. Anesthesiology needs to reverse that trend. Currently our specialty has substantial critical care fellowship capacity. With the help of ASA, perhaps a large effort should be made to encourage anesthesia residents to take critical care fellowships.

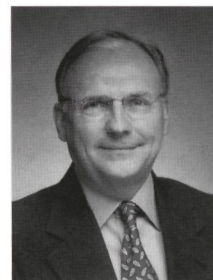
2. About 15-20 anesthesia programs are now ready to train anesthesiologists of the future. Furthermore there may be other programs that wish to make this transition. Perhaps measures can be taken now to unleash these programs to make this vision well-known to medical students so that the appropriate individuals can be recruited into our specialty. How can these programs be stimulated to move forward? Furthermore our trainees and existing physician practitioners must maintain a high degree of general medical knowledge and experience if we are to provide the value-added care and leadership for the full scope of perioperative care. As it is likely that the physician role in operative anesthesia will more likely involve the supervision of nurses and technicians in multiple locations, trainees should be educated for this role as they become senior housestaff.

In conclusion our specialty needs to diversify its practice paradigms in order to ensure its future leadership position in medicine. To have an increasingly dominant role in perioperative management, including critical care, seems to be within our grasp. We must act immediately to create the intellectual environment that will actualize the profession's full and diverse potential by 2025 because change takes time. In some respects, we are already behind, but we have opportunities that can be implemented in the next two to four years.

Epilogue

Orin F. Guidry, M.D., President-Elect

Gene Sinclair's action to create this task force was far-sighted, and the task force has done an excellent job in laying out the future as far as it can be discerned. We have to continue the effort on dual tracks. The first is to continuously look into the future as far as we can see. The second effort is to prepare the specialty to meet coming challenges.



Orin F. Guidry, M.D.

This preparation for the future includes not just the ASA's organizational preparation but also preparing individuals, groups and residents to care for the patients of the future.

Orin F. Guidry



Board of Directors Annual Meeting Summary

The ASA Board of Directors held its annual meeting in Chicago, Illinois, on Saturday and Sunday, August 20-21, 2005. The Board committees on Administrative Affairs, Finance, Legislative Review and Scientific Affairs held open hearings on Saturday to review reports for consideration by the Board of Directors on Sunday. Among the actions taken by the Board of Directors were the following:

Standards and Practice Parameters

Subject to House of Delegates ratification, approved a recommendation to merge the activities of the Committee on Standards of Care into the ongoing work of the Committee on Practice Parameters, thus creating a new Committee on Standards and Practice Parameters.

Also subject to House of Delegates ratification, approved an amendment to the ASA Standards for Basic Anesthetic Monitoring regarding monitoring of the patient's oxygenation and ventilation, to include the following added language:

- Standard II, Blood oxygenation: *"When the pulse oximeter is utilized, the variable pitch pulse tone and the low threshold alarm shall be audible."*
- Standard II, Ventilation: *"When capnography or capnometry is utilized, the alarms shall be audible."*

Received, for review and comment, four new or updated practice parameters that will be submitted to the House of Delegates in October for approval:

1. Practice Guidelines for Perioperative Management of Patients With Obstructive Sleep Apnea (new). This task force is chaired by Jeffrey B. Gross, M.D.
2. Practice Advisory for Perioperative Visual Loss Associated With Spine Surgery (new). This task force is chaired by Mark A. Warner, M.D.
3. Practice Advisory for Intraoperative Awareness and Brain Function Monitoring (new). This task force is chaired by Jeffrey L. Apfelbaum, M.D.
4. Practice Guidelines for Blood Transfusion and Adjuvant Therapies (updated). This task force is chaired by Gregory A. Nuttall, M.D.

Also received information that practice parameters currently being developed or updated are: practice guidelines for prevention of operating room fires; obstetrical anesthesia; neuraxial anesthesia; preoperative fasting; cancer pain and chronic pain management; and transesophageal echocardiography.

American Association of Nurse Anesthetists (AANA)

Subject to House of Delegates ratification, disapproved a recommendation to adopt a Joint Statement on Anesthesia

Practice prepared with leaders of the American Association of Nurse Anesthetists as a means to recognize the evolving roles of anesthesia professionals and to ensure the involvement of anesthesia professionals in the delivery of anesthesia care.

Also subject to House of Delegates ratification, disapproved a resolution that recommended withdrawal from mediated meetings with the AANA leadership. Testimony indicated that dialogue with AANA should continue at the discretion of the Executive Committee.

Also subject to House of Delegates ratification, disapproved a recommendation that ASA Educational Membership no longer be offered to certified registered nurse anesthetists.

Provision of Anesthesia Care by Nonanesthesiologists

Referred a report from the Committee on Patient Safety and Risk Management to the Administrative Council for possible involvement of the ASA leadership in addressing issues related to the provision of anesthesia care by physicians who are not in the specialty of anesthesiology.

Subject to House of Delegates ratification, referred to a committee of the President's choice for further study, the proposed statement "Credentialing Guidelines for Practitioners Who Are Not Anesthesia Professionals to Administer Anesthetic Drugs to Establish a Level of Moderate or Deep Sedation."

2006 Relative Value Guide

Approved a recommendation by the Committee on Economics to insert the following text into the 2006 Relative Value Guide relating to obstetrical anesthesia (new language underscored):

- "Professional charges and payment policies should reasonably reflect the costs of providing labor analgesia as well as the intensity and time involved in performing and monitoring any neuraxial labor analgesic.

- Basic units, plus ~~patient contact time (insertion, management of adverse events, delivery, removal)~~ plus one unit per hour for neuraxial analgesia management plus direct patient contact time (insertion, management of adverse event, delivery, removal)."

Educational Mission Statement

Subject to House of Delegates ratification, approved recommended revisions to ASA's "Educational Mission Statement" as submitted by the Committee on Professional Education Oversight.

Organ Donation After Cardiac Death

Subject to House of Delegates ratification, approved a

recommendation that protocols for individual hospitals should be developed with the assistance of guidelines developed by the Institute of Medicine and the United Network for Organ Sharing for the provision of ethical terminal care for organ donor patients and their families. The Board indicated that the Committee on Transplant Anesthesia, with further input from the Committee on Ethics, should educate ASA members and assist them in developing such guidelines and protocols.

Anesthesia Care Team Statement

Subject to House of Delegates ratification, referred a proposed revision of the Anesthesia Care Team Statement, last amended by the House of Delegates in October 2001.

Trauma and Emergency Preparedness

Subject to House of Delegates ratification, approved a recommendation to establish the current ad hoc committee as a standing Committee on Trauma and Emergency Preparedness.

Performance and Outcomes Measurement

Subject to House of Delegates ratification, approved revisions to the "Guiding Principles for Database Management of Performance Measures" as recommended by the Committee on Performance and Outcomes Measurement (CPOM), which describes guidelines for data management (technical standards and organizational oversight) that will allow ASA to pool performance measurement data into a comprehensive relational database.

Honoraria and Awards

In order to achieve consistency with the new ASA travel and reimbursement policy, approved the recommendations from the Committee on Honoraria and Awards for adjustments to honoraria and awards relating to the Annual Meeting. Approval of these recommendations is subject to ratification by the House of Delegates.

2006 Budget and Dues

Approved a 2006 budget to provide total income of \$23,824,925. The 2006 expense budget of \$24,264,390 was approved and will be forwarded to the House of Delegates for adoption. The 2006 budget includes funding for the Anesthesia Patient Safety Foundation (APSF), the Foundation for Anesthesia Education and Research (FAER) and the Wood Library-Museum of Anesthesiology (WLM) as follows:

APSF	\$500,000
FAER	\$1,500,000
WLM	\$400,000

Recommended that the House of Delegates approve the following 2006 membership dues, which are unchanged from 2005:

Active Members	\$450
Affiliate Members	\$225
Educational Members	\$225
Resident Members	\$25
Educational Student Members	\$25
Medical Student Members	\$10

Member Insurance Benefits

Subject to House of Delegates ratification, recommended that ASA further explore options to offer health insurance and other member benefits to the ASA membership with advice from legal counsel.

Anesthesia Foundation

Subject to House of Delegates ratification, approved a recommendation that the Anesthesia Foundation, in its attempt to strengthen ties with ASA, be recognized by the ASA in the same fashion as the Foundation for Anesthesia Education and Research, the Anesthesia Patient Safety Foundation and the Wood Library-Museum of Anesthesiology. It was noted that there would be no fiscal impact to ASA as a result of this new recognition of the Anesthesia Foundation.

Erratum

In the article "Being Part of a Multispecialty Practice Group Is Not a Good Financial Deal: You Should Secede!" by David A. Lubarsky, M.D., M.P.H., in the August 2005 ASA *NEWSLETTER*, it should be noted that it was not Dr. Lubarsky's intention for his article to be

subtitled "You Should Secede!," as appeared in the print version of that *NEWSLETTER*. The *NEWSLETTER* staff regrets any inconvenience this may have caused Dr. Lubarsky or those affiliated with him.

What Is Organ Donation After Cardiac Death? Why Do I Need to Know?

Susan K. Palmer, M.D., Chair
Committee on Ethics

During this past year, your Committee on Ethics has spent a great deal of effort responding to anesthesiologists who have asked for advice on their role in organ recovery from patients who die by the usual criteria of cessation of cardiac and respiratory activity, also referred to as donation after cardiac death (DCD). Most of these patients will have been in the intensive care unit (ICU) and fully dependent on ventilatory and circulatory support. They or their spokesperson will have declined the further use of ICU modalities and requested that they be withdrawn. Most, but not all, of these patients also will be neurologically devastated but do not meet criteria for whole brain death. In these patients, the ethical principle of "double effect" allows the use of appropriate doses of analgesics and sedatives "intended" to relieve or prevent suffering during treatment withdrawal. It would be illegal, however, to give any drug or dose "intended" only to cause death.

The interest in this group of people as potential organ donors has grown steadily over the last decade, mostly because the demand for usable organs far outstrips the needs of potential recipients. Pressure also has come from donor patients' families who struggle to find some meaning in the death of their family member.

Predicting whether a patient will die rapidly after the withdrawal of ventilatory and circulatory support can be difficult. The selection of patients suitable for withdrawal of ICU modalities and donation of organs is being studied. Also the viability of organs from these donors has already been extensively studied. It is clear that some organs will perform better than others when donated after the cessation of circulation.

Intensivists have been withdrawing ICU modalities from patients who can no longer benefit from such treatments for decades. Nonbeneficial care is defined as care that no

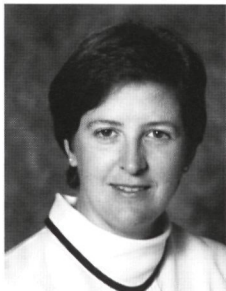
longer holds the promise of restoring a patient to a life that *they themselves have defined as worthwhile*. The further burdens of nonbeneficial care are declined because they are thought to postpone or make an inevitable dying process more burdensome. Humane and respectful withdrawal of circulatory or ventilatory treatments now always involves consideration of how to prevent possible suffering during this process. The patient's own physician is best suited to withdraw unwanted treatments and should be welcomed into the operating room (O.R.) to do this for the patient who desires to donate organs.

Anesthesiologists are the natural leaders of the O.R., and as such, must be prepared to help with patients who come to the O.R. to donate organs. *The best way to prepare to help is to develop written guidelines for DCD before the first case occurs in your hospital.* The main principles for institutional DCD guidelines are:

- 1) that the donor's care and decisions are paramount;
- 2) the decision for withdrawal of ICU treatments must be made before and separate from any decision to donate organs;
- 3) in order to avoid the appearance of conflict of priorities, the physician caring for a donor should not be involved in any of the organ recipient procedures, and that physician should be the declarant of time of death;
- 4) criteria for death by circulatory arrest need to be defined (most institutions accept a two- to five-minute interval of a flat arterial line tracing, since that may be more accurate than electrical silence of the myocardium); and
- 5) the policy needs to outline how long a patient should be in the O.R. after withdrawal of treatments if circulatory death does not occur as predicted. Many institutions say that one hour of observation is appropriate, and plans for where the patient is to be cared for after the hour is up are made in advance. Relatives must be informed of this possibility. Caregivers must not be under any pressure to hasten death when it does not occur as a result of the withdrawal of nonbeneficial treatments.

There was a national consensus conference on DCD in April 2005 in Philadelphia, Pennsylvania. The proceedings from that conference will be available soon from the United Network for Organ Sharing (UNOS) at <www.unos.org>.

Ethically and legally, DCD is not equivalent to donation that occurs after time of death has been documented by



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Efforts Under Way to Revise the Preuse Checkout Recommendations

Jeffrey M. Feldman, M.D.

Task Force on Revising the Preuse Checkout

While chatting with the patient about to undergo a laparoscopic cholecystectomy, you administer an induction dose of propofol and an intubating dose of a muscle relaxant. The patient loses consciousness and spontaneous respiration ceases. You adjust the mask on the patient's face to establish a secure fit and squeeze the reservoir bag, only to find that you are unable to deliver a positive pressure breath. A quick visual inspection of the breathing circuit does not reveal the cause of the problem. Are you confident in your ability to ventilate

this patient before she becomes hypoxic? Is an alternative method of ventilation readily available and functioning? Is there a reliable source of oxygen? Furthermore, you are using a relatively new anesthesia machine that performs an automated checkout procedure. What functions of the anesthesia machine did the automated checkout actually evaluate? Did you perform a thorough check of the machine before use that should have detected the source of this problem?

Failure to check anesthesia equipment prior to use can lead to patient injury or "near misses."¹ Checking equipment also has been associated with a decreased risk of severe post-operative morbidity and mortality.² Indeed a preuse anesthesia apparatus checkout recommendation (AACR) was developed many years ago and was widely accepted to be an important step in the process of preparing to deliver anesthesia care.³ Despite the accepted importance of the AACR, available evidence suggests that the current version is not well-understood and not reliably utilized by anesthesia providers.^{4,5} Furthermore, anesthesia delivery systems have evolved to the point that one checkout procedure is not broadly applicable to all anesthesia delivery systems currently on the market. For these reasons, a new approach to the preuse AACR is being developed. The primary goal of this effort is to develop an approach that is applicable to all anesthesia delivery systems and will be reliably performed.

The effort to revise the AACR was initiated by the Committee on Equipment and Facilities at the ASA 2003 Annual Meeting. A task force was established consisting of representatives from major anesthesia delivery system manufacturers, American Association of Nurse Anesthetists, the American Society of Anesthesia Technologists and Technicians, the anesthesia technician organization and ASA.⁶ The task force met for the first time at the ASA 2004 Annual Meeting but has been working continuously via e-mail since 2003.

Early on in the process, the task force recognized that a single checkout recommendation would not be applicable to all modern anesthesia delivery systems. Not only are there different designs, but some of the systems automate only a portion of the checkout process. As a result, the task force is developing a guideline describing the items that should be checked prior to use rather than an actual checklist procedure. The actual checklist one would use will be based upon the guideline but tailored to the equipment and resources available at a specific anesthetizing location. Once the guideline is established, the task force members intend to develop actual checklists, evaluate them in different departments and, ultimately, make the updated checklists available for reference.

The task force also recognized that complexity is an obstacle to completing the checkout procedure. Much debate has ensued to differentiate the items that must be checked by the clinician from those items that could be checked by appropriately trained anesthesia technicians or clinical engineers. Departments that benefit from skilled technician and engineering support may be able to develop

* Members of the Task Force on the Preuse Anesthesia Checkout: Abe Abramovich (Datascope), Russell C. Brockwell, M.D., James B. Eisenkraft, M.D., Jeffrey M. Feldman, M.D., Carolyn Holland, CRNA, Thomas Krecjic, M.D., Sem Lampotang, Ph.D., Donald E. Martin, M.D., Julie Mills (GE), Michael A. Olympio, M.D., Gerardo Trejo, Cer.A.T., and Michael Wilkening (Draeger).

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checkout procedures that utilize these individuals, thereby reducing the burden on the clinician and increasing compliance with checkout procedures. Certain critical steps in the checkout process will benefit from being checked by more than one individual to reduce the likelihood that human error will fail to recognize an important equipment fault.

Once checkout procedures are developed, it is essential that clinicians be trained to utilize these procedures effectively. This is especially true when a new anesthesia delivery system design is put into service. New designs have significant differences from legacy systems. For that reason, the members of the task force have been very involved with the process of developing the new guideline along with effective training programs.

A number of resources have been utilized by the task force in the process of developing the checkout guideline. Literature on the existing guideline, information from manufacturers and checkout recommendations from other countries have all proven useful. In the past year, a Web-based survey tool has been developed to assess experience with the current AACR. Preliminary results indicate that 29 percent of responders rated their understanding of the existing checklist as poor. Only 20 percent indicated that they perform the preuse check before every case, with the majority (52 percent) performing a preuse check for the first case of the day only.

ASA members are encouraged to take a few minutes to complete the survey anonymously at the University of Florida's Virtual Anesthesia Machine Web site <vam.anest.ufl.edu/logincheck.html>. To access the survey, you need to register as a Virtual Anesthesia Machine user, which is free. After completion of the anonymous survey, you will be provided access to preview a free Web simulation of the 1993 Food and Drug Administration Anesthesia Apparatus

Checkout Recommendations, whose development is funded by the Anesthesia Patient Safety Foundation. The information from the survey is proving invaluable to the process of developing the next checkout recommendation.

The members of the task force will meet at the upcoming ASA Annual Meeting in Atlanta. The goals of that meeting are to complete a draft of the checkout guideline, review recommendations for a departmental policy on equipment checkout procedures and discuss with manufacturers the process of training clinicians to perform an adequate checkout. In the upcoming year, we hope to publish the checkout guideline for wider commentary and to develop and test checkout procedures on a variety of equipment in different departments. Final recommendations from the task force are expected by the 2006 ASA Annual Meeting.

References:

1. Cooper JB, et al. An analysis of major errors and equipment failures in anesthesia management: Considerations for prevention and detection. *Anesthesiology*. 1984; 60:34-42.
2. Arbous MS, et al. Impact of anesthesia management characteristics on severe morbidity and mortality. *Anesthesiology*. 2005; 102:257-268.
3. Anesthesia Apparatus Checkout Recommendations, 1993. <www.fda.gov/cdrh/humfac/anesckot.html>. Accessed on September 9, 2005.
4. March MG, Crowley JJ. An evaluation of anesthesiologists' present checkout methods and the validity of the FDA checklist. *Anesthesiology*. 1991; 75:724-729.
5. Lampotang S, Moon S, Lizdas DE, Feldman JM, Zhang RV. Anesthesia machine pre-use check survey — Preliminary results. (abstracted). *Anesthesiology*. In press. 2005.

What Is Organ Donation After Cardiac Death?

Continued from page 26

whole brain death criteria. We know that for brain dead patients, there can be no consciousness, and therefore no suffering. Our care for those patients usually follows UNOS guidelines for maintaining perfusion of organs until donation occurs. This type of care would be inappropriate for a donor completing the dying process with the cessation of circulation.

Anesthesiologists can show their compassion as physicians by providing leadership on the issue of DCD. Anesthesiologists do care about respecting their patients, their decisions and their comfort, including when they are dying.

For Further Information:

Van Norman GA. Another matter of life and death: What every anesthesiologist should know about the ethical, legal, and policy implications of the non-heart-beating cadaver organ donor. *Anesthesiology*. 2003; 98(3):763-773.

Donation after Cardiac Death: A Reference Guide. This CD is available from the U.S. Department of Health and Human Services, Health Resources and Services Administration. Call your local UNOS/organ procurement organization for a copy. See <www.organdonor.gov/opo.htm> for a list of organ procurement organizations.

2006 Conference on Practice Management: Register Now!

Robert E. Johnstone, M.D., Chair
Committee on Practice Management

ASA will hold its 2006 Conference on Practice Management in Orlando, Florida, on January 27-29. Registration opens this month, with conference brochures to be made available at the ASA Annual Meeting. The conference program will be made available on the ASA Web site in mid-October.

The conference will meet at the Hilton Hotel inside the Walt Disney World Resort in Lake Buena Vista, Florida. Timely registration is encouraged. The conference has sold out in past years, and 2006 registration will be limited to 500. The Hilton is an "official" hotel of Walt Disney World, with a four-diamond rating from the American Automobile Association, making it both comfortable and convenient for conference attendees and their families.

The Conference on Practice Management has a tradition of good speakers addressing hot topics. Speakers represent economic, regulatory, legal and general health care disciplines as well as anesthesiology. Speakers in the plenary and breakout sessions of the 2006 conference will include 16 anesthesiologists, four lawyers, three practice administrators and three consultants, although several speakers could qualify for more than one category. Their topics include those identified as having the greatest impact on the practices of anesthesiologists. The 2004 conference covered the Health Insurance Portability and Accountability Act and privacy requirements, while the 2005 conference introduced pay-for-performance as an emerging issue. The 2006 conference will cover important practicalities of workforce management, customer service, quality improvement and contracting for anesthesiologists.

Talks scheduled for 2006 include: "How to Handle Disruptive Colleagues" by James S. Hicks, M.D., an anesthesiologist, and Judith Semo, J.D., a health care attorney and one of ASA's outside legal counsels; "Strategy for Hospital Contract Renewal in a Subsidy Environment" by Frank A. Rosinia, M.D., an anesthesiologist; "The Future of Anesthesia Practice: A Unified Theory for Anesthesia Group Success" by Mark Weiss, J.D., a legal educator; "Put Fun Into Dysfunction: Improve Group Cohesion" by Will Latham, M.B.A., a health care consultant; and "Customer Service in Anesthesia Practice: Why It Is No Longer Enough Just to Have Good Clinical Outcomes" by Jody Locke, a billing

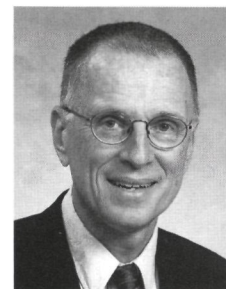
consultant. Two federal attorneys, Gene Rossi, J.D., and Mark Lytle, J.D., will review their activity, "Operation Cotton Candy," which led to the criminal conviction of a pain practitioner. Orin F. Guidry, M.D., will present his "Report From the ASA President," and Genie Blough, M.B.A., will present her "Report From the Anesthesia Administrators Assembly."



Discussion group at 2005 conference. (Photo by the author)

The 2006 conference will again include the popular afternoon discussion tables that allow attendees to move among small groups of speakers and practice management experts reviewing specific topics. The conference also will include a

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Robert E. Johnstone, M.D., is Professor, Department of Anesthesiology, West Virginia University, Morgantown, West Virginia. He is the Director from West Virginia.

When physicians help hospitals to streamline costs and the hospitals reward the physicians, fraud-and-abuse lawyers think of "gain-sharing." Not long ago the federal government barred all forms of gainsharing. Its position has begun to soften, as explained by ASA member Christopher Spevak, M.D., below. An understanding of the legal issues surrounding gain-sharing will become increasingly important as anesthesiologists negotiate pay-for-performance (P4P) incentives into their hospital contracts. The content of this article is provided solely for informational purposes. It is not intended as and does not constitute legal advice. The information contained herein should not be relied upon or used as a substitute for consultation with legal, accounting, tax, career and/or other professional advisors.

Gainsharing: What Every Anesthesiologist Needs to Know

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

Introduction

Anesthesiologists have looked with interest at recently approved gainsharing agreements between hospitals and physician groups. In the past, these agreements were strictly prohibited. What do recent Health and Human Services (HHS) Office of the Inspector General (OIG) advisory opinions mean to anesthesiologists? What are the limitations of the opinions? This article describes gainsharing scope and limitations, as well as the OIG advisory opinion process. It concludes with an analysis of the recent OIG advisory opinions and their implications for anesthesiologists.

Gainsharing Definitions

There are no standard definitions of gainsharing. Gainsharing is understood to mean a financial arrangement between a hospital and physician where a hospital gives the physician a percentage of cost savings generated by the physician's cost reduction and enhanced productivity efforts. Gainsharing always involves two parties — a hospital and a physician (or physician groups). In addition, the employment status of the physician is irrelevant. All that is required is a physician who performs patient care services at a hospital using hospital equipment and supplies.

OIG's Jurisdiction

Historically, the OIG flatly prohibited all gainsharing agreements.¹ However the OIG recently issued advisory opinions approving certain gainsharing agreements between hospitals and physician groups. Advisory opinions apply officially only to the particular case, but they are the best

guidance as to the OIG's views. The current OIG view now recognizes that "proposed gainsharing arrangements could increase efficiency and reduce waste, but must be scrutinized for (i) stinting on patient care; (ii) "cherry picking" healthy patients and steering sicker (and more costly) patients to hospitals that do not offer such arrangements; (iii) payments in exchange for patient referrals; and (iv) unfair competition (a "race to the bottom") among hospitals offering cost savings programs to foster physician loyalty and to attract more referrals."² With the

above in mind, the OIG analyzes proposed agreements against the Civil Monetary Penalty (CMP) statute and federal antikickback statute. Compliance with the Stark Law is under the jurisdiction of the Centers for Medicare & Medicaid Services and therefore not addressed in the OIG advisory opinions. The CMP, antikickback and Stark laws all serve to limit the scope of gainsharing agreements.

Civil Monetary Penalty Limitations on Gainsharing

The CMP provisions of the Social Security Act prohibit payments by hospitals to physicians that may induce physicians to reduce or limit items or services furnished to Medicare and Medicaid beneficiaries.³ Hospitals may be fined a CMP of \$2,000 per patient for violation of the Act. In addition, hospitals are susceptible to a penalty of \$50,000 for each act and not more than three times the total amount of the remuneration offered paid solicited or received.⁴ Congress enacted this legislation when hospital payment was changed from a cost to a prospective payment (diagnosis-related group, or DRG) system as Congress feared the possibility of inappropriate reduction or limitation in beneficiary services. Typical features of gainsharing schemes that would violate the CMP statutes include:

- There is no demonstrable direct connection between individual actions and any reduction in the hospital's out-of-pocket costs (and any corresponding "gainsharing" payment).
- The individual actions that would give rise to the savings are not identified with specificity.
- There are insufficient safeguards against the risk that other, unidentified actions, such as premature hospital discharges, might actually account for any "savings."
- The quality of care indicators are of questionable validity and statistical significance.
- There is no independent verification of cost savings, quality of care indicators or other essential aspects of the arrangement.⁵

Antikickback Statute Limitations on Gainsharing

The antikickback statute prohibits purposeful remuneration to induce or reward referrals of items or services payable by a federal health care program. Parties on both sides of an impermissible “kickback” transaction are liable. “Remuneration” includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind.⁶ HHS has promulgated safe harbor regulations that define practices that are not subject to the antikickback statute as the practices would be unlikely to result in fraud or abuse. The exception applicable to gainsharing agreements is the personal services safe harbor. The personal services safe harbor requires that the aggregate compensation paid for the services be set in advance and consistent with fair market value in arm’s-length transactions.⁷

Stark Limitations on Gainsharing

The Stark (physician self-referral) Law prohibits physicians from referring patients for designated health services (DHS) to entities in which they have a financial interest.⁸ Since inpatient and outpatient hospital services are DHS, gainsharing arrangements are a per se violation of the Stark Law. Similar to the antikickback safe harbors, Stark exceptions to the law may cure the transaction in question.⁹ Stark exceptions that could apply to gainsharing arrangements include the personal services, fair market value, indirect compensation and academic medical center exceptions. Each exception, however, requires that the compensation not vary with the volume of referrals.¹⁰

OIG Advisory Opinion Process

Before analyzing the recently approved gainsharing agreements, it is necessary to understand the advisory opinion process. An OIG advisory opinion is a legal opinion issued by the OIG to the party requesting information as to whether the OIG would consider the party’s proposed business arrangement lawful. An OIG advisory opinion is legally binding on HHS and the requesting party. A party that receives a favorable advisory opinion is protected from OIG administrative sanctions if the arrangement is conducted in accordance with the submitted facts. It is important to note that other parties, however, cannot rely on advisory opinions to avoid sanctions even for identical arrangements.¹¹

The OIG applies legal standards to a set of facts involving certain identified persons. These identified persons have provided specific statements about key factual issues. Because each opinion applies to specific individuals or entities in specific situations, no third parties are bound by, nor may they rely on, an advisory opinion as a blessing upon their own business arrangements.

Cardiology and Cardiac Surgery Proposed Agreements

This brings us to the OIG’s opinions issued on February 18, 2005. Three opinions were directed to arrangements between hospitals and cardiology groups, and three were directed to hospitals and cardiac surgery groups.¹² The OIG grouped the cost savings for products used in the proposed arrangements for cardiac surgery into four categories. The first involved “open-as-needed items.” The second involved “use-as-needed” items. The third consisted of product substitution recommendations, and the fourth category involved product standardization. An independent program administrator would collect and analyze the data and the hospital would pay the physician group 50 percent of the cost savings for a period of one year.

The OIG divided the cardiology proposed arrangements into two of the four categories established for the cardiac surgery program. The first category consisted of 10 product standardization recommendations. The second category included two recommendations consisting of limiting the use of certain vascular closure devices to an “as needed” basis for coronary interventional procedures and diagnostic procedures. As in the cardiac surgery proposed agreement, an independent program administrator would collect and analyze the data, and the hospitals would pay the physician groups 50 percent of the cost savings for a period of one year.

CMP Analysis — Violation But No Sanctions

In the surgery group proposed arrangements, the OIG concluded that the CMP would apply to the limitations on use of certain surgical supplies and product standardization. Likewise, the cardiology proposed arrangement standardization of devices and limitations on the use of vascular closure devices would constitute an inducement to reduce or limit the current medical practice at the hospital and thus trigger the CMP. In all five proposed arrangements, however, a combination of several features provided sufficient safeguards so that the OIG would not seek sanctions. The OIG reasoned that the clearly and separately cost-saving actions, supported by credible medical evidence, would not adversely affect patient care.

In addition, the payments were based on all procedures regardless of the patients’ insurance coverage (subject to the cap on payment for federal health care program procedures) and were reasonably limited in duration and amount. Inappropriate reductions in services were further prevented by utilizing objective historical and clinical measures to establish baseline thresholds below which no savings accrue to the physicians. The product standardizations assured continued physician choice, thus further protecting against reductions in services. In addition, the proposed arrangements provided written disclosures to patients, giving them

an opportunity to review the cost savings recommendations. Finally, the physician's profits would be distributed to group members on a per capita basis. Any incentive for an individual physician to generate disproportionate cost savings would thus be minimized.

Antikickback Analysis — Violation But No Sanctions

The OIG was concerned that the proposed arrangement could be used to disguise remuneration from the hospital to reward or induce referrals by both the cardiology and surgical groups. Specifically, the proposed arrangements could encourage the physicians to admit federal health care program patients to the hospital. The more procedures a physician performs at the hospitals, the more money he or she is likely to receive under the proposed arrangements. The proposed arrangements would not fit in the safe harbor because both the cardiology and the surgical groups would be paid on a percentage basis and thus the compensation would not be set in advance.

The OIG believed the proposed arrangements could result in illegal remuneration if the requisite intent to induce referrals were present. The OIG would not impose sanctions, however, due to the safeguards of the proposed arrangements. First, the circumstances and safeguards of the proposed arrangement reduce the likelihood that the arrangement will be used to attract referring physicians or to increase referrals from existing physicians. Participation is limited to the physicians in the proposed arrangements. The savings are capped and limited to one year. Second, the structure of the proposed arrangements eliminates the risk of rewarding referring physicians to the cardiology and surgery groups. The cardiology and surgery groups are the sole participants in the proposed arrangements. Third, the proposed arrangements set out with specificity the particular actions that will generate the cost savings on which the payments are based. They would be limited in amount, duration and scope.

Conclusion

Gainsharing agreements between physicians and hospitals are no longer flatly prohibited by the OIG. Anesthesiologists and hospitals must nevertheless continue to approach the subject with caution. While the recent opinions may indicate that the gainsharing door is opening, they cannot be read to imply that all gainsharing agreements will not run afoul of the CMP, antikickback and Stark laws. As emphasized above, the OIG opinions cannot be relied upon by anyone other than the requestors.

Readers are urged to keep abreast of gainsharing issues, as they have the ability to decrease costs, increase efficiency and increase revenue to anesthesiologists.

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2006 Conference on Practice Management: Register Now!

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preconference mini-course on "Leadership for Anesthesiologists" taught by faculty from the ASA Certificate of Business Administration (CBA) program.

New for the 2006 conference are industry exhibits and a networking event. Thirty exhibitors from the consulting, billing and management industries will present their

products and services in the breakfast and break areas. An evening reception with drinks and hors d'oeuvres will allow conference attendees to meet alumni of the CBA program, Committee on Practice Management members and other anesthesiologists interested in practice management.

ASA Attends National Conference of State Legislatures' Annual Meeting

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

For its fifth year, ASA participated in the Physicians Advocating for Patients exhibit booth at the National Conference of State Legislatures (NCSL) Annual Meeting in Seattle, Washington, on August 16. The exhibit booth also included representatives of the American Medical Association, American Academy of Family Physicians, American College of Surgeons, the American Academy of Otolaryngology-Head and Neck Surgery, American Academy of Pediatrics, American College of Cardiology, American College of Obstetricians and Gynecologists, American Society of Plastic Surgeons, American Osteopathic Association, American Academy of Ophthalmology and the Washington State Medical Association (WSMA).

NCSL's Annual Meeting provides ASA with an opportunity to increase the visibility of anesthesiologists and to educate state legislators about the achievements in patient safety as well as other issues facing physicians. Anesthesiologists participating on behalf of the Washington State Society of Anesthesiologists (WSSA) included Peter J. Dunbar, M.D., Mark F. Flanery, M.D., and L. Charles Novak, M.D.

The Annual Meeting's venue in Seattle provided an opportunity for representatives of WSMA and WSSA to discuss the tort reform ballot initiative I-330. **Washington** voters will have an opportunity to vote on I-330 on November 8, 2005. I-330, modeled after California's Medical Injury Compensation Reform Act law, would place a \$350,000 to \$1,050,000 cap on noneconomic damages, depending upon the number of individuals and institutional defendants.

It also would place the following limitations on attorney fees: 40 percent of the first \$50,000 recovered; 33 1/3 percent of the next \$50,000 recovered; 25 percent of the next \$500,000 recovered; and 15 percent of any amount over \$600,000. I-330 would eliminate joint and several liability to ensure that defendants are only liable for their proportionate share of fault.

The ballot initiative also would allow for voluntary arbitration agreements and periodic payment of future damages that exceed \$50,000. Juries would be informed of all other

sources of prior and future payments to the injured patient. Additional information is located at <www.yesoni330.org>.

The trial attorneys have placed an initiative on the ballot, I-336, as well. Included in the provisions is the requirement that the Department of Health investigate any health care professional with three paid claims within the most recent five-year period that had indemnity paid in excess of \$50,000. Existing law requires liability carriers to report when there are three paid claims of any amount in a five-year period. I-336 also would increase the number of public members on the Medical Quality Assurance Commission (MQAC) by two; four consumer members currently serve on MQAC.

Additionally MQAC would be required to revoke a physician's license if the physician has had three or more incidents of medical malpractice in a 10-year period found in a final judgment by a court of law. I-336 would require physicians and other providers to disclose to a patient or an immediate family member of a deceased or disabled family member all information regarding an "adverse medical event."

Medical Litigation Reform

Illinois Governor Rod Blagojevich signed S.B. 475, which provides for a \$500,000 cap on noneconomic damages for physicians and \$1 million for hospitals. Among other provisions, S.B. 475 strengthens the expert witness standards and excludes from court "I'm sorry" statements made within 72 hours of the discovery of the outcome/error.

Office-Based Surgery

The **New York** State Health Department plans to reconvene the Committee on Quality Assurance in Office-Based Surgery to study and recommend improvements in safety and outcomes in response to recent adverse incidents in the office setting. Established in 1997, the committee developed office-based surgery guidelines that were adopted by the Department of Health in 2000 and upheld by New York's highest court last year.

Mentoring Research: Reclaiming Our Role as Research Leaders

*John P. Kampine, M.D., Ph.D., Chair
Academy of Anesthesiology Mentors
Foundation for Anesthesia Education and Research*

*Myer H. Rosenthal, M.D., Immediate Past Chair
Board of Directors
Foundation for Anesthesia Education and Research*

The Foundation for Anesthesia Education and Research (FAER), joined by an increasing number of anesthesiology department chairs and others in academic anesthesiology, has been extremely concerned over the insufficient level of anesthesia research originated from our anesthesia programs. It has become quite evident that anesthesiology's share of national competitive funding as measured by data from the National Institutes of Health (NIH) as a specialty is far below that which should be expected. Examination of NIH funding over the past several years to 2003 demonstrates a growth in its research budget of more than 16 percent annually as anesthesiology's share increased less than 1 percent, receiving only 0.3 percent of available NIH research funds. With the annual budget of NIH, beginning with 2004, increasing at a far lower rate of 2.5 percent and with 2005 at 1.99 percent and 2006 at 0.88 percent, the anesthesiology community is in jeopardy of even further erosion of research support. One of the critical indicators of the vital role of academic anesthesia as a major component of anesthesiology as a medical specialty is the continued quest for new knowledge that expands our ability to provide the best care for our patients. Further evidence of the critical state of anesthesia research and research training is found in examining the numbers of academic anesthesiol-

ogy training programs receiving NIH funding. Of the 128 programs approved by the Accreditation Council for Graduate Medical Education, only 54 received any funding in 2004, with 19 of those receiving only one or two grants. Furthermore, of the 1,322 NIH training grants awarded in 2004, only 10 were received by anesthesiology departments.

Recognizing the need for improved academic research productivity, FAER organized an internal advisory committee in 2002 to provide information on mentoring and how

“One of the critical indicators of the vital role of academic anesthesia as a major component of anesthesiology as a medical specialty is the continued quest for new knowledge that expands our ability to provide the best care for our patients.”

FAER could promote and enhance the activities of mentors with regard to the academic career development of anesthesiologists in research and education. The committee consisted of Alex S. Evers, M.D., Simon Gelman, M.D., Ph.D., John P. Kampine, M.D., Ronald D. Miller, M.D., and Ronald G. Pearl, M.D., Ph.D., and was chaired by Dr. Kampine. During the course of several meetings, the committee recommended to the FAER Board of Directors that

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A Resident's Perspective on CMS' Teaching Rule

Jerome Adams, M.D., M.P.H.

Academic anesthesiologists running two resident-staffed operating rooms (O.R.s) with Medicare patients are compensated for only one room. This has been the case since 1995, when the Centers for Medicare & Medicaid Services (CMS) enacted its infamous "teaching rule" reimbursement policy for anesthesiology. Outrageously, an academic surgeon similarly running two resident-staffed O.R.s with Medicare patients receives full reimbursement for both cases, as does an internist or pediatrician overseeing multiple resident clinic rooms, or an academic emergency room physician overseeing concurrent procedures/workups performed by residents on Medicare patients.

Despite numerous assurances that the rule would be changed, CMS did not modify its unfair teaching rule policy in the proposed 2006 Medicare fee schedule changes, which were released on August 1. Academic anesthesiologists remain the only high-risk specialist prohibited from performing overlapping cases and receiving a full fee for each.

Over the past decade, this unfair compensation scheme has demolished academic anesthesiology departments across the United States, both from a fiscal and workforce perspective. Resident education has suffered as our attendings' energies are diverted to keeping departmental finances in the black. O.R.-to-attending ratios have increased (with nurse anesthetist staffing) in order to balance the books, leaving less time for hands-on teaching. The teaching rule's financial strain on departmental morale is obvious — and lessens the attraction of entering academic anesthesiology for the graduating resident.

In ASA's 2004 comments to CMS regarding the teaching rule, former ASA President Roger W. Litwiller, M.D., noted the failing health of academic anesthesiology departments. According to a survey of departments, 78 percent had open faculty positions (average 3.7 open positions), and 25 percent of departments closed an anesthetizing location due to lack of faculty. ASA estimates that the teaching rule costs roughly \$463,000 per teaching program annually and notes that hospital institutions had to take up Medicare's slack by increasing institutional support per full-time equivalent by 75 percent from 2000-02 and another 43 percent in 2003. (ASA's 2004 teaching rule comments can be viewed at www.ASAhq.org/Washington/ASACommentsonTeachingRuleSep04.pdf).

The impact on anesthesiology residents is obvious. A decreased number of academic anesthesiologists also will decrease the number of mentors for research. With staff being pulled into O.R.s to cover cases at the expense of aca-

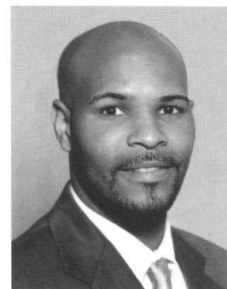
ademic time, department budgets drying up and morale low, academic endeavors suffer. If we do not continue to encourage and foster future research and researchers, then we will relinquish our role as leaders in the field of anesthesiology. With issues such as scope of practice and intraoperative awareness looming, we must remain in the forefront.

"With staff being pulled into O.R.s to cover cases at the expense of academic time, department budgets drying up and morale low, academic endeavors suffer."

Not only will the availability of academic anesthesiologists to residents continue to dwindle under the current teaching rule, but so too will the opportunities of residents to work with the elderly. Faced with a reduction in payment if they let a resident participate in an additional Medicare case, many programs are forced to exclude residents in favor of staff running the rooms with nonphysician anesthesia providers. The number of opportunities a resident gets to provide anesthesia to elderly patients is being diminished in some institutions by the teaching rule. Less experience handling the multiple comorbidities that come with an increasingly aging population will result in less well-trained anesthesiologists and potentially poorer patient outcomes.

Additionally our best and brightest colleagues have historically been heavily recruited to stay on as faculty at academic institutions. With the reimbursement restraints imposed by CMS' teaching rule, however, attendings are essentially functioning as private anesthesiologists at 50

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History as a Subspecialty of Anesthesiology

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

The human soul longs for enduring continuity in life and understanding of the past in order to provide clues to the present and perhaps even the future. Within every enduring organization there exist these three perspectives: past, present and future. In anesthesiology, which was the first medical specialty to be born in the United States, those with an eye for past tradition are alive and well.

Many groups devote time, money and energy to preserving our unique heritage, and I will highlight just a few. First of all, ASA has a tradition of support for the Wood Library-Museum of Anesthesiology (WLM) located at the ASA headquarters office in Park Ridge, Illinois. This unique institution contains a comprehensive library of books and journals, historical archives, an ever-growing rare book collection and a world-class museum of important artifacts and historical equipment, many of which are virtually irreplaceable.

The WLM, however, is more than just a collection of "stuff." It is a hard-working, hands-on Board of Directors (headed by President William D. Hammonds, M.D., and Vice-President Lydia A. Conlay, M.D., Ph.D.), two dedicated librarians (Patrick Sim and Karen Bieterman) as well as Honorary Curator George S. Bause, M.D., and Collections Supervisor Judith Robbins. Many past trustees and committee chairs who have rendered decades of leadership and service include Elliott V. Miller, M.D., Charles C. Tandy, M.D., C. Ronald Stephen, M.D., and Alan D. Sessler, M.D. This group meets three times a year, and their efforts include not only acquisition and preservation of the WLM holdings but active, ongoing educational programs.

Among the many WLM-sponsored events is the Lewis H. Wright Memorial Lecture occurring during the ASA Annual Meeting. Named for Lewis H. Wright, M.D., who pioneered the use of curare in anesthesia, this lectureship has been awarded to such notables as Chauncey D. Leake, Ph.D., Thomas E. Keys, D.Sc. (h.c.), John S. Lundy, M.D.,

Leroy D. Vandam, M.D., B. Raymond, Fink, M.D., Selma H. Calmes, M.D., John W. Severinghaus, M.D., Nicholas M. Greene, M.D., Dr. Stephen, Francis F. Foldes, M.D., M.T. "Pepper" Jenkins, M.D., E.S. Siker, M.D., Peter Safar, M.D., and Maurice S. Albin, M.D., to name just a few. This centennial year, the Wright Memorial Lecturer will be Dou-

"In anesthesiology, which was the first medical specialty to be born in the United States, those with an eye for past tradition are alive and well."

glas R. Bacon, M.D., who has built his academic career, in good part, on the history of organizational anesthesiology. The lecture will be presented on Tuesday, October 25, from 1 p.m. to 2:10 p.m. in the Georgia World Congress Center, Atlanta, Georgia.

There also are four WLM fellowships awarded each year to ASA members to spend time utilizing WLM resources. One special fellowship is named the Roderick K. Calverley Memorial Fellowship, donated by the University of California-San Diego Department of Anesthesiology in honor of Roderick K. Calverley, M.D., a past trustee who was notable for encouraging young anesthesiologists to study their specialty's history.

The most prestigious award that the WLM bestows is the Laureate of the History of Anesthesia, founded by Dr. Greene and awarded every four years to an outstanding scholar and contributor in the field. The first, second and third named Laureates were Gwenifer Wilson, M.D., (1996), co-laureates Norman Bergman, M.D., and Thomas Boulton, M.D., (2000) and Donald Caton, M.D. (2004).

Finally the WLM functions as a university press and publishes scholarly works and co-sponsors the *Bulletin of Anesthesia History* with the Anesthesia History Association (AHA). The *Bulletin*, published quarterly, contains both peer-reviewed and editorially expedited articles that only grow more valuable over time. All articles are indexed by the U.S. National Library of Medicine in PubMed and are available to all interested seekers.

AHA is a community of those interested in anesthesia history founded in 1982 primarily due to the efforts of Dr. Calmes and Dr. Calverley. Additionally that year, the AHA



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Newsletter, later to become the *Bulletin of Anesthesia History*, was inaugurated. Early editors were Dr. Calmes and Dr. Stephen. The society grew, and now AHA organizes biannual meetings, often with other societies such as the History of Anaesthesia Society (HAS) of the United Kingdom, and is established as a specialty section of the American Association for the History of Medicine.

In 1957 the journal *Survey of Anesthesiology* was founded and contained a "Classical File" section written by David M. Little, Jr., M.D., who regularly discussed the characters and developments of the specialty. In his honor, AHA awards the yearly Little prize for the most outstanding scholarly article written the preceding year about the history of anesthesiology.

The International Symposium on the History of Anaesthesia — combining anesthesia history societies from Austria, Australia, Brazil, Canada, Crete, Czech Republic, France, Germany, Ghana, Japan, South Africa, Spain, The Netherlands, the United Kingdom and the United States — meets every four years. The first International Symposium on the History of Anaesthesia was held in Rotterdam, The Netherlands, in May 1982. Subsequent meetings were held in London, United Kingdom (1987), Atlanta, Georgia, United States of America (1992), Hamburg, Germany (1996),

the fifth in Santiago de Compostela, Spain (2001) and this past September in Cambridge, England.

The AHA Annual Dinner is well-attended, and recent dinner talks and speakers include Dr. Albin, "The Wounding, Amputation, and Death of Thomas Jonathan 'Stonewall' Jackson: An Anesthetic Insight"; Robert J. T. Joy, M.D., F.A.C.P., "Ambroise Paré and War and Trauma Surgery in the Renaissance"; Dr. Siker, "Anesthesia, But No Curare"; H. Michael Marsh, M.B., B.S., "Clinical Problems of War: An Australian Family Memoir — 1899-1946"; and Dr. Bause, "Ethereal Pursuits: In Search of Anesthesia's Treasures." This year, Mark A. Rockoff, M.D., will present the "History of Conjoined Twins."

You can become a part of this lively history community by joining the Anesthesia History Association <www.anes.uab.edu/anesthesia_history_association.htm> and the Friends of the Wood Library-Museum <www.ASAhq.org/wlm> and attending the historical events at ASA or AHA meetings. New research findings, schedules of events and opportunities for study can be found in the *Bulletin of Anesthesia History*, which is received by membership in either the Friends of the WLM or AHA. Do not miss the opportunity to meet wonderful people who have made and are making history!

Mentoring Research

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career development awards (FAER Research Training Grants) given to mentored awardees be accompanied by a stipend awarded to the recipient's mentor through the mentor's department with the stipulation that the mentor be provided identifiable time for mentoring the FAER awardee. This recommendation was approved and is now incorporated into the FAER Research Training Grant.

The committee also recommended that an organization be established consisting of mentors whose contribution to the academic development of anesthesiology trainees is recognized to be at the highest level. The Academy of Anesthesia Mentors was established in 2004. The objective of the Academy is to recognize those individuals who, through their activities as mentors, have made important contributions to the development and advancement of academic anesthesiologists in

the areas of research and education. An additional objective is to promote the activities of mentoring among others in the specialty of anesthesiology with the goal of increasing academic activities in research and education and promoting the academic image of anesthesiology. At the present time, membership includes 30 individuals representing 19 academic departments. At its next meeting, topics to be covered will include membership, bylaws, organizational activities and short-term versus long-term goals.

Although much additional effort must be made to improve the current levels of academic productivity in our specialty, it is hoped that the initial steps identified above will begin to provide the impetus and enthusiasm for the progress that is so vital to the future growth of our medical specialty.

2006 CBA Program

ASA is pleased to announce the 2006 Certificate in Business Administration (CBA) Program. The program is designed to provide physicians with the business skills needed to successfully manage the operations and functions of their health care organization or medical practice. The first on-site session will be held the weekend of March 18-19, 2006, at the Woodlands Resort and Conference Center in Houston, Texas, with three additional on-site sessions at the Woodlands throughout the coming year:

August 5-6, 2006
November 4-5, 2006
January 13-14, 2007

The program will consist of a total of 10 modules. Five of the modules will be presented at the on-site sessions, and five of the modules will be completed through distance learning via DVD-ROMs. Please look for the brochure and other information regarding the 2006 CBA program at the ASA Annual Meeting on October 22-26 in Atlanta. Also, please feel free to contact Jeff Schulz in the ASA Executive Office at (847) 268-9145 for additional information.

Component Society News:

Member Assumes University-Wide Role in Cardiovascular Genomics at Duke

Debra A. Schwinn, M.D., a practicing anesthesiologist, was named Program Director for Cardiovascular Genomics at Duke University in July 2005. Dr. Schwinn was the inaugural honorary lecturer for the Foundation for Anesthesia Education and Research in October 2001.

Part of the Duke University Institute for Genome Science and Policy's (IGSP's) Center for Genomic Medicine, the Program in Cardiovascular Genomics focuses on identification, development and implementation of translational models for enhancing the delivery of cardiovascular medicine. Genomics-based research is being used to elucidate new mechanisms underlying the complexity of cardiovascular disease, identify high-risk individuals, design preventive strategies and design optimal interventions.

In her new role, Dr. Schwinn will foster interdisciplinary initiatives

designed to answer fundamental questions in cardiovascular medicine. Teams of researchers include faculty and students from many departments across Duke University as well as other medical centers. Dr. Schwinn comments that, "In many ways, our original (and ongoing) department of anesthesiology-based perioperative genomics research group serves as a model of how teams of investigators can be more powerful at answering 'big' questions than single, isolated researchers."

Duke's perioperative genomics group is comprised of anesthesiologists, surgeons, internists, biostatisticians and statistical geneticists. The group uses genetic variability to identify patients at high risk for adverse outcomes after surgery, enhancing physician ability to intervene with the most appropriate therapy to optimize patient outcome.



Debra A. Schwinn, M.D.

A Resident's Perspective on CMS' Teaching Rule

Continued from page 35

percent of the compensation: running three or four operating rooms, no academic days to organize resident teaching/research and minimal time for hands-on resident teaching in the operating room. Where, then, is the attraction in academic anesthesiology?

The current Medicare teaching rule is unfair to academic anesthesiologists and dangerous to the future

of anesthesiology and must be fixed. The real threat of not fixing it lies in a future generation of anesthesiologists who are not as well prepared as they could or should be.

A decision not to fix the teaching rule will seriously hurt the quality of resident education and the safety of the patients they will care for in the future. In the face of an increase in the elderly population, the very pop-

ulation Medicare serves, such a decision seems penny-wise and pound-foolish.

ASA asks that all members write letters to their Members of Congress about the teaching rule. You can contact Capitol Hill via the Web at <www.ASAhq.org/news/cmsproposal082405.htm>.

Pay for Performance an Insult to Profession

I have read the "Washington Report" column by Ronald Szabat, J.D., LL.M., in the August 2005 ASA NEWSLETTER.

Am I the only physician who finds the idea of a carrot-and-stick approach to reimbursement abhorrent? As a physician, I find it insulting that Medicare and organized medicine would seem to go along with the idea that we need to be somehow financially encouraged to provide quality medical care and discouraged with financial penalties for providing substandard medical care.

Most physicians, including myself, provide excellent medical care to our patients because it is our ethical responsibility as physicians to do so. *We provide the same excellent care to our self-pay patients as we do to our commercially insured patients regardless of the reimbursement.*

Do physicians not see that this is simply another ploy on the part of government to ratchet down reimbursement under the rubric of promoting quality medical care?

There is not going to be any additional money added to Medicare for this. Medicare is already a bankrupt system with multiple unfunded mandates. The government continues to pile on more mandates for spending without any significant increase in revenue. We should return to a system where patients pay us directly for the medical care we provide and value the services we render to them.

Pay for performance, dear physicians, means only one thing: We ultimately will be paid less and less for the medical services we render.

We will continue to see efforts to reduce Medicare reimbursements under a variety of different guises. Never mind the fact that no one has actually done a *large-scale, double-blinded* study to prove that the pay-for-performance concept even works. The same goals of improved care could be accomplished swiftly and at less cost by better educating physicians *rather than treating us as though we are Pavlovian dogs, salivating to the sound of a bell.*

Pay for performance should not be implemented "carefully, slowly and fairly."

It should not be implemented at all. All of organized medicine needs to take a firm stand against this proposal now.

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

MRI Procedures Truly a Team Effort

I read the letter to the editor "Rethinking Anesthesia Care During MRI" in the May 2005 ASA NEWSLETTER by Paul M. Kempen, M.D., Ph.D. His statistics at a California refresher course were appalling [that of those he polled, no provider remained in the scanner room with the patient]. I am now retired, but from 1989 to 1996, I administered — along with a nurse anesthetist (usually the same one) — most of the anesthetics for MRI at a large Midwestern teaching hospital. One of these was even for a 34-year-old fully grown, rather small, silverback lowland gorilla. This was the most fascinating anesthetic I ever administered.

This was a full-sized adult 1.5 Tesla scanner operating at full power. We *always* administered these anesthetics while remaining inside the scanner room. One of the reasons for this, besides being the proper way to monitor the patient, was because of a very close relationship with the MRI technicians. They allowed us to take a standard anesthesia machine inside the scanner but outlined the limits, and we meticulously obeyed these limits. Once we figured out which infusion pump would work within the scanner, we used it. This was easier than *being* the infusion pump with a handheld syringe, which I had done. We also monitored pulse oxymetry and capnography along with EKG and BP.

There is a definite learning curve for administering anesthesia for MRI, and I suggest that this not be given to the youngest or least experienced anesthesiologist but to a team that does most of these all the time. Also we as anesthesiologists need to provide a good working environment for the MRI technicians so that we both work in harmony for the benefit of the patient.

This same team administered multiple anesthetics for children for radiation therapy. We could not stay next to the patient here but did go behind the radiation shield with the technician for the short administration of the radiation. We administered as many as 75 anesthetics to the same patient, some twice a day. Again, the cooperation with the radiation therapy team was most helpful. Seeing the same anesthesia team for most every anesthetic was very reassuring for the patient and parents.

Bernard C. De Leo, M.D.
Sun City Center, Florida

The views and opinions expressed in the "Letters to the Editor" are those of the authors and do not necessarily reflect the views of ASA or the NEWSLETTER Editorial Board. Letters submitted for consideration should not exceed 300 words in length. The Editor has the authority to accept or reject any letter submitted for publication. Personal correspondence to the Editor by letter or e-mail must be clearly indicated as "Not for Publication" by the sender. Letters must be signed (although name may be withheld on request) and are subject to editing and abridgment.

FAER Activities at the 2005 ASA Annual Meeting

The Foundation for Anesthesia Education and Research (FAER) joins with our ASA colleagues and supporters in expressing our sincere condolences to those most affected by Hurricane Katrina. We continue to offer our support for their swift and complete recovery. As of this writing, FAER staff has been monitoring information from ASA regarding details of the Annual Meeting to be held in Atlanta, Georgia, on October 22-26. We hope to have information soon that will assist us to plan for alternate space and time for the various FAER activities, where appropriate.

In deference to the educational needs of the Society, but even more so due to everyone's more somber nature prompted by the recent devastation in the South, after conferring with the ASA Ad Hoc Committee on ASA's 100th Anniversary, the Gala has been postponed and will be rescheduled for the 2006 Annual Meeting in Chicago. Based upon the overwhelming support received for this event in 2005, a larger venue will be sought for the Chicago event in 2006. Members with reservations for the 2005 celebration have expressed a desire to have their reservation held for the 2006 event.

The following list covers FAER's planned events for the 2005 ASA Annual Meeting.

FAER Booth Activities at ASA — Visit Often!

The FAER Booth will contain descriptions of the various FAER programs and initiatives, including:

- Research and education grant programs
- Medical Student Anesthesia Research Fellowship program
- FAER/Abbott Resident Scholars program
- Development activities, including FAER Research Councils
- Academy of Anesthesia Mentors
- Patient information and brochures.

Friday, October 21

Subject to last-minute program changes, on Friday morning, for the second year, one-third of the FAER Resident Scholars will arrive a day early to attend the Society for Education in Anesthesia (SEA) program.

Saturday, October 22

The FAER/Abbott Resident Scholar Program provides selected residents an opportunity to participate in activities at the Annual Meeting, including workshops, scientific sessions, exhibits and, on a space-available basis, refresher courses. Residents also have the opportunity to attend activities of the ASA Resident Component. On Saturday, the 7 a.m. FAER/Abbott Resident Scholar Orientation breakfast for Resident Scholars will be held. Speakers at the event

will include James R. Zaidan, M.D., Chair, Resident Scholar Program; Eugene P. Sinclair, M.D., ASA President; Charles H. McLeskey, M.D., Global Medical Director/Global Marketing Director Anesthesia/Sedation, Abbott Laboratories; Joanne M. Conroy, M.D., Chair, FAER Board of Directors; and Benjamin D. Unger, M.D., Chair-Elect, Resident Component Governing Council. Lee A. Fleisher, M.D., will present "How the Resident Scholar Program and FAER Starter Grant Helped Me Return to the University of Pennsylvania" and Terese T. Horlocker, M.D., will present "Physician, Educate Thyself: The Feasibility of Virtual Regional Anesthesia."

The Saturday noon Luncheon for Friends of the Foundation, FAER Award Recipients and Corporate Partners will be chaired by Mark J. Lema, M.D., Ph.D. The discussion topic is "Raising Money From Industry: Beyond Clinical Trials and Within Ethical Guidelines." The speakers are Bruce Gingles, Vice President, Cook Critical Care, who will discuss "Strategies for Seeking Funding from Device Companies," and Dr. McLeskey from Abbott Laboratories will talk on "Garnering Industry Interest in Providing Financial Support."

Sunday, October 23

FAER booth opens in the ASA Resource Center of the Georgia World Congress Center. Contributions will be accepted for both FAER and the ASA Centennial Fund Development Campaign.

Monday, October 24

2005 FAER Honorary Research Lecture: Alex S. Evers, M.D., "Understanding Anesthetic Steroids: Sites and Mechanisms of Action."

2005 FAER Panel: "Clinical Research in Anesthesiology: Who Should Do It, How to Fund It and How to Publish It." Ronald G. Pearl, M.D., Ph.D. (moderator); David O. Warner, M.D., David J. Clark, MD, Ph.D., Alison E. Cole, Ph.D., and Michael M. Todd, M.D.

Tuesday, October 25

The scholars program closes with a reception Tuesday night attended by ASA officers and FAER Board members. Sponsorship of the program is shared by Abbott Laboratories and FAER.

Moving the ASA Annual Meeting from New Orleans to Atlanta has been a monumental task, but it pales in comparison to the challenges ahead for our fellow citizens trying to recover from Hurricane Katrina. It is with their recovery in mind that we rededicate ourselves to our mission.

Explore the FAER activities at ASA meeting this year. Please stop by our booth in the ASA Resource Center.

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ASA 2005 Annual Meeting

**Complete coverage of the ASA 2005 Annual Meeting will appear in
the December 2005 and January 2006 ASA NEWSLETTERs**