

Who Was Really



Human acupuncture chart with measurements illustrated in Hua Shou's *The elucidation of the fourteen acu-tracts* c.1341.



Who discovered painless surgery? History gives us clues but not always answers, and yet, the history of anesthesia and pain medicine has helped to shape our specialty into what it is today. In this issue, we recognize those who have made history and those who strive to preserve it.

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SUBSTANCE ABUSE HOTLINE:

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Lost Luggage

Editor's Note: *I have been involved with the Wood Library-Museum of Anesthesiology (WLM) since 1989 when I was first awarded a WLM Fellowship. I have served on the Board of Trustees since 1996 and as Secretary-Treasurer since 2001. The opinions expressed here are my own and are not those of the WLM or the Board of Trustees or its officers.*

There is nothing quite as frustrating as arriving at a destination ready to begin a vacation or a meeting — and then learning that the airlines misplaced your luggage. The History of Anaesthesia Society was meeting in Dundee, Scotland, in late June. It is a two-day meeting, usually with fascinating papers and many dear friends. The trip did not start out well, with a three-hour delay on the ground in Rochester, Minnesota, waiting for thunderstorms to clear at O'Hare International Airport in Chicago. Connections were tight, and our arrival in Heathrow was two hours behind schedule, which means we missed our scheduled flight to Glasgow. Four hours late, we arrived in Scotland — with none of the luggage! During our stay, rumors of the arrival of one bag occurred. On Saturday, shortly after the close of the meeting, two terrorists drove a truck into the main terminal of Glasgow Airport. Any hope of getting home the next day dimmed, and the luggage seemed lost forever.

In some ways, the history of anesthesiology can be likened to the luggage on my recent trip. The work of the WLM is to preserve our heritage before it is completely lost to time. Named after Paul Meyer Wood, M.D., the first recipient of the ASA Distinguished Service Award (DSA), the WLM serves as an active library and as a repository of the history of anesthesiology — with an emphasis on what has happened in the United States specifically and North America in general. The museum has a gallery with display cases filled with equipment that delineates our shared history. Beginning with a replica of the 1846 Morton Inhaler, through to the last generation of the Ohmeda and Drager anesthesia machines, how anesthesia was administered and how anesthesiologists have made anesthetics safer is there for the entire world to see. A recent innovation created by Honorary Curator George Bause, M.D., and Collections Supervisor Judith Robins, M.A.L.I.S., is a self-guided audio tour. Thus our accomplishments are now available to the general public as well as those who specialize in anesthesia.



Douglas R. Bacon, M.D.,
Editor

One display cabinet is reserved for memorabilia associated with the founder, Paul Wood. Forever immortalized in the library-museum's name, Dr. Wood's life has always fascinated me. He was a hero of World War I, having organized an ambulance corps and served on the Italian front. His medals are on display. Also preserved are his DSA citation and a loving cup given to him for his service to the specialty by the Associated Anesthetists of the United States and Canada, an organization that folded into the International Anesthesia Research Society. Dr. Wood never served as president of ASA; rather he toiled as its secretary-treasurer at a time when the Society's membership grew 10-fold. A founding director of the American Board of Anesthesiology and

(no surprise!) its first treasurer, Dr. Wood's career was one of dedicated service without ever truly seeking the limelight. This dedicated service to the specialty — because it was the right thing to do — has always inspired me.

The library component of the WLM remains the best single source for any publication written on anesthesiology in the 19th or 20th centuries. Many of these references are unique to the WLM — and anything that is not within the confines of the collection can be obtained by interlibrary loan. For ASA members not affiliated with a major medical center or a strong library, the WLM is an attractive alternative for reference needs. A reasonable number of reference requests remain free to ASA members. Even more important in our increasingly electronic age, it is possible to speak with a real person. Librarian Karen Bieterman, M.L.I.S., is an exceptional individual with the right combination of experience and intelligence to make obtaining the reference material painless. As these words are written, the WLM has just hired an assistant librarian, Catlin O'Connor, M.L.I.S., to help with the overflow.

One of the less visible parts of the WLM is its archival collection. As the official repository of ASA documents, it is possible to trace the history of a committee or a position that the Society has taken through the years. Additionally, anesthesiologists have donated their papers, books and memorabilia to the archives. The collected letters of Paul Wood, for example, are a window into the world of anesthesiology from 1930-1963. The collection is varied and rich, covering many eras in anesthesiology history. Each collection received is like a "lost" suitcase returned and a bit of our heritage returned to its home. Earlier this year,

an archivist, Felicia Reilly, M.A.L.S., was hired to help organize and preserve our collection. Soon “Finder’s Aids,” documents that delineate the nature and extent of an individual collection, will be on the Web, making the WLM’s collection accessible to scholars who do not wish to travel to Park Ridge, Illinois, to assess it.

The recent addition of two staff members has been possible through both the ongoing, generous support of ASA and the sound financial management of the WLM Board of Trustees. This sound financial backing has allowed new programs to proceed, such as digitizing the rare book collection, a treasure trove of unique material from primarily the 19th century. But the collection also houses documents going back hundreds of years that are connected to the “prehistory” of the discovery of surgical anesthesia in the 1840s. Restoration and cataloging of the museum collection in a digital format also is proceeding. The images of the equipment can then be used by scholars to study how and with what materials the early specialists in our field created a certain apparatus. Posting these images on the Web also will let the world know about our collection and allow for more widespread use.

Yet the rarest gem at the Wood Library-Museum of Anesthesiology is Paul M. Wood Distinguished Librarian Patrick Sim, M.L.S. He has been in his current post for more than 35 years and has watched the WLM grow and prosper over that time. The repository of knowledge within his mind concerning the archives, rare book collection and museum is extraordinary. One of the challenges faced by the WLM Board of Trustees has been transferring this knowledge to paper or electronic files. In the coming year, Mr. Sim and the WLM will publish his annotated bibliography of the rare book collection. This publication will catalog the collection and put into historical context the importance of each item. It will be both a source for historians and a guide to the most important collection of rare anesthesiology references in the world.

So far, like the luggage I checked on that June day in Rochester, all seems well. There are, however, omens present, not dissimilar to the three-hour ground delay on my trip to Scotland. The WLM does not attract corporate sponsorship and thus is far more dependent on ASA funding than the Anesthesia Patient Safety Foundation (APSF) or the Foundation for Anesthesia Education and Research (FAER). Outside sponsors intuitively understand the need for research. Patient safety is a “hot button” item at the moment, and APSF has led the specialty and the world of organized medicine in this critical, vital endeavor. Indeed APSF has revolutionized the way in which errors within the practice of medicine are viewed. While corporations understand their obligations to continue research efforts and wish to make safer the world of medicine in which their products and services are used, there is little intrinsic

understanding of why the heritage of anesthesiology needs to be preserved.

The WLM endowment is substantial. It is a work in progress, started more than 35 years ago as a way to help support the WLM mission. The money is enough to help with expenses in the short term, but not enough to support the full mission or provide a sizable portion of the budget over the long haul. The Board of Trustees is at a crossroads — should the endowment be spent to support current expenses and leave the future in doubt, or should money be put aside to ensure that the programs of the WLM, such as the Laureate, the fellowships and the Lewis H. Wright Memorial Lecture, continue in perpetuity along with the myriad other financial responsibilities to which the WLM is committed? Fifteen years ago, the WLM, along with FAER and APSF, was told to seek ways to become financially independent of ASA. Walking an austerity pathway for 10 years, money was laid aside to build the WLM endowment, and some of the exciting programs now beginning were put on indefinite hold. Over the past five years, ASA changed its financial philosophy, requesting that the WLM and other foundations not seek fiscal independence; rather, a “guarantee” from ASA was given that funding would be available and uninterrupted except in the event of a major funding shortfall. This decision has allowed the WLM to slowly ramp up these long-neglected projects. Significant reduction in funding at this point could cause the WLM to retrench, return to the austerity mentality and attempt to mature the endowment to the point where there is no longer financial dependence on ASA. The 2008 ASA budget allocation may begin this decision process definitively for the WLM Board of Trustees.

As we begin our long march through the 21st century and begin to create our second 100 years of history, ASA as a whole, and each anesthesiologist individually, needs to determine what the value of our heritage — and indirectly the WLM — may be. As these words are generated, 80 percent of my luggage has been returned from its Scotland sojourn. The collections of the WLM catalog an ample portion, but not yet 80 percent of our history. We are the best specialty-specific library and museum in the world. Our heritage — and the story of how anesthesiology came to where it now stands, replete with the roads taken and the paths that were not trod — is critical to understanding who we are and what our specialty could possibly become. In many ways, it defines the specialty’s view of professionalism. Furthermore, that heritage can be used to inspire new research ideas, create new initiatives and revive programs, when necessary, that worked in the past.

The WLM guards and protects our heritage, allowing it to be used appropriately. Like all ASA activities, it is a tremendous responsibility gladly taken.

— D.R.B.

ASA Financial Check-Up: Are the Mission and the Checkbook in Alignment?

John M. Zerwas, M.D., Treasurer

Open an organization's "checkbook" and you should clearly see its moral and ethical compass, its vision and its mission. I believe ASA is no exception to this rule. Through its House of Delegates (HOD), the Society strives to bring the voice of the membership to all of its deliberations and decisions. Approximately two-thirds of the annual budget is dedicated to those programs and initiatives that the HOD deems most relevant to the integrity of the practice of anesthesiology and value to the membership.

Upon review of the budget for the past several years, it is clear that ASA is dedicated to bringing relevant education and resources to its members that will foster the development and communication of new knowledge. Our Foundations are an example of this, where we have spent approximately 10 percent of our annual income to promote patient safety (Anesthesia Patient Safety Foundation [APSF]), foster new knowledge (Foundation for Anesthesia Education and Research [FAER]) and preserve our rich history (Wood Library-Museum of Anesthesiology [WLM]). This is in addition to the numerous committees and initiatives that ASA has created at the direction of the HOD. The ASA Annual Meeting is considered the premier venue for educational opportunities for anesthesiologist worldwide. Likewise, the journal *Anesthesiology* is among the best of all medically oriented publications. On the whole, more than 40 percent of our revenue is dedicated to promoting new and current knowledge in anesthesiology.

In addition to our commitment to clinical excellence and safety, ASA has a primary role in advocacy and practice management. Our Washington Office staff is among the most respected on the Hill and has had a terrific impact on our behalf over the years. The Legislative Conference is a sell-out every year, and our ASA Political Action Committee is among the most effective political action committees. Similarly, our annual Conference on Practice Management continues to set record numbers in attendance and has become the "must attend" conference for many of our members. In all, we spend approximately 15 percent of our annual revenues toward practice management and advocacy-related activities.



John M. Zerwas, M.D.

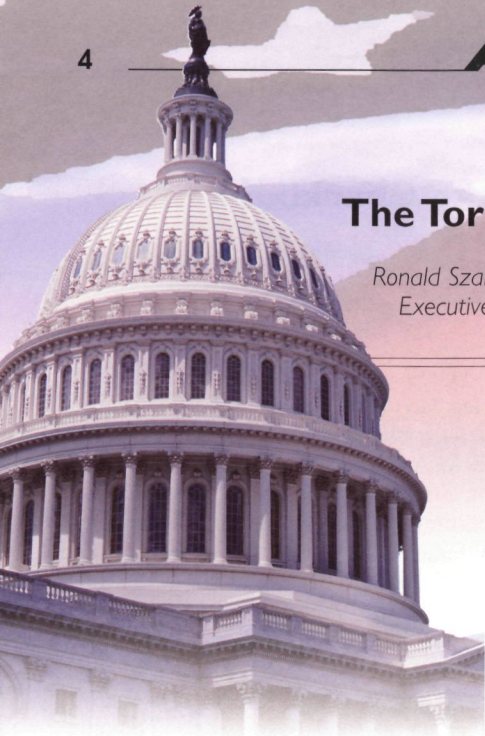
The financial affairs of the Society are delegated to the Section on Fiscal Affairs (SFA), with ultimate authority granted to the ASA Board of Directors. This section consists of the treasurer, the assistant treasurer and members of the Committee on Finance of the Board of Directors. All actions and reports of the SFA and the board are subject to review and/or approval by the House of Delegates.

The fiscal year for ASA is also the calendar year, which is typical for many organizations and businesses. Though we were budgeted for a slight net loss this past year, the budget came in with a very strong bottom line at more than \$2.2 million. This considerable swing from budget to actual is related to unbudgeted revenue from publisher Lippincott

Williams & Wilkins and to the conservative spending by the committee chairs and members. The 2007 budget is also targeted for a net loss, but year-to-date is tracking very close to the prior year performance. Our total assets continue to grow as a result of our strong financial management in the Park Ridge, Illinois, office as well as a sound investment strategy. Our audit occurs annually by the firm of Blackman & Kallick. There have been no concerns or recommendations from our auditors.

The budgeting process begins early in the fiscal year when a request is made to all committee chairs to submit a budget request for the following year. This documentation is then compiled along with the proposed budgets for the Park Ridge and the Washington offices. The SFA meets at the March meeting of the Board of Directors and considers funding proposals from APSF, FAER and WLM and makes recommendations to the Budget Committee on their funding as well as other issues of importance to creation of the next year's budget. The Budget Committee (consisting of the president, president-elect, first vice-president, treasurer and assistant treasurer), along with ASA staff, then meets in the late spring to create a draft budget. This budget goes to the Administrative Council for consideration and approval in June and is subsequently presented at the Board of Directors meeting in August for approval. Final approval is vested in the HOD at the Annual Meeting. Modifications to the

Continued on page 5



The Tortured Path of Legislation

Ronald Szabat, J.D., LL.M.

Executive Vice-President – External Affairs and General Counsel

Whatever you learned in high school civics, forget it. Or better yet, use that earlier learning, however dimly recollected, as only some indication of “how a bill becomes law.” Why? Because the legislative process is not linear.

True, it was somewhat easier to follow during the recent Republican-controlled years in the U.S. House of Representatives, when committees of jurisdiction were largely ignored and bills were simply taken straight to the House floor; but that streamlining of the process assumes too much familiarity.

Even my own daughter, who just earned top marks in a high school sophomore advanced placement gov-

ernment course, still has endless questions for me. Where, she asked (as my wife picked me up at midnight in front of the House Longworth Office building after grueling all-day committee markups), did the members of Congress physically do most of their work? And as we drove away to a weekend business meeting at that ungodly hour, my wife and I, both former Hill staffers, simply smiled and started explaining.

With apologies for these personal references, these questions, your questions and the unique way that our federal democracy makes law remind me that it is frequently a highly foreign process to anyone outside immediate lobbying circles.

So, why is all this “process talk” important right now? Because major legislation that will shape the course of government funding for Medicare and a 10-year reauthorization of the State Children’s Health Insurance Program (CHIP) is making its way in a tortured path through the House and Senate and into a joint House-Senate conference committee. And, all the while, President Bush says that he will veto whatever Congress sends him, meaning

Congress will have to go back and start again.

Back to basics, there are three congressional committees that handle Medicare legislation: House Ways and Means, which has jurisdiction over all of Medicare, both Part A (hospitals) and Part B (physicians and other health care providers); House Energy and Commerce, which has jurisdiction over Medicare Part B and such huge programs as Medicaid and CHIP; and the Senate Finance Committee, which has broad sway over all of Medicare and these other major federal health programs. Of special note, Ways and Means and Finance also are the sole tax-writing committees in Congress. When organized medicine lobbies, it therefore spends an inordinate amount of its time working with and trying to influence the chairs and members of these committees.

All things being equal, if the majority of these folks are not with us, especially the Democrats who now control both Houses, then our hopes and aspirations will never be realized. That is why, for example, you will not currently find information on our Web site on well-meaning bills by House Republicans to abolish the sustainable growth rate (SGR) formula. Under current committee and House rules, there is simply no way for those bills to move forward. As with any Congress, our principal efforts must be in building support with our friends on the majority side of the aisle for legislation that can and must move forward, while also keeping well-traveled open channels to the minority. That’s not partisan politics on our part; it’s just the way it is.



Ronald Szabat, J.D., LL.M., is ASA Executive Vice-President – External Affairs and General Counsel, managing its Washington, D.C., office.

Regarding the CHIP and SGR bills, high theater has prevailed in its recent consideration. In late July, for example, House Republicans, angry about their minority status and lack of ability to influence these bills in a substantive way, literally delayed committee proceedings in the House Energy and Commerce committee for many hours by insisting on a verbatim reading of the 500-page bills in committee, and they were able to do so multiple times. Ultimately that committee simply gave up and allowed nearly the same bill to work its way through the Ways and Means Committee, later through the House Rules Committee (where further changes were made mostly behind

closed doors), and onto the House floor before the five-week congressional recess. At the same time, at the beginning of August, the Senate endured endless procedural obstacles in moving its CHIP bill forward.

Ultimately, movement of these huge, costly and controversial bills is very important to every anesthesiologist and physician in America. Unless Congress acts, anesthesiologists and all of medicine face a 10-percent cut in Medicare payments beginning in January 2008 and a 15-percent cut from the current baseline in 2009 due to the unfair SGR formula. The House bills under consideration would provide a two-year positive Medicare physician

payment update and would set the stage for a repeal of the SGR. Such movement is highly consistent with ASA's public policy goals.

Consequently, ASA and all of medicine are heavily involved in shaping bill content and seeing that legislative movement is forward, not backwards or sideways as is always possible in the nonlinear world of legislation. The path ahead will surely take us late into the year. Please stay tuned for opportunities to help advance our ASA causes. For up-to-date information on the details and progress of these bills, please visit our Web site at www.ASAhq.org/government.htm#alerts.

Administrative Update: ASA Financial Check-Up

Continued from page 3

budget can and do occur throughout the year at the discretion of the president and the board within rules established by the Society.

The ASA balance sheet reveals a very strong cash and cash equivalent position. ASA's assets at the end of the 2006 fiscal year were in excess of \$60 million and have continued to grow through the 2007 fiscal year. The Society's assets are invested in a diversified portfolio that reflects a balance of 35 percent fixed assets and 65 percent equities.

This investment strategy was fully implemented in January 2007 and has yielded a return of more than 14 percent from July 2006 to June 2007. The firm of DiMeo Schneider & Associates manages the overall portfolio and meets with the SFA on a quarterly basis by conference call or in person.

In conclusion the 2007 ASA fiscal checkup reveals a strong and vibrant Society dedicated to creating member value. The mission, vision and values of the Society continue to be the lighthouse that guides the budgeting process. I thank all the members of the SFA for their hard work and dedication: James D. Grant, M.D. (Assistant Treasurer), James M. West, M.D. (Committee on Finance Chair), Karl E. Becker, Jr., M.D., Richard R. Johnston, M.D., Lawrence J. Roy, M.D., and Kenneth I. Mirsky, M.D. I also commend our current President, Mark J. Lema, M.D., Ph.D., for his hard work and prudent financial decisions as he leads this great Society.

Lewis H. Wright Memorial Lecture:

Rodney N. Westhorpe,
M.B., B.S., F.R.C.A.,
F.A.N.Z.C.A., to present

*'He Took It Well,
Didn't He?'*

Susan A. Vassallo, M.D., Chair
Lewis H. Wright Memorial Lecture Committee
Wood Library-Museum of Anesthesiology

The Lewis H. Wright Memorial Lecture is sponsored annually by the Wood Library-Museum of Anesthesiology (WLM) and honors its namesake, who was a pioneer in American anesthesiology. Dr. Wright was committed to enhancing the stature of anesthesiology as a clinical science and as an advanced medical specialty. He was a founding member of the WLM Board of Trustees and later served as its president emeritus. In 1973, the New York State Society of Anesthesiologists endowed this lectureship to honor Dr. Wright, who died in 1974.

This year's distinguished guest is Rodney (Rod) Neill Westhorpe, M.B., M.S., F.R.C.A., F.A.N.Z.C.A., Councillor, Australian and New Zealand College of Anaesthetists; Past President of the Australian Society of Anaesthetists (1998-2000); and Specialist Paediatric Anaesthetist, Royal Children's Hospital, Melbourne.

Dr. Westhorpe is a third-generation Australian whose great grandparents emigrated from England, Ireland and Scotland.

In 1977, he graduated from Monash University Medical School and served as a resident medical house officer at Australia's Ballarat Base Hospital (1972-74). He then spent two years in England as a Senior House Officer in Anaesthesia.

"How then did anesthesiologists and anesthesiologists distinguish themselves in this environment? Dr. Westhorpe will analyze this struggle for status and recognition. He will highlight key events in our specialty's development and will pay special attention to the relationship between anesthesiologists and surgeons."

Lewis H. Wright Memorial Lecture

Tuesday, October 16, 2007
12:50 p.m. – 1:50 p.m.
Moscone Center South,
Gateway Ballroom 102

After an appointment as a senior registrar at Hammersmith Hospital, Dr. Westhorpe returned to Melbourne and has practiced at the Royal Children's Hospital for 30 years.

During this long tenure, Dr. Westhorpe's clinical practice



Susan A. Vassallo, M.D., is Anesthetist and Assistant Professor of Anaesthesia, Massachusetts General Hospital and Harvard Medical School, Boston, Massachusetts.

included anesthesia for all types of pediatric surgery. Coincidentally he developed a talent for medical administration. He served as the Chairman of the Victorian Section of the Australian Society of Anaesthetists and, in 1987, was a founding member of the Australian Patient Safety Foundation. His commitment to anesthesia and organized medicine was recognized when he was elected as President of the Australian Society of Anaesthetists (1998-2000). From 1995 to June this year, Dr. Westhorpe was a councillor of the Australian and New Zealand College of Anaesthetists. This board sets the standards for anesthesia training programs, executes examinations and oversees continuing medical education programs. As one of 12 elected councillors, Dr. Westhorpe played a pivotal role in the governance of the College.

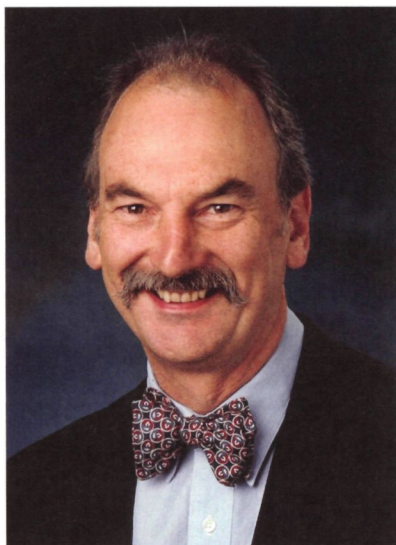
In 1995, Dr. Westhorpe joined the editorial board of the journal *Anaesthesia and Intensive Care*. Each month the iconic cover features a significant piece of equipment with a special relevance to our practice. The "cover notes" or description of the artifact and its place in history have become the hallmark of this journal. Since 1989, Dr. Westhorpe, assisted by Christine Ball, M.D., has designed 83 covers and authored the corresponding "cover notes." Some of the artifacts he has highlighted include Vaporisers, Trendelenberg's Cone, Magill's Laryngoscope and White's Ethyl Chloride Inhaler. His topics have spanned a century and a half, and he has even described "modern inventions" such as etomidate and propofidid. Dr. Westhorpe has a special interest in the history of barbiturates and has shared his perspective on their introduction into clinical practice. In 1997, he was appointed Honorary Curator, Geoffrey Kaye Museum of Anaesthesia History at the Australian and New Zealand College of Anaesthetists in Melbourne.

This year's Lewis H. Wright Memorial Lecture is titled "He Took It Well, Didn't He?" Dr. Kasner Moss, a pioneer Australian anaesthetist, made this statement in 1921. He observed, "After a successful anaesthetic of 3-4 hours, the surgeon doesn't congratulate the anaesthetist, he simply remarks 'He took it well didn't he?'" In this year's lecture, Dr. Westhorpe will reveal the evolution of medical profes-

sionals throughout the ages. While medicine was a respected endeavor in Egyptian, Greek and Roman times, its place in society's hierarchy fell during the Middle Ages. Priests held the upper hand; although physicians advanced in status, surgeons were held in less esteem. This hierarchy changed during the major wars of the 17th and 18th centuries. As surgeons developed more sophisticated instruments and techniques, their skills were recognized and valued. In turn, physicians and surgeons sought to gain the public's support and approval. Advancement and promotion were not always based on merit and achievement. This flaw motivated physicians and surgeons to conduct more rigorous training and specialization. In the 1840s, there were obstetricians and surgeons, but there were no anesthetists. Dr. Crawford W. Long, a surgeon, and William T.G. Morton, a dentist, were administering anesthesia in America, and soon, general practitioners incorporated this skill into their practices.

How then did anesthesiologists and anesthetists distinguish themselves in this environment? Dr. Westhorpe will analyze this struggle for status and recognition. He will highlight key events in our specialty's development and will pay special attention to the relationship between anesthetists and surgeons. He will recount the contributions of prominent anesthetists through the world. Dr. Westhorpe will describe the evolution of the practitioner "chloroformist or etherizer" to "anesthetist."

The WLM is proud to have Rod Westhorpe as the 2007 Lewis H. Wright Memorial Lecturer. Under his direction the cover note for the journal *Anesthesia and Intensive Care* has become an iconic feature. Each month we are reminded of the drugs, equipment and people who have influenced our clinical practice. With his stewardship, the Geoffrey Kaye Museum of Anaesthesia History has flourished and is a remarkable institution that honors the history of anesthesiology. We thank Dr. Westhorpe for sharing his perspective on the evolution of the anesthetist and for recognizing the achievements of our forefathers.



Rodney N. Westhorpe, M.B., B.S., F.R.C.A., F.A.N.Z.C.A.

Preserving our Heritage

Lydia A. Conlay, M.D., Ph.D., Vice-President
Wood Library-Museum of Anesthesiology Board of Trustees

It has been a remarkable year for those interested in preserving anesthesiology's heritage. ASA, through the Wood Library-Museum of Anesthesiology (WLM), has been at the forefront of such efforts. This seems most appropriate insofar as — regardless of “who was first” — anesthesiology is a uniquely American innovation. And although the cycles of the medical antiquities market are poorly understood, following a seemingly protracted “dry spell,” a number of interesting items have recently come on the market. Such items may well be available for purchase only once, and are either preserved by museums, or may disappear into private collections.

The trustees of the WLM dedicate their efforts to preserving the heritage of our craft for our members, students of medical history and interested individuals around the world. There are several quite distinct activities involved in this endeavor: finding and/or acquiring the items of interest (as highlighted in last year's September *NEWSLETTER*); preserving them for decades to come; and last but not least, making the objects and/or knowledge associated with them available while keeping them safe.

Each September the WLM Trustees compile a section of the *NEWSLETTER* with the goal of updating our membership on issues related to our specialty's heritage.



Lydia A. Conlay, M.D., Ph.D., is Professor of Anesthesiology, Baylor College of Medicine, Houston, Texas.



Pictures of portraits of Charles T. Jackson, M.D., and Élie de Beaumont, M.D.

This issue is one of several with the goal of sharing with our membership the “nuts and bolts” of maintaining and running a library and a museum. First, in addition to the WLM, there are two other major museums containing anesthesiology artifacts: The Arthur E. Guedel Memorial Anesthesia Center in San Francisco (see page 25) and the Crawford W. Long Museum (see page 22) just outside of Atlanta. Selma H. Calmes, M.D., and William D. Hammonds, M.D., are or have been trustees of these organizations in addition to their roles at WLM, and each has provided a brief description of the museums and their respective collections. Next, WLM Honorary Curator George S. Bause, M.D., provides a pictorial sampler of this year's new acquisitions. The incomparable Paul M. Wood Distinguished Librarian Patrick Sim describes an exciting new acquisition, classic Chinese texts on acupuncture circa 1600, and also puts an interesting spin on the question of “Who was really first?” (page 11). Last but not least, following two decades in Boston, I write regarding the acquisition of a previously unknown letter demonstrating just how fast the news of ether — and of the ether controversy — spread across the globe. But first, some of the “nuts and bolts.”

Not to listen to the false statements of Morton, or to those of his hired writers. A ~~man~~ person by the name of Edward Warren is Morton's agent, and partner. He has written abusive articles against me and I understand Morton tries to make profit at a distance believing that he is Doctor Warren an eminent surgeon. I saw by a letter received lately from a gentleman in France that he has thus been imposed upon. Well, I believe is now just entirely hors du combat by the publication of his own letters showing that he knew nothing about the application of ether vapour.

When you find the letter from Dr. Jackson to Elie de Beaumont and I do not wish to believe that only to use it as a long & the letter. It will not answer the ends of justice in nothing more or less with the letter from Dr. Jackson to Elie de Beaumont.

Dr. Elie de Beaumont
Paris
Rue de la Paix
Paris
France

Paris, France, 10th Nov 1847

REC
17MAY
1847

LIVERPOOL
MAY 15
1847

FORWARD
MR R. GREEN
AGENTS
LIVERPOOL

I write you this letter to put you in possession of the facts but I do not desire at present its publication, since it would interfere with my public duties to have to defend every point I have written upon, and I shall wait until I can bring my evidence before a Court of Justice where it will be admissible and where I shall not be exposed to vexatious suits for bringing it forth. I shall leave it for your discretion as to the extent of publicity you may give to the case. It may be well that you should caution your friends in the Academy

"It is only by mutual support that Scientific men can hope to rescue their discoveries from the rapacious hands of speculators and pirates."



"His ignorance is only equaled by his insolence and dishonesty."

Previously unknown and unpublished letter from Dr. Jackson to Elie de Beaumont.

By What Paths Do Acquisitions End Up in the WLM?

The first step in managing any collection is the formulation and updating of the collection policy. This is a major and recurring undertaking by the trustees, since it dictates what is of sufficient interest to warrant the expense of buying, cataloging, storing, archiving, etc. An example of a recent change to the collections policy includes the collecting of early Web sites in our specialty. One of the earliest, and probably the earliest in anesthesiology, was the Society for Ambulatory Anesthesia (SAMBA) Web site, mastered by J. Lance Lichtor, M.D. When I've seen Lance at meetings for the past several

years, I've always asked him if he's found an early version of the SAMBA Web site anywhere. The answer has always been the same: "No." No, he didn't keep any old computers. No, then-SAMBA Executive Director Gary W. Hoormann didn't back it up. And *no* to any of the other possible places where a copy might have been. But about a month ago, I got an e-mail from Lance who, while moving, found a copy of the old disks. Although Web sites are an entirely new medium for WLM, this information will surely be of interest in 50 years. Our thanks to Dr. Lichtor for his perseverance and his painstaking packing.

Probably the most exciting and colorful part of acquiring artifacts comes from their purchase or acquisition, in

that the medical antiquities business is not so dissimilar from the antique business in general. Much of the information is transmitted by contacts and dealers known to trustees, in some cases, for decades. Desirable items from dealers are not on the market for very long, so the WLM's Rapid Acquisition Team (RAT) quickly convenes, examines information regarding the item(s) in question — such as its provenance and any information that might lend credence to its authenticity (or not) — and estimates its value. If from a major dealer, the process and price may be negotiable. Sometimes the item is acquired, and sometimes not. Two items featured in this issue were obtained this way (the acupuncture collection and the Charles T. Jackson, M.D., letter — see graphic on this page and acupuncture article on page 11).

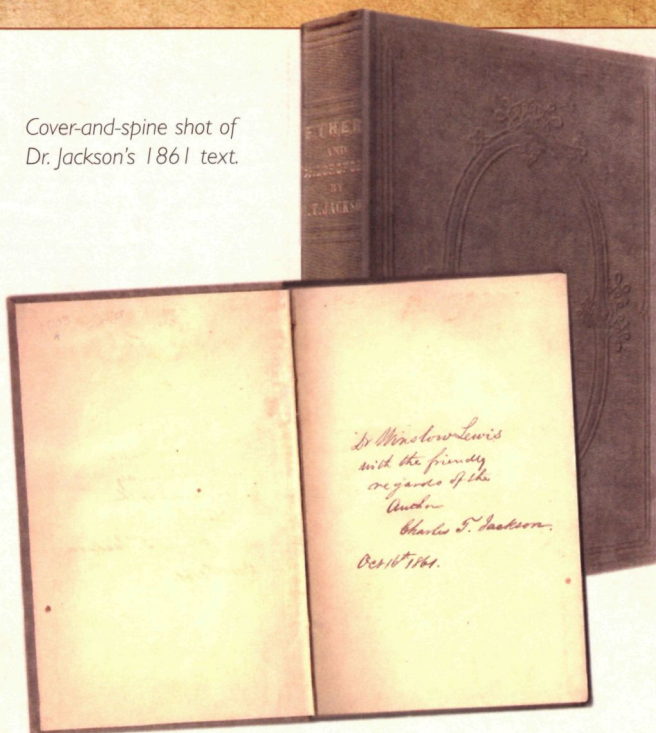
A variant on this process, perhaps surprising to some, is eBay. Representatives of the WLM routinely peruse this venue, and if an item of interest is identified, the RAT is convened. On eBay, items may sometimes be obtained at a fraction of their appraised value. Care is taken, however, to preserve the WLM's anonymity insofar as possible, since any knowledge of such interest in an item lends authenticity and thus increases its value. Examples of items acquired this year on eBay include: a circa-1916 Albany Ether "Pro Narcosis" ether tin and a 1920s CF Boehringer "Muriate of Coca" bottle, shown in the article by Dr. Bause (page 20).

Another way that artifacts and papers of historical significance end up in the WLM is through the kindness and altruism of our members and their families. On occasion, papers, artifacts and other items of interest are donated or bequeathed to the museum, library or archives and are valued in some instances at multiples of five or six figures. An outstanding example of such generosity was the recent donation of the Dorsch and Dorsch collection (described on page 21). The WLM, ASA and indeed the specialty of anesthesiology are most grateful for the opportunity to benefit from such generosity for decades if not centuries to come.

Does "Who Was First" Really Matter?

One of the most interesting acquisitions of the WLM are some items of Charles T. Jackson, M.D., a physician, geologist, artist, teacher and brother-in-law of Ralph Waldo Emerson. Following graduation from the Harvard

Cover-and-spine shot of Dr. Jackson's 1861 text.



Dr. Jackson's inscription to Winslow Lewis.

Medical School, Dr. Jackson studied both medicine and geology in France for several years. During this period, he befriended Élie de Beaumont, M.D., also a geologist and a member of the French Academy of Sciences. Dr. Jackson continued to correspond with Élie de Beaumont following his return to the United States and was ultimately appointed a United States Geologist.

During the long New England winter of 1841-42, Dr. Jackson discovered the anesthetic properties of sulfuric ether. He began advocating the use of ether to physicians and dentists, but without any success. Then on September 30, 1846, Jackson told an enterprising young student, William T.G. Morton, of this finding. Some two weeks later, ether was demonstrated in public at the Massachusetts General Hospital.

Another recent acquisition is a previously unknown and unpublished letter from Dr. Jackson to Dr. Élie de Beaumont, addressing his frustrations regarding Morton taking credit for the discovery of ether as an anesthetic. This letter from Dr. Jackson, dated April 30, 1847, just seven months after Morton's demonstration, and was hand-stamped in Liverpool and then Paris. Jackson's ini-

Continued on page 33

Acupuncture from East to West:



Figure 1: Symbols of internal organs associated with the five elements in nature. From Teachings of acupuncture with the copper doll, 1715.

Chinese Medicine and Therapeutics: Early Texts Represented in the WLM Collection

Lydia A. Conlay, M.D., Ph.D., Vice-President
Wood Library-Museum of Anesthesiology Board of Trustees

Patrick Sim, M.L.S.
Paul M. Wood Distinguished Librarian

Surgical Anesthesia in Ancient China

The earliest known painless surgical operation in China was ascribed to Pien Ch'iao in 255 B.C. It was recorded that he gave narcotic wine to two patients who were rendered unconscious for three days, opened their chests, removed their hearts, exchanged them and put them in again. The two patients reportedly recovered.¹ Modern sinologists-historians considered such recording anecdotal, and at best described a composite

Lydia A. Conlay, M.D., Ph.D., is Professor of Anesthesiology, Baylor College of Medicine, Houston, Texas.



Patrick Sim, M.L.S., Paul M. Wood Distinguished Librarian, has served the WLM and ASA since 1971.





Figure 2: Acupuncture in Chinese-Japanese literature, with annotations in both languages. From Hua Shou's *The elucidation of the fourteen acu-tracts*, 1341.

of the experiences of Chinese physicians spanning this period in ancient history. Thus instead of referring to an individual, Pien Ch'iao became a term used to represent all ancient Chinese physicians over the course of several centuries.²

The first Chinese physician who applied surgical anesthesia was Hua T'uo, 190-265. Hua was known to dissolve a drug in wine for anesthetic purposes. The drug known as *ma-fei-san*, or *ma-yao*, is believed to have been morphine or opium. Unfortunately, for political reasons, Dr. Hua T'uo was executed in a turbulent era of Chinese history. While imprisoned he intended to entrust his jail guard with his writings, but the latter feared its dangerous consequence. Hua T'uo instead burned his medical writings before he died.

Acupuncture, Diagnostics and Therapeutics in Chinese Medicine

Chinese medicine traces its origins back some 4,000 years. It is based upon a philosophical principle of *tao*, which manifests the great harmony in life transcended from

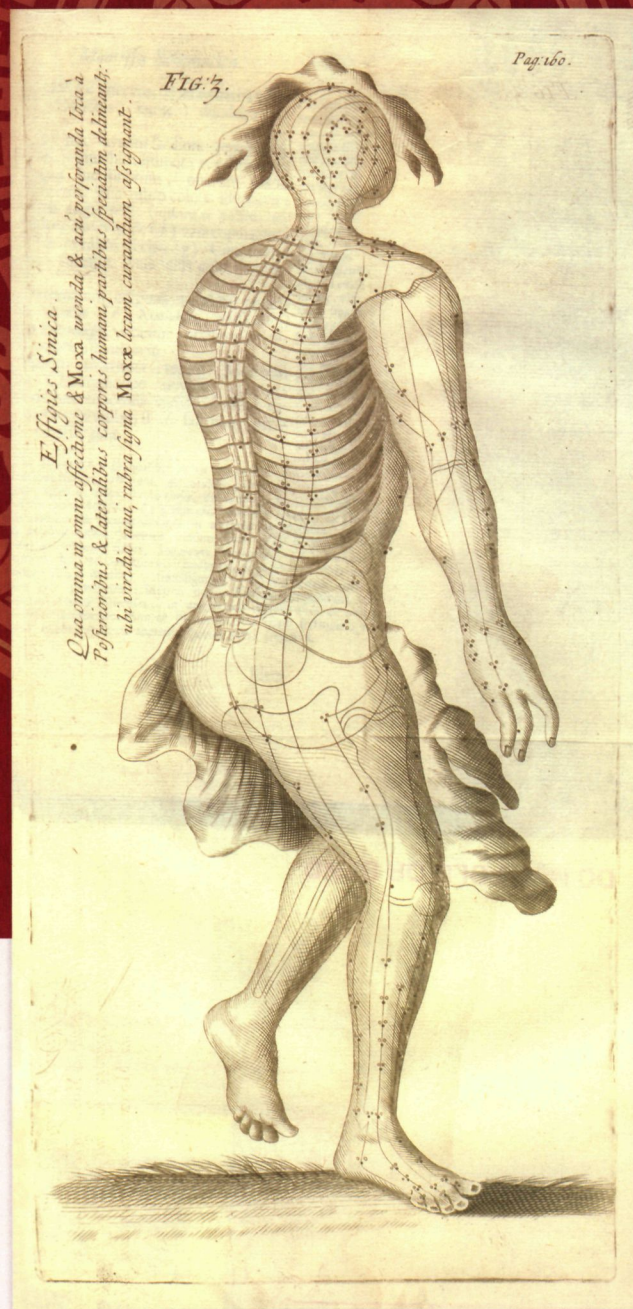


Figure 3: Western anatomical interpretation of the posterior acu-tract, tu-mo, as illustrated in Willem ten Rhijne's *Dissertatio de Arthritide, ...De Acupunctura*, 1683.

natural phenomena in the universe. Most Westerners are by now familiar with the two forces interacting in nature, yin and yang, which are broadly interpreted as negative and pos-



Figure 4: Manual pulse monitoring for therapeutic diagnosis in Chinese sphygmology. From Andreas Cleyer's *Specimen Medicinae Sinica*...1682.

itive elements. A healthy body is one that maintains the great harmony of the *tao*, attained by a balance of *yin* and *yang*. Such bodily equilibrium indicates the presence of an abstract vital pneuma called *chi*, which is contained in tracts or meridians deeply imbedded within muscles. There are 365 *acu-points* on these tracks (one for each day), which emerge to the surface of the body and present themselves for needling for therapeutic purposes. The ancient Chinese believed that an excellent physician would control disease before any illness is manifested by a careful monitoring of the *chi* in the *meridians* embedded in the body.³ Thus pre-

"Most of the cited classics in Chinese medical literature on acupuncture and therapeutics have been collected in the WLM. It is hoped that this attempt to understand the evolution of this ancient medical art with reference to key literature on the subject would provide a relevant identity for each of our titles related to the subject."

vention is the foundation of Chinese medicine [Figure 1].

The Yellow Emperor (Huangti) ruled the Chinese Kingdom around 4,000 years ago at the dawn of Chinese history. His *Nei Ching* (*Cannon of Internal Medicine*) is the earliest medical treatise and forms the foundation for medicine in China. It is written in the style of a dialogue between the emperor Huangti and his minister Chi-Puo on matters both medical and philosophical. These writings included two volumes: the *Su-Wen*, or "Simple Dialogues," and the *Ling-Hsu*, "On Acupuncture." Through history the volume on acupuncture has intermittently appeared and disappeared.

As this oldest medical treatise was incomplete, Chinese medical scholars made it their tasks to research, study and elaborate the principles and wisdom emanated from Huangti and his minister. Huangfu Mi became the first authority to take up this task in 256 A.D., to discuss the principles and practice of acupuncture in a comprehensive treatise called



Figure 5: 18th century Chinese anatomical drawing of internal organs and their pathological functions. From Teachings of acupuncture with the copper doll, 1715.

chen-chiu chia i ching. His book dealt systematically with physiology, pathology, diagnosis and therapy. It also discussed the prophylactic functions of acupuncture, described accurate acu-points, and instructed needling techniques in terms of degrees of penetration and duration for cure of diseases and pain relief. It became the most influential book on Chinese medicine in Japan.

In the 6th century, the spread of Buddhism was accompanied by the spread of acupuncture. Buddhist monks well-versed in medical matters traveled to Korea. From Korea, religion and medicine further spread to Japan. In China at the dawn of the first millennium (1027), Wang Wei-I cast the

first life-size bronze statue with small holes on its metal wall indicating the acu-points, accompanied by a manual of instruction to aid students and practitioners of acupuncture.⁴ Subsequent studies of acupuncture would make reference to the bronze statue as Chinese medicine spread to other Asian cultures in Korea and Japan.

Soon Japanese students were dispatched to China on learning missions, which included the popular transcription of Chinese medical classics into Japanese. These rare volumes include important 14th century treatises in which text in traditional Chinese style calligraphy was transcribed in black ink by hand on volumes of stitch-bound rice paper. Two such in this tradition were recently acquired by the Wood Library-Museum of Anesthesiology (WLM). Written in 1341 by the prominent Chinese physician Hua Shou, these volumes are hand-transcribed from the Chinese text by Japanese scholar physicians. They are titled *shih ssu ching fa hui* ("The elucidation of the fourteen acu-tracts") and *do ren hsing chen ku ji nan sho* ("Transcribed guides to acupuncture on a bronze figure") and represent the earliest Chinese-Japanese work on acupuncture in the WLM [Figure 2].

Hua Shou was an academic physician from a prominent scholarly family whose writings on acupuncture were considered the last great landmark on the subject in the Yuan (Mongolian) Period. Hua's brother, Liu Chi, was a brilliant military strategist who helped the founding emperor of the Ming Dynasty overthrow the Mongolian regime in the 14th century. For political reasons, our scholar-physician took the pseudonym "Hua Shou" to disassociate himself from his influential brother and allow him to continue the practice of medicine.

Hua Shou was the first to define the acu-points as openings or cavities along the meridians, and not simply as points of pneuma energy. He considered these openings as valves for the flow of pneumatic energy, which regulate the wellness of internal organs for good health. Hua Shou emphasized the importance of the two auxiliary meridians running anterior and posterior of the body, the *jen-mo* and the *tu-mo*, for maintaining the proper flow of *chi*. These treatises in the WLM collection bibliographically have dual significance of both Chinese and Japanese origins, reflecting the characteristics of the medical traditions in two East Asian cultures.

Acupuncture and Chinese medical therapeutics found their way to Europe in the second half of the 17th century. One important aspect involved therapeutics based upon the theory of the circulation of blood in the system and the effects of pneuma energy (as indicated by the pulse) on the

14 meridians. Monitoring the pulse allowed Chinese physicians to determine the sources of illness due to abnormalities of the internal organs. Andreas Cleyer's *Specimen Medicinae Sinicae*, Frankfurt, 1682, is a Latin translation of the Chinese theory of the pulse based on two Chinese classics on sphygmology from the 3rd and 9th centuries.⁵

Curiously, Cleyer did not claim to write this book, but rather listed himself as editor and ascribed authorship to Polish Jesuit Michael Boym. A religious evangelist, Fr. Boym had devoted his life to aiding a converted Ming royal in his futile efforts to reclaim the throne from the new Ching ruler of the Chinese Empire. Fr. Boym did not live to see the publication of his own translation of the 10th century classic on sphygmology, published several years after Cleyer's. Nevertheless medical scholars have found little similarity between Cleyer's version and Boym's, other than their agreement on the relationship between pulse diagnosis and the 14 acu-tracts of the body⁶ [Figure 4].

Cleyer's book significantly influenced the work of English physician Sir John Floyer, who wrote *Physician's Pulse-Watch, or an Essay to explain the Old Art of Feeling the Pulse, and to Improve it by the help of a Pulse Watch*, 2 volumes, 1707, 1710 (also a part of the WLM collection). Floyer paraphrased Cleyer's work and was credited for his effort to accommodate Chinese and European observations about the pulse into his two-volume work on sphygmology. He also introduced the use of a stopwatch in the study of pulse rate in many diseases, a precursor of patient monitoring.

Perhaps the surgeons of the Dutch East India Company were even more important to the spread of Chinese medicine. Willem ten Rhijne, 1647-1700, joined the Dutch service in 1673. He was assigned to Deshima, Japan, although Japan was closed to foreign contacts at that time. Ten Rhijne met and conferred with Japanese physicians for almost two years and wrote the first treatise on acupuncture in the western world, titled *Dissertatio de Arthritide, Mantissa Schematica; De Acupunctura; et Orationes Tres*, circa 1683 (title abstracted).

Ten Rhijne's volume copiously illustrated the acupuncture points and observed that acupuncture and cautery were the primary techniques employed by both the Chinese and Japanese for the relief of every pain derived from illness. Ten Rhijne also pointed out that Chinese medicine emphasized the circulation of blood but opposed phlebotomy, fearing that venesection would remove both healthy and diseased blood and thus shorten life. Instead the Chinese used acupuncture to expel blood's bad elements.⁷ Ten Rhijne's volume was simultaneously published in London, the Hague and Leipzig. WLM recently acquired a copy of the London imprint.

The theories and efficacy of the acu-tract and acu-point system in acupuncture continued to influence medicine in continental Europe and England into the 19th century. Other important and seminal literature from this era also is

represented in the WLM collection, such as works by Chevalier Salandré, who employed electric current in acupuncture, and Jules Cloquet, who adopted acupuncture in hospital clinics. In England, also in the 19th century, J. M. Churchill published two books on acupuncture in 1821, *A Treatise on Acupuncturation ... 1821* and another 1828. His achievements included cure of rheumatic conditions, sciatica, back pain, trismus, achieving immediate numbness and eventual cure, and are also chronicled in the collection of the WLM.⁸

Acupuncture and Therapeutics From the WLM Collection

Most of the cited classics in Chinese medical literature on acupuncture and therapeutics have been collected in the WLM. It is hoped that this attempt to understand the evolution of this ancient medical art with reference to key literature on the subject would provide a relevant identity for each of our titles related to the subject. Despite the antiquarian nature of such literature, it is intended to acquaint the reader with an ancient philosophical wisdom on the matter of health and healing.⁹

Sadly, religious stigma and reverence for the physical body in Chinese society put the practice of surgery in a lowly social position and thus stifled its development through the ages. However, with this short article, perhaps one humble librarian can put to rest the anesthesia controversy regarding "Who Was First?" Who was really first? The Chinese!

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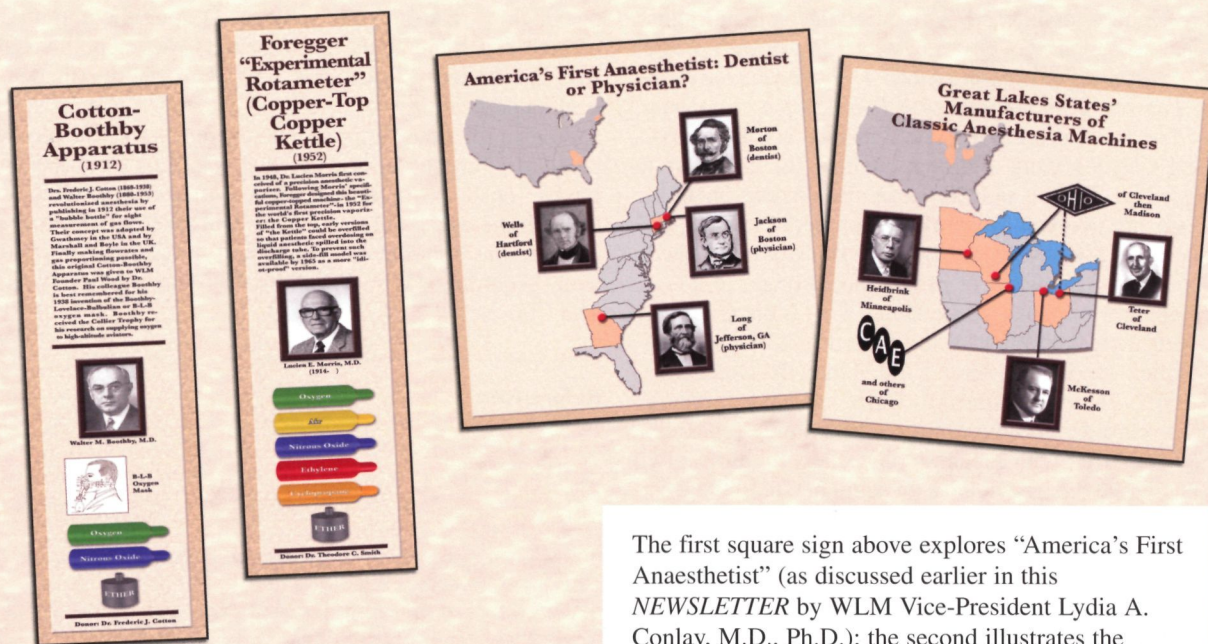


2007: A Busy Year for the Wood Library-Museum of Anesthesiology

George S. Bause, M.D., M.P.H., Honorary Curator
Wood Library-Museum of Anesthesiology

Gallery Signage and Graphics

The ASA Headquarters building houses the world's largest library and museum devoted to anesthesia, the Wood Library-Museum of Anesthesiology (WLM). Occupying one-third of the ground floor of ASA's building, the WLM gallery displays many of the earliest known ether and chloroform inhalers. This past year, Honorary Curator George S. Bause, M.D., and Collections Supervisor Judith Robins generated graphics and signage for all 50 platforms and display cabinets. Examples are pictured below.



George S. Bause, M.D., M.P.H., is
Clinical Associate Professor, Case
Western Reserve University,
Cleveland, Ohio.

The first square sign above explores "America's First Anaesthetist" (as discussed earlier in this *NEWSLETTER* by WLM Vice-President Lydia A. Conlay, M.D., Ph.D.); the second illustrates the WLM's fortuitous Chicagoland location smack in the middle of the Great Lakes, where much of America's anesthesia gas machinery was pioneered. To the left, two taller signs salute Drs. Walter Boothby and Lucien Morris. Along with Dr. Frederick Cotton, Dr. Boothby designed a "bubble bottle" for sight measurement of gas flows. Four decades after their first Cotton-Boothby Apparatus, Dr. Morris invented the "first precision vaporizer for administering anesthetic gases," the Copper Kettle.

Ramping Up the Exhibits

A major challenge in renovating the WLM gallery was the shifting of 200- to 400-pound anesthesia machines on and off the elevated display platforms. Fortunately, ASA had plenty of wooden pallets for building up ramps to each platform.



Moving Walls — Rare Books and Rare Art



Recent renovations in the WLM's K. Garth Huston, Sr., Rare Book Room (RBR) have expanded shelving space by means of a series of moving walls: a mobile carriage system. The vendor's initial plans (to orient mobile shelving perpendicular to the RBR's length) were themselves shelved by the curator. Instead a curatorial design doubled existing shelf space and provided staff safety by paralleling the moving walls to the RBR's length (see above left). An annotated bibliography of the RBR's classic tomes will soon be published by our Paul M. Wood Distinguished Librarian, Patrick Sim, M.L.S.

WLM Librarian Karen Biertman, M.L.I.S., and Library Assistant Margie Jenkins assisted Curator Bause with hanging paintings and prints in our third-floor library. Subsequently, in the first-floor museum gallery, graphic artist William Lyle hung a wall full of watercolors painted by the late Leroy D. Vandam, M.D. Since then, many anesthesiologists mentored by Professor Vandam have found the convex gallery wall to be a moving testament to the artistry of this nationally ranked watercolorist (see above right).

Acquiring Rare Books:

Japanese Acu-texts from the R.C. Rudolph Library



1.



2.



3.



4.

Over the past 30 years, WLM Acquisitions Chair Charles Tandy, M.D., has cultivated a network of antiquarian bookdealers. Recently, one of his San Francisco dealers alerted the curator about “A Collection of Japanese Medical and Scientific Books from the Library of Richard C. Rudolph, Founder of Asian Studies at UCLA.” With the blessing of Dr. Tandy’s five-member WLM Acquisitions Committee, the curator closed a deal for these remarkable classics on acupuncture and moxibustion:

1. Okamoto Ipposhi’s 1693 translation of *Jushi keraku hake wage* (“Elucidation of the Fourteen Acupuncture Tracts”), from his Chinese source, Hua Shou’s 14th-century work;
2. Hayashi Kyubee’s 1699 *Jushikei keibiki no ben* (“On the Fourteen Acupuncture Tracts”), also based on Hua Shou;
3. Ogino Gengai’s 1791 *Shinkan Geka seiso* (“Traditional Surgery”), from his Chinese source, Ch’en Shih-kung’s 1617 work; and
4. the 1854 printing of Hara Nanyo’s 1803 compilation *Keiketsu ikai* (“Collected Opinions Concerning the Correct Points on the Fourteen Meridians”).

Acquiring Museum Objects:

Hedley Inhaler From England



"BY ACT
OF
PARLIAMENT
6 & 7 *Victoria*
Cap. 65
REGISTERED
7th April 1847"

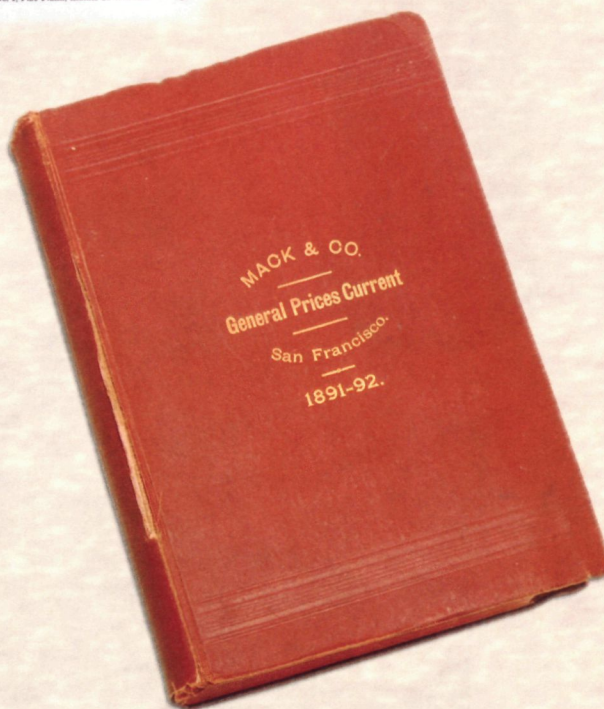


Hedley of Bedford, England, registered his ether inhaler in April 1847. Made of ivory, porcelain or wood, the Hedley Ether Inhaler provided a brief bridge, for some anaesthetists, between their early use of inefficient brass and glass inhalers and their delayed use of inhalers with metal housings. One such wooden Hedley Inhaler is part of the Wellcome Collection in London; another, pictured here, surfaced on the private medical antiques market. To spare the WLM's pennies, the device was hand-carried on flights from England to Chicagoland via Ireland over 18 hours. Such WLM acquisitions would not be possible without its nimble, responsive Board of Trustees.

Other Museum Acquisitions:



*An excerpt from the
1891-92 Mack & Co.
catalog below*



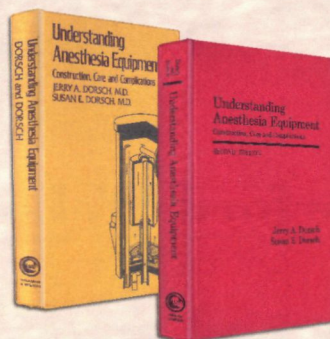
A Philadelphia Trio

This nifty threesome was acquired by the WLM from a Pennsylvania medical antiques dealer. Both the green apothecary bottle and the tin hail originally from France. The former contained a "Fluid Extract of Coca"; the latter, Menthol-Borate-Cocaine Pastilles for "afflictions of the throat." The red Mack & Co. Wholesale Druggists catalog lists a variety of narcotics and anesthetics available in San Francisco from 1891-92. Page 221 features a Truax & Co. Poison Case with chloroform bottle; page 515, John Wyeth & Bros. hypodermic tablets of morphine and of cocaine. Such catalogs are invaluable references for identifying and cataloging our WLM objects.

Facilitating a “Smokin’ Donation”



NASA's
view of
wildfires' smoke



Dorsch & Dorsch

In May of this year, as wildfires raced through southern Georgia and northern Florida, the curator's plane landed on a smoke-filled runway in Jacksonville. There he was greeted by the Doctors Dorsch. Jerry and Susan Dorsch are a dynamic and complementary duo, respectively, an academic and a private practitioner. They mused that Jerry provided much of the content and Susan much of the style behind their multi-edition, best-selling text, *Understanding Anesthesia Equipment*.

For years, Dr. Jerry Dorsch had salvaged obsolete apparatus and anesthesia machines from Mayo Clinic Jacksonville. Many pieces were photographed for inclusion in the “Dorsch & Dorsch” textbook. When a down-sizing in future departmental office space threatened his mini-museum, Dr. Jerry Dorsch contacted the WLM about a Mayo-approved donation of the entire collection. Smoky haze from nearby wildfires surrounds Dr. Jerry Dorsch as he stands behind the moving van.

If you own or learn of a treasure of anesthesia that belongs in your national collection, please contact the Trustees or staff of your Wood Library-Museum of Anesthesiology. Thank you!



The Crawford W. Long Museum: A NEW BEGINNING

William Hammonds, M.D., M.P.H., President
Wood Library-Museum of Anesthesiology Board of Trustees

On March 30, 1842, Crawford W. Long, M.D., a graduate of the School of Medicine at the University of Pennsylvania, administered the first anesthetic



William D. Hammonds, M.D., M.P.H., is Professor, Department of Anesthesiology and Perioperative Medicine, Medical College of Georgia, Augusta, Georgia.

for surgery in his office on the corner of the village square in Jefferson, Georgia. Dr. Long was a native of nearby Danielsville, Georgia, and had recently returned home after completing several months of advanced training in surgery in New York City. The patient was a friend, James Venable, and the surgery was the excision of a lump from the back of Mr. Venable's neck. Dr. Long eventually moved away from Jefferson and settled in Athens, Georgia. His claim to have performed the first anesthetic was largely ignored by the rest of the world, but the citizens of Jefferson never forgot this pioneering physician. After he moved, the building that Dr. Long used for an office continued to be occupied by another physician for a while but was eventually torn down, and in the late 1800s, two buildings were built on the site. One of the buildings was a general store until

1957 when it was converted to a museum honoring Dr. Long and his historic accomplishment at that location.

Historical Growth

The Crawford W. Long Museum was operated by volunteers until the 1990s when it underwent a remarkable period of growth. A consultant from Cleveland, Ohio, supervised a reorganization of the collection. The buildings on both sides of the old general store were purchased and added to the museum in order to have space for the expanded collection. The museum added items reflecting the history of anesthesiology to the existing collection centered on Dr. Long. During this period of remarkable growth, the citizens of Jefferson were instrumental in the leadership of the museum. The Jefferson City Council provided support to the museum in the form of salary for the director. The Georgia Society of Anesthesiologists also provided monetary support for the museum. John E. Steinhaus, M.D., former chair of the Department of Anesthesiology at Emory University, sat on the board of directors of the museum, and new anesthesiology residents at Emory University regularly made field trips there. Ownership of the museum remained with the Crawford W. Long Museum Association.

Pledge of Support

During this interval, the Wood Library-Museum of Anesthesiology (WLM) established a formal relationship with the Crawford W. Long Museum. In 1994, Elliott V. Miller, M.D., then president of the WLM Board of Trustees, arranged a meeting of the two boards in Jefferson, Georgia. A formal document was



GIVEN BY
DR. LAMARTINE GRIFFIN
HARDMAN,
OF COMMERCE, JACKSON CO., GA.,
IN THE NAME OF HIS
FATHER AND MOTHER,
DR. W. B. J. HARDMAN AND
MRS. E. S. HARDMAN,
LIFE LONG FRIENDS OF
CRAWFORD W. LONG,
DR. W. B. J. HARDMAN, BEING
A PHYSICIAN IN JACKSON CO.

LONG

signed by the presidents of both boards, pledging "mutual support." That support has taken the form of exchange of duplicate artifacts and the sale of WLM items in the museum gift shop. Additionally I was chosen to be the first representative of the Crawford W. Long Museum Board of Directors to the WLM Board of Trustees.

Uncertain Times

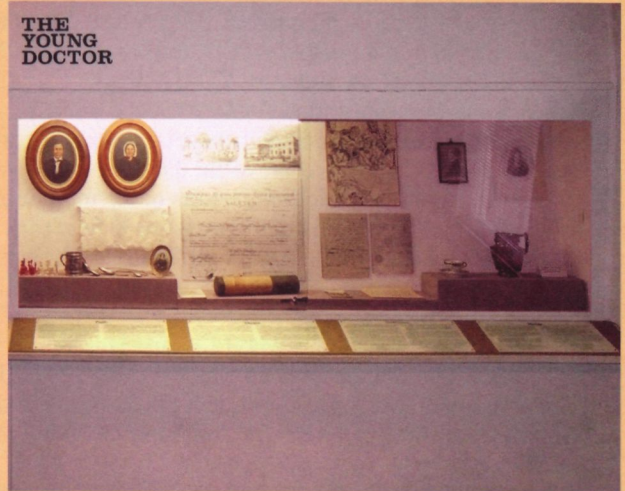
By 2006, the contribution of the Jefferson City Council no longer met the expenses of the Crawford Long Museum, and the shortfall was not met by other contributions. For several months, the future of the museum was uncertain; during this time, the director left for employment elsewhere. On April 16, 2007, the Jefferson City Council voted unanimously to assume total responsibility for the museum. On May 3, 2007, the museum board of directors voted unanimously to transfer ownership of the museum and all its holdings to the city of Jefferson, Georgia. As this is being written, lawyers for both sides are arranging the transfer.

A Long Time Coming

Over the past several years, repairs to the museum have been postponed because of its precarious financial position. Part of the arrangement with the city of

Continued on page 30

"His claim to have performed the first anesthetic was largely ignored by the rest of the world, but the citizens of Jefferson never forgot this pioneering physician."



Anesthesia Heritage Outside the WLM: Arthur E. Guedel Memorial Anesthesia Center

Selma H. Calmes, M.D., President, Board of Trustees
Arthur E. Guedel Memorial Anesthesia Center
Member, Wood Library-Museum Board of Trustees

The Arthur E. Guedel Memorial Anesthesia Center in San Francisco, named in honor of notable anesthesiologist Arthur E. Guedel, M.D., is a library and museum devoted to the history of anesthesiology. Its holdings include old anesthesia equipment, a library of anesthesia texts, the Richard Gill collection of items from his curare exhibitions to the Amazon, and memorabilia and papers from Dr. Guedel. It is supported by annual voluntary donations from members of the California Society of Anesthesiologists (CSA) and is open to all visitors interested in the history of anesthesiology.

A Look Inside

The Guedel Center is one of several collections located in a historic building that previously was the library for Stanford Medical School. The building is now owned by

California Pacific Medical Center, and it serves as the library for this multicampus organization. A long-term relationship allows the Guedel space in the building and



Selma H. Calmes, M.D., is now retired. She is a member of the Wood Library-Museum Board of Trustees and a member of the ASA Subcommittee on History and Education.

The Arthur E. Guedel Memorial Anesthesia Center is in this building, the library of the California Pacific Medical Center. Courtesy of the Guedel Memorial Center Collections.

the services of the librarian, currently Mrs. Anne Shew. Mrs. Shew is a modern librarian, a leader in Web-based library services.

The Guedel Reading Room, recently refurbished in period style, is the main display area and also contains most library holdings. Journal holdings are in the main library's stacks. An additional display area upstairs is shared with the other historic collections. Archival material must be pulled by the librarian.

What We Do

The Guedel Center's activities include maintaining a Web site www.cpmc.org/professionals/hslibrary/collections/guedel. This site has introduced the Guedel Center to a larger audience. For example, the British Broadcasting Company recently found our video holdings (transferred from the original film) on the Gill expedition and used some footage for a television documentary on curare. To maintain interest by our CSA supporters, we do a column on historic anesthesiology subjects in the quarterly *CSA Bulletin*. Exhibits of Guedel items are usually done at the CSA's annual meetings, and open-house events are held occasionally. Previously the Guedel Center's purposes included collecting anesthesiology journals for distribution to needy overseas anesthesiologists and maintaining a current collection of worldwide anesthesiology journals, but these functions are no longer needed.

A Little History

The Guedel Center developed in the early 1960s when

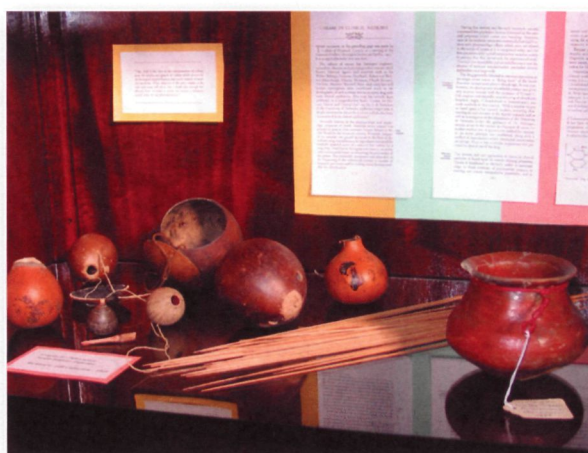
A quiver with darts and a gourd pot for carrying paste curare while hunting. Cotton with a dab of curare paste would be placed on the arrows' tips when a target was seen. Collected by Richard Gill on his curare expeditions. Courtesy of the Guedel Memorial Center Collections.



the collection of anesthesia equipment and memorabilia belonging to Paul M. Wood, M.D., which forms the basis of the Wood Library-Museum of Anesthesiology (WLM), was looking for a physical home. Soon after ASA agreed to take the collection in 1960, William Neff, M.D., then chair of anesthesia at Stanford, argued that putting Dr. Wood's collection in Park Ridge, Illinois, would "bury the WLM in suburbia." Dr. Neff felt strongly that many more people would travel to San Francisco than to Park Ridge to see the collection. And there was space available for it in San Francisco: the then-vacant library building of the old Stanford Medical School, which had recently moved to Palo Alto. The ASA plan for a building addition to house Dr. Wood's material was well under way, and so the WLM stayed at ASA headquarters.



Two feather hats collected by Richard Gill. Courtesy of the Guedel Memorial Center Collections.



Gourd pots for carrying curare, arrows and a clay pot for cooking the curare paste. Collected by Richard Gill. Courtesy of the Guedel Memorial Center Collections.



Part of the reading room (above) and display case with Arthur Guedel memorabilia (inset) at the Guedel Memorial Center. Courtesy of the Guedel Memorial Center Collections.



The strained feelings left from this episode led to the suggestion of a West Coast history of anesthesiology museum. This came from Chauncey Leake, M.D., Professor of Pharmacology at the University of California-San Francisco, a person with strong ties to anesthesia; he had previously been at the University of Wisconsin with Ralph M. Waters, M.D. Dr. Leake also suggested dedicating the museum to the memory of Dr. Guedel, a pioneer of modern anesthesia on the West Coast, who had recently died. Although Dr. Guedel had a busy private practice in Los Angeles, he often traveled to San Francisco to do research with Dr. Leake, and they became close friends.

The Guedel Center opened in 1962 in an anesthesia billing agency's building, with a volunteer librarian. As the collection grew, more space was needed, and it moved to its present site in the late 1970s. From the beginning of the center until his death in 1997, Dr. Neff was a committed, vigorous and forceful Guedel Center leader.

Come See Us!

The upcoming ASA Annual Meeting in San Francisco offers an opportunity to visit the Guedel Memorial Cen-

ter, located at 2395 Sacramento St., San Francisco, CA 94115. Hours vary due to the dental school's schedule, so it is best to call first (415) 600-3240. Visiting anesthesiologists will be most intrigued by the early anesthesia textbooks and anesthesia machines. Arthur Guedel's memorabilia, including the portable anesthesia machine he designed to carry in the trunk of his car as he moved from case to case in different Los Angeles hospitals, is also of interest. The Guedel Center hopes you can find time to visit any time you are in San Francisco! **ASA**

**The Arthur E. Guedel Memorial
Anesthesia Center is located at
2395 Sacramento St.,
San Francisco, California**

To plan a visit, call (415) 600-3240

Avian Influenza H5N1

Jill A. Antoine, M.D., Chair
Committee on Trauma and Emergency Preparedness

Tai L. Antoine, M.P.H.

Pandemic is a Latin word used to describe an infectious event occurring over a wide geographic area and affecting an exceptionally high proportion of the population. Most recently this word is being used to describe the likely event of a global H5N1 influenza outbreak within the next several years.

Influenza is a disease with which we are all familiar. We line up diligently for vaccination yearly and consider ourselves protected. The probable characteristics of an H5N1 pandemic preclude the likelihood of effective immunization practices protecting us, our families or our patients. It is currently unknown how many people have been exposed to but not contracted the disease. Death rates of as high as 50 percent have been reported in outbreaks since 1997.

H5N1 is an avian influenza virus now, as most influenza viruses are. Currently it is not capable of sustained human-to-human transmission. One concern is that this virus will mutate and develop the ability to pass from human to human resulting in a pandemic with a high death rate similar to that of the pandemic of 1918, known as the Spanish Flu, which has historical death rates listed from 5 percent to as high as 50 percent of infected individuals. Another concern is the probability that the deaths will be highest in the 20- to 50-year-old age range, resulting in a huge impact on the global economy.

H5N1, a .1-micron virus particle, is thought to be spread by droplet, aerosol and direct contact. This means that when we intubate infected patients, we are at high risk of becoming infected if we are not protected. We also are putting others at risk who may be in the room with us as we perform intubation.

How should we protect ourselves from the high death

rate associated with infection by H5N1? There are those who suggest that N-95 face protection is sufficient. This was the recommendation to physicians during the SARS outbreak, and many health care workers were infected ... and some died.

The common sense approach to preparedness for a pandemic would be:

1. Family preparedness first and foremost: Get a kit, make a plan and be informed. Please visit the Red Cross Web site at www.redcross.org/services/prepare/0,1082,0_239_00.html.
2. All elective health care stops, including elective surgery in the event of a pandemic. Prepare for surge.
3. Personal protective equipment and powered air-purifying respirators should be utilized while performing high-risk procedures with infected patients, such as intubation and bronchoscopy; and a fitted N-95 respirator (a government efficiency rating that means the mask blocks about 95 percent of particles that are 0.3 microns in size or larger) should be worn by all hospital personnel caring for patients with known or suspected H5N1 influenza.

If you would like to learn more about this topic and all-hazards preparedness in general, please attend this year's ASA Annual Meeting and the panel "Are We Ready: All-Hazards Preparedness and Response: Role for Anesthesiologists" at 9 a.m. on Saturday, October 13, in San Francisco. Check the ASA Annual Meeting program book for more details.



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Tai L. Antoine, M.P.H., is a J.D. candidate for 2009, Case Western Reserve University School of Law, Cleveland, Ohio.

New York Increases Oversight of Office-Based Surgeries

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

For more than a decade, the New York State Society of Anesthesiologists (NYSSA) has sought to enhance the safety of office-based surgery. In 2000, guidelines were adopted by the Department of Health (Department) that include recommendations for anesthesia, presurgical and postsurgical evaluations, monitoring equipment, informed consent, emergency protocols and credentialing. The guidelines survived legal challenges, and in 2004, New York's highest court upheld the validity of the guidelines.

NYSSA continued to advance its commitment to patient safety, which recently resulted in the enactment of legislation that creates additional safeguards for patients undergoing office surgeries. A. 7948/S. 6052 defines office-based surgery as any surgical or other invasive procedure requiring general anesthesia, moderate sedation or deep sedation and any other liposuction procedure that is performed in a location other than a hospital. This legislation requires full accreditation by a nationally recognized accrediting agency and adverse event reporting. An adverse event includes patient death within 30 days; unplanned transfer to a hospital; unscheduled hospital admission within 72 hours of the surgery or for longer than 24 hours; or any other serious or life-threatening event. Licensees (physicians, physician assistants and special assistants) must report adverse events to the Department's patient safety center within one business day of the occurrence. The reported data is confidential and cannot be released except under limited circumstances.

Additionally, accrediting agencies shall report to the Department, at a minimum, aggregate data on adverse events for all office-based surgical practices accredited by the agencies. The Department may disclose reports of the aggregate data to the public. Lastly, the Department's commissioner must adopt and enforce regulations to effectuate this legislation. If such rule would affect the scope of practice of a health care practitioner (other than physicians, physician assistants or special assistants), the regulation must be made with the concurrence of the Commissioner of Education.

Congratulations to NYSSA, especially Scott B. Groudine, M.D., and Rebecca S. Twersky, M.D., for their commitment to this issue.

Office-Based Surgery Regulations Proposed in Indiana

Indiana's office-based surgery proposed regulation is the culmination of six years of discussions by interested parties concerning the need to regulate the office-based setting. The Indiana Society of Anesthesiologists has been a major

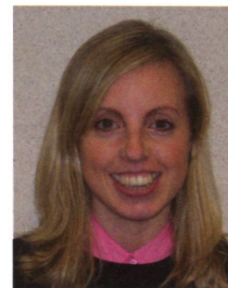
player throughout the process. In August, the Medical Licensing Board of Indiana will conduct a public hearing on the proposal. Per Indiana law, the proposed rule must be reviewed by Indiana's budget agency and approved by the governor before it becomes law.

The proposed rule applies to any facility, clinic, office or other setting where procedures are performed that require moderate sedation/analgesia, deep sedation/analgesia, general anesthesia or regional anesthesia. Regional anesthesia would include local or superficial nerve blocks if the total dosage administered exceeds the recommended maximum dosage per body weight described in the manufacturer's package insert.

Because sedation is a continuum, practitioners intending to produce a given level of sedation would be able to rescue a patient whose level of sedation becomes deeper than initially intended. Practitioners (M.D./D.O.) administering regional anesthesia or supervising or directing the administration of regional anesthesia would be knowledgeable about the risks of regional anesthesia and the interventions required to correct adverse physiological consequences that may occur. Additionally, health care providers could not administer or monitor anesthetic agents containing alkylphenols unless the provider is trained in the administration of general anesthesia and is not involved in the conduct of the procedure.

As of January 1, 2010, accreditation would be required by an accrediting agency approved by the medical licensing board. To approve an accreditation agency, the board would ensure that the certification program, at a minimum, includes the following standards for anesthesia, procedures and facilities and equipment:

Standards for Anesthesia: With respect to anesthesia, practitioners would select patients for office surgery by



Lisa Percy, J.D., manages state affairs for ASA in its Washington, D.C. office.

criteria, including the ASA Physical Status Classification System. The level of anesthesia would be appropriate for the patient, procedure, setting, educational training of the personnel and equipment available.

The health care provider administering anesthesia would be licensed, qualified and working within the provider's scope of practice. If a nonphysician provider administers anesthesia, the provider would be under the direction and supervision of a practitioner. If the nonphysician provider is a nurse anesthetist, the nurse would be under the direction and in the immediate presence of a practitioner (M.D./D.O.).

A health care provider who administers anesthesia and practitioner who performs the procedure or directs or supervises the administration of anesthesia would maintain current training in advanced resuscitation techniques (advanced cardiac life support [ACLS] or pediatric advanced life support [PALS]).

At least one person with ACLS or PALS training would be immediately available until the patient is discharged. In addition to the health care provider performing the procedure, sufficient numbers of qualified health care providers would be present to evaluate the patient, assist with the procedure, administer and monitor anesthesia, and recover the patient. Other health care providers involved would maintain training in basic cardiopulmonary resuscitation, at a minimum.

Patients who have pre-existing medical or other conditions who may be at particular risk for complications would be referred to a hospital, ambulatory surgical center (ASC) or another office-based setting appropriate for the procedure and the administration of anesthesia.

The health care provider administering anesthesia or supervising or directing the administration of anesthesia would: perform the preanesthetic examination and evaluation

or ensure that it has appropriately been performed by a qualified health care provider; develop the anesthesia plan or personally review and concur with the plan if developed by a nurse anesthetist; and remain physically present during the operative period and immediately available until the patient is discharged from anesthesia care.

Standards for Procedures: Procedures performed in the office setting would be provided by qualified health care providers and would be of a duration and complexity that permit patients to be discharged in less than 24 hours.

Standards for Facilities and Equipment: Practitioners who perform a procedure requiring anesthesia or who direct or supervise the administration of anesthesia would have admitting privileges at a local hospital, transfer agreement with another practitioner who has admitting privileges or an emergency transfer agreement with a local hospital. Such practitioner would demonstrate competency by maintaining privileges at an accredited or licensed hospital or ASC for the procedure to be performed. Alternatively, the governing body of the office would be responsible for a peer-review process for privileging practitioners based on nationally recognized credentialing standards. Practitioners would have appropriate education and training and would ensure that informed consent is obtained prior to performance of the procedure.

Written procedures for peer review to determine the appropriateness of clinical decision making and quality of care would be established and reviewed at least annually. Lastly, agreements with local emergency medical services (EMS) would be in place to transfer patients to the hospital should an emergency arise. EMS agreements would be re-signed at least annually.

The Crawford W. Long Museum: A New Beginning

Continued from page 24

Jefferson is that the city will assume responsibility for the needed repairs. Bids for those construction projects are being taken at the present time. The repairs are extensive and will require disruption of the interior of the museum. During these repairs, the museum will be closed and will probably not reopen until spring 2008.

Daniel Holden is the new Acting Director of the Crawford W. Long Museum. He is very knowledgeable about Crawford W. Long's role in what has been called

"America's greatest contribution to medicine," and he is well-versed in other aspects of the early history of anesthesiology.

All of this constitutes a new beginning for the museum and gives hope that the site of the first anesthetic will be preserved as an important part of the heritage of anesthesiology.



Paramedic Education, and Why Should an Anesthesiologist Care?

Adolph H. Giesecke, M.D.

George W. Hatch, Jr., Ed.D., L.P., EMT-P

The emergency medical service as we now know it began in the early 1960s because of the innovative genius of two anesthesiologists working independently: Peter Safar, M.D., and Eugene Nagel, M.D.^{1,2} They recognized that if the newly discovered technique of external cardiopulmonary resuscitation (CPR) was to benefit the public outside of the operating room, then they must train paramedics who would be widely distributed in society and create systems for emergency care in the hospitals to receive the victims who were resuscitated in the field. Their inspiration has grown into the highly integrated, highly successful system that currently benefits our public. All that we have to do is to dial "9-1-1," and this incredible public service comes to our aid, starting with a well-trained paramedic.

Paramedics are an essential component in the prehospital care of the traumatized or acutely ill patient, and they possess the knowledge, skills and behaviors consistent with performance of that duty. Specifically, they can evaluate and form a presumptive diagnosis, measure vital signs, take and interpret a 12-lead electrocardiogram and transmit this information to a base station, called a "BIOTEL." At the base station, a medical doctor, usually a specialist in emergency medicine, reviews the information and prescribes a treatment from the list of competencies in the paramedic's scope of practice. These include starting an I.V., giving drugs by bolus or infusion and managing the airway (including bag and mask ventilation, insertion of oral and nasal airways, endotracheal intubation and use of rescue devices such as Combitube® or laryngeal mask airway [LMA]). They can perform CPR, defibrillations, insert chest tubes, stabilize fractures, stop bleeding and deliver babies. In addition, they can do these things in a roadside ditch near an overturned car, in a burning building or in other hazardous situations.

Paramedics receive their training in one of approximately 600 programs in the United States. The training follows a



Figure 1. Paramedic students practice CPR skills in the laboratory of the training program at Southwestern Medical School in Texas. Photo by Kenny Navarro.

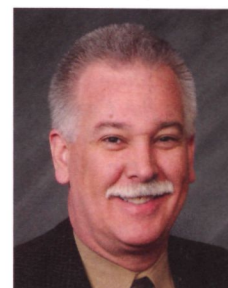
curriculum prescribed by the National Highway Transportation Safety Administration (NHTSA). The curriculum can be viewed on the NHTSA Web site www.nhtsa.gov/people/injury/ems/EMT-P. The curriculum requires approximately 900 clock hours to complete and consists of classroom lectures, skills laboratory, clinical hospital preceptorships and field internship experience. The graduating student receives a certificate, an associate's degree (A.A.S.) or a baccalaureate (B.S.) degree depending on the program. Programs based in fire services, hospitals or ambulance services usually offer the certificate; those based in community colleges usually offer the A.A.S.; and those in universities or medical schools usually offer the B.S.

More than 250 of the programs are nationally accredited by the Committee on Accreditation of EMS Programs/Commission on Accreditation of Allied Health Education Programs (CoAEMSP/CAAHEP) www.coaemsp.org/www

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George W. Hatch, Jr., Ed.D., L.P., EMT-P, is Executive Director, Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions, Houston, Texas.



.caahep.org. ASA has two liaison representatives on the CoAEMSP Board of Directors: William H. Montgomery, M.D., of Honolulu, Hawaii, and Adolph H. Giesecke, M.D., of Dallas, Texas. National accreditation is required in 14 states, which are identified in Table 1. Graduates of nationally accredited programs are eligible to take the National Registry of EMTs (NREMT) examination. Those paramedics with the designation NREMT-P have been trained and proven by examination to perform to national standards. The level of standardization of educational programs in the remaining 36 states, where approval is provided by state health departments, is as varied as their state flowers. Many programs are excellent — many require a lot of work to achieve the national standard. The need for a standardized approach to the evaluation of educational programs in EMS became painfully evident following September 11, 2001, and Hurricane Katrina. The paramedic of the future must be able to function in any state in the nation where a mass casualty event occurs. Universal accreditation of EMS educational programs within the United States will help to meet that need by ensuring that all programs meet rigorous requirements.

Universal Accreditation

In 2000, the *EMS Educational Agenda for the Future: A Systems Approach* detailed the steps required to bring training programs and graduates into compliance with national guidelines for the profession.³ At the time, the document was wide-reaching in its scope. Much of the agenda has been completed; however, the promise of universal accreditation is unrealized. In fact, extensive negotiations are needed to encourage the remaining 36 states to require accreditation.

Table 1. States requiring national accreditation for paramedic training programs.

Alabama	Kansas	New York
Arkansas	Maryland	Utah
California	Minnesota	Virginia
Colorado	Mississippi	Washington
Indiana	New Mexico	

The case for national standardization of EMS education was advanced by the release of the Institute of Medicine's report *Future of Emergency Care: Emergency Medical Services at the Crossroads* (2006),⁴ which called for universal accreditation for all paramedic education in the nation.⁴ In addition, the NREMT Board of Directors is considering the far-reaching requirement that all candidates for the national certification examination must come from CoAEMSP-accredited programs by 2013. The EMS community will likely be greatly engaged in extensive debate on this topic.

The new requirement should be viewed as an opportunity to improve the profession of EMS providers, but opponents will see it as an attempt to limit their ability to offer their own version of high-quality paramedic education.

The CoAEMSP is prepared to accept a large number of applications from uncertified programs and will be positioned to move ahead with universal accreditation efficiently and expeditiously without compromising quality. The whole discussion seems strange to medical specialists whose training programs have required national accreditation for decades.

Why Should Anesthesiologists Care?

Many reasons come to mind. First, we may someday need the services of a paramedic. We would like advanced reassurance that the paramedic who responds to our personal emergency is trained to a national standard. Second, anesthesiologists conceived the EMS; it is our brainchild, and even though it has evolved away from us, we should maintain an interest in its welfare. Third, because many of the skills required by a paramedic reside in the domain of anesthesiologists, and we are best-suited to teach and refresh those skills. We refer to the skills required for airway management, such as good mask fit; good head position, especially in obese patients; use of oral and nasal airways; use of the LMA and Combitube and, of course, endotracheal intubation. Anesthesiologists can and should provide supervised experience in these skills in the operating room, and that experience is positively correlated with improved success in airway management in the field.

My coauthor George Hatch relates the following anecdote:

"My own experience was one in which a noted anesthesiologist in our community was not in favor of paramedics utilizing endotracheal intubation in our early days of practice in the late 1970 and 1980s. He was concerned that our abilities were not where they needed to be, and I would agree with that assessment. We received additional work at another hospital to hone those valuable skills, which paid off in the future. Surprisingly enough, we were called to a cardiac arrest in the neighborhood where he lived and successfully resuscitated a neighbor in the front yard of the home. The anesthesiologist subsequently became a huge supporter for our program and our students."

George was able to win one over. The situation across the country, however, is at crisis level. Anesthesiologists and nurse anesthetists are progressively withdrawing and refusing to offer training to paramedic students.⁵ The reasons given are fear of liability, sharply reduced use of endotracheal intubation in anesthesia practice, lack of informed consent and fear of Health Insurance Portability and Accountability Act violation. Nobody that we know is will-

ing to say that additional mannequin practice will substitute for supervised experience with live humans in the operating room. We feel strongly that if anesthesiologists cannot overcome these reasons to oppose training in airway management for paramedics, then they must help to create alternatives to the skills involved and help to train paramedics in the proper use of the alternatives. To complicate this crisis, evidence is building that prehospital endotracheal intubation does not offer the benefits that we once believed it would. In fact some studies suggest that prehospital intubation increases morbidity and mortality, especially in children.⁶ Other studies suggest that the LMA, Combitube or Laryngeal Tube[®] are suitable alternatives.⁷

This crisis in the training of paramedics in airway management will not be solved easily. The solution will require a consensus of decision-makers among paramedics, emergency medicine physicians, surgeons, pediatricians, cardiologists and anesthesiologists, all of whom share a commitment to high-quality prehospital care. We urge all readers of this article to participate in the operating room training of paramedics and to help establish the consensus regarding the type of airway management that should be practiced by paramedics.

“Anesthesiologists can and should provide supervised experience in these skills in the operating room, and that experience is positively correlated with improved success in airway management in the field.”

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Preserving Our Heritage

Continued from page 10

tial letter, no doubt considerably more politic, was read to the French Academie of Sciences on January 18, 1847, and published in its *Compus Rendus*. This newly-acquired letter is important because of its presumed confidential nature and because it also indicates how very quickly the word about ether spread around the world. It was acquired along with several other items of Jacksonia, including a Jackson-signed presentation copy of his *A Manual of Etherization* (1861), inscribed for Massachusetts General Hospital surgeon Winslow Lewis, a student of John Collins Warren, M.D.

Preserving Our Heritage

As a relative newcomer to the WLM, I am impressed by the skills, the expertise and the commitment to the history of anesthesiology, anesthesiologists and the ASA by very capable members and individuals. Some are

experts in rare books, some in artifacts, some in publishing, and so on. Their talents and knowledge, often developed over decades, could have been used to amass valuable personal collections. Instead they help to preserve the heritage of anesthesiology through the good auspices of ASA and WLM.

It is, nevertheless, worthwhile remembering that the most effective means of preserving anesthesiology heritage comes from within our membership. Indeed the “first” Jackson to Élie de Beaumont letter, from November 13, 1846, is currently owned by a private collector. The WLM is most eager to work with individuals or businesses that may have access to such items of historical interest and can readily facilitate donations or bequests. As a nonprofit organization, donations are tax-



My Introduction to the World of Anesthesiology

Timothy D. Quinn

My introduction to anesthesiology came the summer after my first year at medical school during an internship with Nader D. Nader, M.D., Ph.D., at the Veterans Affairs (VA) Hospital in Buffalo, New York. I had no idea what to expect as a novice in the hospital and had no previous exposure to anesthesia. I found anesthesia to be a dynamic field with meaningful patient contact in a variety of settings. If it were not for this experience early in my medical education, however, I may not have considered it as a specialty. Time constraints in many third year clerkship schedules make it impossible to fully explore all career options. Students may go through their entire medical education without a rotation in anesthesia, where pharmacology and physiology truly come to life in a practical way.

First Observations

At the VA, I was introduced to the concept of perioperative anesthesia care. I witnessed anesthesiologists performing the initial patient interview, managing the patient during the surgical procedure and following up on their patients postoperatively. During the preoperative interview, the anesthesiologists took a full and detailed history to assess any risk factors above and beyond the focus of the surgery. They reviewed patients' medical history, including recent tests; interviewed and performed the physical examination; extracted information from the history, physical examination and other physicians' notes to determine the best plan of anesthesia for their patient; and, finally, assessed the need for postoperative pain management. Medications, allergies, personal and family history of anesthesia complications, and social history of tobacco or drug use also were incorporated and were important to developing the anesthetic plan. It became clear to me that the anesthesiologist must have a broad understanding of human physiology and pathology to effectively screen a patient for surgery.



Timothy D. Quinn is a fourth-year medical student, Georgetown University School of Medicine Class of 2008.

Preoperative Interview

The preoperative interview provides the anesthesiologist with the opportunity to not only learn about the patient's medical history but also to gain the patient's trust before the procedure. I realized that in order to be effective, the anesthesiologist must quell any anxiety while conveying a confident and relaxed demeanor. During my internship, several residents remarked that preoperative interviews at the VA were the best clinical experience they had ever had. More often than not, important information about the patient's medical history was elucidated during the interview — information that had not been addressed in other examinations. It is also a chance for anesthesiologists to demonstrate their dedication to provide patients with the best care. For example, I witnessed one resident track down a paper copy of an anesthesia report from medical records to learn how a patient with a difficult airway was intubated in a previous procedure.

Story of Mr. B

Perioperative anesthesia care has expanded the role of the anesthesiologist, resulting in more patient interactions over a longer period of time. A perfect example of this was Mr. B. Another resident and I did a full preoperative interview with Mr. B for a left inguinal hernia repair. On the day of surgery, we followed Mr. B from the preoperative room, through hernia surgery, and safely to the postanesthesia care unit. We visited him the next day on the floor and discharged him home with pain medication. Less than a week later, Mr. B returned to the E.R. with left scrotal edema, and exploratory surgery was scheduled for that day. The same anesthesia team saw him in the E.R. and safely guided him through another procedure. I believe Mr. B is a great example of anesthesia's role in excellent perioperative care. Through his first interview and surgery, we developed a rapport with him that carried over into another procedure. We understood how anesthesia affected him and how to best control his pain after surgery. It was very gratifying to successfully manage Mr. B during the procedures.

There From Start to Finish

Patients present with diverse conditions and reactions to anesthesia; therefore, a thorough preoperative interview and a well-orchestrated anesthetic plan can greatly increase the likelihood of a safe and successful surgery. After surgery it is time to ensure a smooth transition to consciousness and the recovery room. I remember one instance where a code

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Jess B. Weiss, M.D. — 1917-2007

Ellison C. Pierce, Jr., M.D.

Jess B. Weiss, M.D., 1979 ASA President, a pioneer in the area of obstetrical anesthesia and unquestionably ASA's unchallenged authority on the economics of anesthesia, died on June 28 in Holy Cross Hospital, Ft. Lauderdale, Florida. As I remember my good friend Jess, his most outstanding career trait was that he was absolutely adamant that the practice of anesthesiology, especially charges for services, must be based upon ethical considerations. In recognition of his numerous contributions to the specialty, he was awarded ASA's Distinguished Service Award in 1994.

Jess was born in New York City and raised in Mt. Vernon, New York, where he played high school football. After two years at the City College of New York, he migrated to the University of Alabama, where he thought he might be able to play football at that mecca of the sport. One day of practice told him he was out of his league in both height and weight. Upon graduation, he entered St. Mungo's College of Medicine in Glasgow, Scotland, where he reveled in the British university way of life. He was denied re-entry to the United Kingdom for his second year, since World War II was imminent. He continued his medical studies at Middlesex University School of Medicine in Massachusetts.

After internship and a year of general practice, Jess was drafted into the Navy. He was stationed in San Francisco with his new wife Shirley, whom he had met on a blind date on December 7, 1941, during medical school. With completion of his service requirements, he returned to general practice in Boston, where he was occasionally called upon to administer anesthesia. After several years, he entered anesthesiology residency at Massachusetts Memorial Hospital, Boston University.

Following residency and fellowship, Jess was recalled into the Navy and, with Shirley and four young children, was sent to Guam as Chief of Anesthesia at the U.S. Naval Hospital. The hospital served most South Pacific naval institutions and trained many native practitioners from all



Jess B. Weiss, M.D.

over the region. Though Jess and Shirley frequently recalled with fondness this tour of duty replete with a very active social life, ample time for golf and the opportunity for frequent travel all over the South Pacific, Jess declined an offer from the Navy to continue in the service at the Bethesda Naval Hospital because he wanted to work in a teaching hospital.

In 1960 he joined the anesthesia staff at Boston Lying-In Hospital, Harvard Medical School, and soon became chief of the service. It was there that his many contributions to obstetrical anesthesia began. Over time he changed obstetric anesthesia from largely inhalational, often ether, to regional, with anesthesiologists rather than obstetricians running the anesthesia show. In collaboration with others, he examined mater-

nal morbidity and mortality in a classic study that led to significant reductions in morbidity. He strongly supported the development of fetal monitoring and modified the Tuohy epidural needle with the addition of "wings" to assist in placement and a more blunt tip, giving rise to the very popular Weiss needle, which is now used worldwide for epidural anesthesia. In 1992, in recognition of his contributions to regional anesthesia, he was awarded the Distinguished Service Award of the American Society of Regional Anesthesia.

With the merger of the Lying-In and Brigham Hospitals, Dr. Weiss became Vice-Chairman of Anesthesia at Brigham and Women's Hospital and Associate Professor of Anesthesia, Harvard Medical School. In 1992, he received the Distinguished Service Award of the American College of Obstetricians and Gynecologists (ACOG), a unique honor for an anesthesiologist. During his tenure at Brigham & Women's, hundreds of anesthesiologists from all over the

Ellison C. Pierce, Jr., M.D., was President (1984-2000) and Executive Director (2000-04) of the Anesthesia Patient Safety Foundation and ASA President in 1984. He is now retired.

world were trained, thousands of babies were born, and not one mother died under his department's care. Dr. Weiss's publications in the field of obstetric anesthesia are numerous.

The other arena in which Jess made a truly significant contribution was in the economics of the specialty. He became chair of the Committee on Economics of the Massachusetts Society of Anesthesiologists and subsequently of the ASA Committee on Economics as well as a member of the American Medical Association (AMA) Current Procedural Terminology-4™ Editorial Board, ASA representative to the National Association of Blue Cross and Blue Shield, and the anesthesia representative to Massachusetts Blue Shield. His greatest role in this arena was his major involvement in preservation of the ASA Relative Value Guide (RVG) after the Federal Trade Commission (FTC) accused several medical societies of fixing prices and secured consent decrees resulting in cessation of publication of their guides. While ASA escaped notice of the FTC, it was accused of similar price fixing by the U.S. Department of Justice. Uniquely, upon advice of counsel, rather than agreeing to discontinue publication of its RVG, ASA (during Jess' tenure as president) fought the suit in federal court. The court found that the RVG did not violate antitrust laws. It would be difficult to overestimate the importance of this outcome for anesthesiologists practicing today.

From his long years of numerous visiting professorships and working in ASA, AMA, the World Federation of Societies of Anaesthesiologists, Blue Cross/Blue Shield, the Council of Medical Specialty Societies, the Academy of Anesthesiology, ACOG, both the American and European Societies of Regional Anesthesia, the Anesthesia Foundation and other organizations, Jess and Shirley Weiss had many, many friends the world over — especially in Scandinavia and Scotland — but, of course, in the United States as well. In addition to his ASA presidency, Jess served a number of other organizations in a similar capacity. At dinners of many society meetings, Shirley was frequently the social arbiter, making certain that friends found perfect places at perfect tables; I was often one of them.

Jess and Shirley retired from Brookline, Massachusetts, to Pompano Beach, Florida, where she will continue to live. In addition to his wife of 63 years, Dr. Weiss leaves daughters Susan Friedman of Boston and Barbara Friedman of Los Angeles, sons Stephen of Philadelphia and Lewis of Miami, a brother Harold of San Francisco, a grandson Nick Friedman of Los Angeles, granddaughter Jennifer Friedman of Boston and great-granddaughter Cady Bubeck of Boston.

Residents' Review: My Introduction to the World of Anesthesiology

Continued from page 34

was called in the recovery room for an obese man with a long history of cardiac problems and other co-morbidities. The anesthesiologist stood at the head of the bed, managing the airway and directing the resuscitation effort. What impressed me the most was how calm and composed the anesthesia team was while taking control of a chaotic situation. After the patient was stable, it was back to the O.R. for another case.

Applying What I've Learned

Now a fourth-year medical student, I will be applying for an anesthesia residency this fall. The most important lesson I learned during my summer internship was the expanding and multifaceted role that anesthesiologists play in patient care.

They can be primary care physicians during the initial patient interview while performing a detailed history and physical and assessing overall health.

They can be intensivists during the procedure, overseeing and maintaining physiological function.

They can be pain specialists, providing appropriate and timely relief.

They can run a code and manage the operating rooms. Most importantly they are advocates and guardians throughout the entire surgical process, safeguarding the patient from harm and always reassessing whether the risks outweigh the benefits for any action.

11 Candidates Announce for Elected Office

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

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The ASA Board of Directors has approved the following regulations for the announcement of candidacies for elected office:

1. On or before August 1, any candidate for ASA office may send to the Executive Office a notice of intent to

run for a specific office.

2. The Executive Office shall prepare a list of candidates submitted to be published in the September issue of the *ASA NEWSLETTER* and the Handbook of Delegates.

3. The announcement for candidacy does not constitute a formal nomination to an office, nor is it a prerequisite for being nominated.

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

As approved by the Board of Directors in August 2000, a Candidates' Forum will be made available on the ASA Web site at www.ASAhq.org/candidates.

In Memoriam

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

Kevin Conway, M.D.
Roanoke, Virginia
March 15, 2007

John C. Cwik, M.D.
Stone Harbor, New Jersey
May 23, 2007

Richard G. Fullam, M.D.
Pittsford, New York
February 2, 2007

Barry S. Goldstein, M.D.
St. Louis, Missouri
June 8, 2007

Robert L. Jones, M.D.
Milford, Connecticut
July 3, 2007

Roy V. Maxson, M.D.
Whitestown, Indiana
July 16, 2007

James R. Smolko, M.D.
York, Pennsylvania
May 21, 2007

Gary R. Thomas, M.D.
Elkhart, Indiana
June 7, 2007

J. Donald Wentzler, M.D.
Watsonstown, Pennsylvania
June 26, 2007

Info Request on Possible Awareness Case

The article written by Karen B. Domino, M.D., in the March 2007 issue regarding a "Registry on Awareness under Anesthesia" brought to mind an incident I encountered a few years ago when serving as chair of a survey team credentialing a surgery center for AAAHC.

An anesthesiologist at that center was attempting to maximize the rate of return to postoperative consciousness in the recovery room and subsequent early discharge from the facility. The technique used was to administer extremely small doses of propofol and miniscule doses of short-acting narcotic, and simultaneously run a continuous esmolol beta-blocker infusion to blunt the patient's cardiovascular response (tachycardia and hypertension).

As a surveyor reviewing charts from months prior, I was unable to interview the patient regarding awareness during anesthesia. It seems to me that such a technique would increase the likelihood of awareness, and I am wondering if there is any information pro or con regarding this technique? Does Dr. Domino have any information on this subject?

Clair S. Weenig, M.D.
Walnut Creek, California

Korean War Vet Not So Well-Equipped

I read with great interest and much humor the articles in the March 2007 *NEWSLETTER* on combat trauma. The pictures of the anesthesia setup floored me! What equipment!

I was the anesthesiologist at Baker Medical Company, 1st Marine Division in the Korean War, operating within one mile off the Main Line of Resistance (MLR) in the last several months of the war, just south of the Imjin River, 20 miles north of Seoul, when the North Koreans were trying desperately to win back territory.

My anesthesia setup consisted of two portable Heidbrink anesthesia machines in "suitcases" about 15 x 15 x 24 inches, with a CO₂ absorber, a G cylinder of oxygen and a G cylinder of nitrous oxide, plus several intravenous drugs. Two operating tables were set up end to end, with one stool for me in between so that I could handle two cases at the same time. Thanks to terrific cooks, I ate all my meals in the O.R. while operations were going on, and I left the O.R. only to go to the head, while a dentist covered for me. Every doctor carried sidearms, i.e., .45 caliber automatics, because of the nearness to the MLR and because an English medical company had been overrun recently. All corpsmen stacked their carbines along the O.R. wall for instant possible use. The sterilizer was a Coleman-type, gas-pumped heat source, with water obtained from a brook which ran outside the medical setup. Thumbs became sore from pumping the air compressor. The Army "supplied" our drugs, and they were very meager, making our corpsmen the greatest thieves in the world, getting the necessary drugs by stealing them from the Army depot in Inchon, 25 miles away.

We were so close to the line and the chopper pilots were so good, carrying two patients at a time on the sled-like platforms on the sides of the small choppers, we received our wounded Marines before they had time to bleed much and certainly were never in shock. We heard no big guns but heard plenty of swishes of big stuff going above us.

In two battles, Berlin and East Berlin, in the mountains just below the Imjin River: In the first battle, I got 14 hours sleep; and in the second battle, I got five hours sleep. That's five hours in five days! Every one of my patients went home! In so-called "minor" surgery, the wounded were numerous, and all wounds were handled with plenty of local anesthesia with stretchers on boxes.

Two of the surgeons reported the largest series of arterial grafts in the world at that time from the 1st Marine Division. With all the fancy equipment the physicians use in Iraq, I wonder if their record was as good as ours.

Ray T. Smith, M.D.
Ex-Lt, MC, USN
Longmeadow, Massachusetts

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 2007 ASA Annual Meeting Activities

Alan D. Sessler, M.D., President

The Foundation for Anesthesia Education and Research (FAER) supports a number of activities and programs during the ASA Annual Meeting, which will take place this year on October 12-17. Through FAER's efforts, medical students, residents, physicians, educators and researchers have the opportunity to exchange knowledge about the latest techniques, advances and challenges impacting anesthesiology.

FAER/Abbott Laboratories-Volwiler and Tabern Resident Scholar Program: The Resident Scholar Program provides anesthesiology residents with the opportunity to attend a national scientific meeting with access to multiple scientific and educational sessions. Resident Scholars are expected to attend the ASA House of Delegates meeting on Sunday, October 14, the FAER Honorary Research Lecture and the FAER panel. They are encouraged to sample the full range of ASA Annual Meeting activities.

Friday, October 12

Resident Scholars Welcome Reception: The reception will take place from 8:30 p.m. to 10:30 p.m. at the Hotel Nikko in the Golden Gate Room. This is an informal welcome reception allowing the residents an opportunity to meet FAER Board members and other scholars before the ASA meeting sessions.

Saturday, October 13

Resident Scholars Orientation: The orientation will be held from 7 a.m. to 8:45 a.m. in Nikko I at the Hotel Nikko.

Guest speakers and topics are:

- Timothy J. Brennan, Ph.D., M.D., Professor and Vice-Chair for Research, University of Iowa Hospitals and Clinic, "Postsurgical Pain — Why Does It Hurt?"
- William L. Lanier, M.D., Professor of Anesthesiology (neuroanesthesia), Mayo Clinic; editor-in-chief, Mayo Clinic Proceedings, "FAER Awards and Career Opportunities."

Tuesday, October 16

Resident Scholar Reception: The farewell reception will be held from 6:30 p.m. to 8:30 p.m. at the Nikko Hotel in Nikko I & II. Attendees include the 2007 resident scholars, 2007 FAER Medical Student Anesthesia Research Fellowship participants, ASA officers, FAER Board members and staff.

Saturday, October 13

FAER Luncheon: The FAER Luncheon will be held from 12 noon to 1:30 p.m., at the Hotel Nikko in Nikko I. The luncheon is held to express FAER's appreciation to individual and corporate sponsors for their support and to

strengthen industry relations with FAER, ASA and specialty leadership.

This year's panel moderator is Jeanine P. Wiener-Kronish, M.D., Professor of Anesthesia and Medicine, Vice-Chairman, Department of Anesthesia and Perioperative Care, Investigator, Cardiovascular Research Institute, University of California, San Francisco.

Topics and panelists are:

- Peter F. Dunn, M.D., Executive Medical Director, Operating Rooms, Massachusetts General Hospital, Assistant Professor of Anesthesia, Harvard Medical School, "The Future of Operating Rooms."
- Michael A. Gropper, M.D., Ph.D., Professor and Vice-Chair, Department of Anesthesia and Perioperative Care, Director, Critical Care Medicine, Chair for Medical Quality University of California, San Francisco, "The Future of Critical Care Units."
- James D. Marks, M.D., Ph.D., Professor of Anesthesia and Pharmaceutical Chemistry, Chief of Anesthesia, San Francisco General Hospital, Vice-Chairman, Department of Anesthesia and Perioperative Care, University of California, San Francisco, "Discovering and Translating Next-Generation Biodefense Therapeutics."
- Michael S. Higgins, M.D., M.P.H., Professor of Anesthesiology, Surgery and Biomedical Informatics, Chair, Department of Anesthesiology, Vanderbilt University School of Medicine, Executive Medical Director for Perioperative Services, Vanderbilt University Medical Center, "Communication Technology in the O.R. and ICU."

Sunday, October 14

FAER Booth: At 12:30 p.m., the FAER booth opens in the ASA Resource Center. The 2007 FAER booth hours are: Sunday, October 14, 12:30 p.m. to 6 p.m., and Monday and Tuesday, October 15-16, 9 a.m. to 4 p.m. Those visiting the booth will have the opportunity to talk with current and for-



Alan D. Sessler, M.D., is Professor and Chair Emeritus, Mayo Clinic, Rochester, Minnesota.

mer grant recipients, FAER Board Directors and FAER staff. Please stop by to learn more about FAER's research and education grant programs, Medical Student Anesthesia Research Fellowship program, FAER/Abbott Laboratories-Volwiler and Tabern Resident Scholars program, FAER Academy of Research Mentors in Anesthesiology as well as the many other initiatives that FAER supports in its effort to advance anesthesiology.

Monday, October 15

FAER Academy of Research Mentors in Anesthesiology Workshop: The workshop "Finding the Right Mentor" will be held on Monday, October 15, from 8 a.m. to 11 a.m. in Moscone Center South Gateway Ballroom 102. Mentoring is a key factor in the successful development of a research investigator. As part of the Academy of Research Mentors' efforts to improve research mentoring in our specialty, this workshop will provide a discussion of how to identify the right mentor. Lectures on selecting the right mentor will be given by co-moderators Paul D. Allen, M.D., Ph.D., Professor of Anesthesia at Brigham and Women's Hospital, and Alex S. Evers, M.D., Henry E. Mallinckrodt Professor of Anesthesiology at Washington University School of Medicine. Lectures will be followed by brief presentations by individuals on how they identified their mentors and then a panel discussion.

Celebration of Research: On Monday, October 15, 12:30 p.m. to 2 p.m. in Moscone Center South, the journal *Anesthesiology* and FAER will co-host the Celebration of Research, providing lunch and educational programs. This year, James C. Eisenach, M.D., will succeed Michael M. Todd, M.D., as host of the Celebration of Research, Award for Excellence in Research presentations and the Residents' Research Essay Contest winners presentations. Lunch will be sponsored by FAER and Anesthesia Business Consultants, LLC.

The Seventh FAER Honorary Research Lecture: "Why We Need To Know How Anesthetics Work"

Mervyn Maze, F.R.C.A., F.R.C.P., F.Med.Sci., Ph.D. Professor Maze will present the Seventh Honorary Research Lecture on Monday, October 15, 2007, from 2 p.m. to 3 p.m. Dr. Mervyn Maze, Sir Ivan Magill Professor and Department Chair of Anaesthetics, Pain Medicine and Intensive Care at the Imperial College in London, will describe how research into the molecular species and neural substrates involved in the action of general anesthetics can improve the way we use existing drugs and how these also can inform us how to use anesthetics for clinical opportunities outside of perioperative care.

FAER Panel: 2007 FAER Panel: "Medical Education for the Next Generation of Physicians" will be held on Monday, October 15, 2007, from 3 p.m. to 5 p.m., Moscone Cen-

ter South, Gateway Ballroom 102-103. Panel members will present information on the current and future status of medical education, including medical school, residency and continuing medical education. Sean K. Kennedy, M.D., Associate Professor of Anesthesia, University of Pennsylvania, Chief of Anesthesia, Philadelphia Veterans Affairs Medical Center, will moderate the session.

Panelists and topics include:

- Stephen Slogoff, M.D., Dean Emeritus, Stritch School of Medicine, Loyola University, Chicago, "The New Paradigm for Medical Student Education."
- Simon Gelman, M.D., Ph.D., Leroy D. Vandam/Benjamin G. Covino Distinguished Professor of Anaesthesia, Harvard Medical School, Department of Anesthesiology, Perioperative and Pain Medicine, Brigham and Women's Hospital, "Future of Medical Education."
- M. Christine Stock, M.D., James E. Eckenhoff Professor and Chair, Department of Anesthesiology, Feinberg School of Medicine, Northwestern University, "Portfolio-Based Records: The Next Wave in Graduate Medical Education."
- Arnold J. Berry, M.D., M.P.H., Professor of Anesthesiology, Emory University, "The Role of Continuing Medical Education in Improving Patient Care."

Tuesday, October 16

Medical Student Anesthesia Research Fellowship Symposium: The symposium will be held on October 16, 2007, from 3:30 p.m. to 5 p.m. at Moscone Center South, Gateway Ballroom 102. As part of the FAER Medical Student Anesthesia Research Fellowship, FAER offers students the opportunity to make a research presentation during the ASA Annual Meeting at the FAER Medical Student Anesthesia Research Fellowship Symposium. The 2007 symposium will be moderated by Donn Dennis, M.D., F.A.H.A., FAER Director, the Joachim S. Gravenstein, M.D., Professor of Anesthesiology and Director of Nanomedicine at the University of Florida College of Medicine, and Vice-President of Pharmacology at ARYx Therapeutics, Inc., Fremont, California. In addition to presentations by selected students, poster presentations will be located in the room for viewing and the students available for discussion. Following the symposium, the students and their mentors will join the Resident Scholars at the **FAER/Abbott Laboratories-Volwiler and Tabern Resident Scholar Program Reception** from 6:30 p.m. to 8:30 p.m. at the Nikko Hotel in Nikko I&II.

The aforementioned programs and events are just a few of the ways FAER serves the specialty. Without the support of those who give their time, talent and financial support, FAER would be unable to grow and fulfill its research and education mission. The FAER Board of Directors and staff look forward to a successful meeting, and we thank you for your support.

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San Francisco



ASA 2007 Annual Meeting October 13-17, 2007

**Registration opens at 3 p.m. Friday, October 12, 2007,
at Moscone Center.**