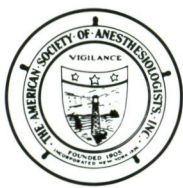




AMERICAN SOCIETY OF ANESTHESIOLOGISTS



# NEWSLETTER

SEPTEMBER, 1993

VOLUME 57 NUMBER 9

*Only the past*



*The Waters-Morton House*

*is immortal*





Watercolor by Leroy D. Vandam, M.D.

As this quotation by American writer Delmore Schwartz emphasizes, our specialty's history must be preserved and examined to enrich the future of anesthesiology. Through the efforts of the WLM, the important history of anesthesiology will live on for present and future generations to learn from, enjoy and share in our heritage.

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

### SUBSTANCE ABUSE HOTLINE

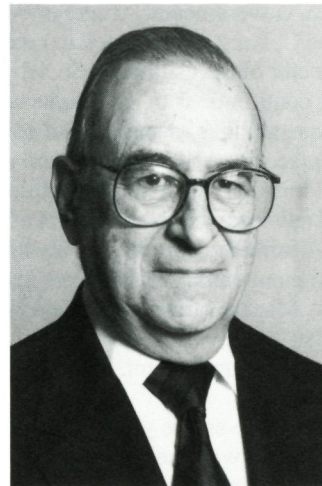
Contact the ASA Executive Office at (708) 825-5586 to obtain the addresses and telephone numbers for State Medical Society Programs and Services which assist impaired physicians.

## **Organized Medicine: A Public Utility, Fact or Fancy**

As one carefully examines the crystal ball, it becomes increasingly apparent that the ultimate goal of career bureaucrats is to create a public utility out of what is euphemistically referred to as "health care." The "providers" deliver, not unlike the telephone company or local power company, a service for which they are remunerated. Unfortunately, unlike the existing public utilities, medicine will not find it as easy to request rate hikes as conditions warrant.

It is into this crystal ball that the ASA Task Force on Structure and Function must peer to anticipate a recommended course of action for ASA to follow, as the Task Force charge directs.

On page 30 of this issue, John B. Neeld, Jr., M.D., Task Force Chair, summarizes some of the concerns and possible courses of action to be undertaken. Hopefully, ASA will continue "to advance the science and art of anesthesiology" as stated in the introductory portion of its Statement of Policy.



*Erwin Lear, M.D.*

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

Erwin Lear, M.D.  
Editor



## Endings and Beginnings

*Peter L. McDermott, M.D., President*

After seven years as Director of the ASA Office of Governmental Affairs in Washington, D.C., Adrienne C. Lang has resigned to take a position as Executive Director of the California Society of Anesthesiologists. Her contributions to ASA have been extraordinary. Her unique abilities as analyst and advocate make her truly irreplaceable. We wish her well in her new job, and we will miss her valuable contributions to policy development and advocacy in governmental affairs.

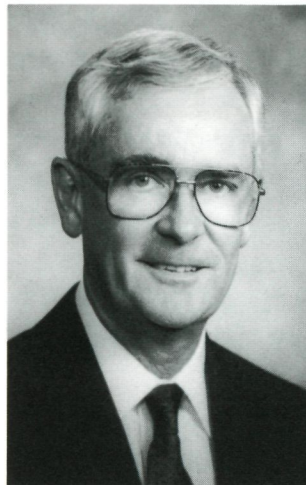
A further occurrence in Washington: S. Diane Turpin, who monitored and evaluated state issues as State Relations Manager from the same office, has been accepted as a first-year law student at Washington University and has left ASA employment. Diane's talents and energy will be missed.

I want to assure you that ASA is dealing quickly and effectively with these changes. We see these staff departures as an opportunity to reconfigure the Washington office and to redefine its role in serving the interests of ASA members.

We have had the great, good fortune to obtain the full-time, in-house employment of Michael Scott, Esquire, ASA's legal counsel of many years, as the new Director of our Washington office. He brings with him a wealth of experience and knowledge specific to anesthesiology. He is without peer in the analysis and interpretation of law, regulation and contracts as they apply to our specialty. He also enjoys a cordial and effective working relationship with ASA's lobbyist, Dan Maldonado.

What new possibilities for ASA are there in these changes? For one, it gives ASA an opportunity to develop the capacity to assist its members on issues of practice management. Health system reform and the increasing emergence of managed care programs make it essential that anesthesiologists have access to expertise in contract evaluation and in the development of negotiating skills. Relationships with hospitals, physician groups, insurance programs and regulatory agencies will become more and more complicated. ASA can become a clearing-house and a resource to its members on matters related to practice management — sharing experiences and expertise.

We will, in addition, augment our ability to monitor and evaluate state issues such as scope of practice, physician reimbursement and the implementation of managed care plans. We should be able to create a consultation service for Component Societies and individual ASA members



*Peter L. McDermott, M.D.*

which will improve their ability to survive in the face of change.

Informing and preparing its members for tomorrow's challenges is a duty ASA owes its members. The future will belong to those who ask the right questions and to those who show up with the right information.

Times are changing — one era gives way to another. ASA goes from strength to strength as it prepares to embark on a decade of health system reform. It would be a mistake to think that health system reform will occur overnight or that it will be the product of a few imposed upon the many.

A lengthy process has begun, and there will be many players. ASA will be part of the national debate and one of those players. Mike Scott and the team he builds in Washington will have a powerful role to play in anticipating change and in planning our strategies. We have a contribution to make in advocating at every level for the interests of anesthesiology and the people we as physicians are privileged to serve.



## HCFA Clarifies Consultation Codes

*Adrienne C. Lang, Director  
Office of Governmental Affairs*

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Some anesthesiologists have inquired as to whether they can bill Medicare for preoperative evaluations. The preoperative evaluation is, of course, contained in the value of the base units for each anesthetic and cannot be unbundled for separate billing.

A second question is often asked about more comprehensive history and physical consultations that are not usually, but might occasionally be, done by anesthesiologists. There are consultation codes that can be used by other physicians which are appropriate when, for example, a surgeon might request an extensive history and physical for a particular patient.

The Health Care Financing Administration (HCFA) requires that the following criteria be met in order to be reimbursed for such a consultation:

- The surgeon requests the physician's opinion or advice on the evaluation and/or management of a certain problem.
- The patient's medical record documents the surgeon's request and need for a consultation.
- The patient's medical record documents the consultant physician's opinion and services the consultant orders or performs; these must be communicated to the surgeon.
- The physician doing the preoperative consult provides all services required to meet the CPT description for the level of service being billed. In addition, only one physician could bill for such a consult for any given patient.

Anesthesiologists should not be billing separately for usual preopera-

tive evaluations, whether the day of surgery or in preoperative clinics days before surgery.

## AMA Answers Questions on Reform

As the summer months come to a close, we have not yet seen the Clinton Administration health reform plan. Congressional and Administration officials now admit that enactment of a major legislative package is impossible for 1993.

The latest timetable put forward by the White House is a mid-September release of broad principles, followed by legislative language in mid-October. However, as of August 1, the components that are the most basic and the most difficult had not yet been decided by the White House: what constitutes a basic benefits package, will there be universal access and how will the multibillion-dollar tab be paid?

The continued delays have given organized medicine more time to refine the issues as viewed by many physicians and to get the message out to the public.

The American Medical Association (AMA) has produced a list of 20 questions and answers explaining its position on national health system reform. The AMA has provided this information to the state, county and specialty medical societies. The points made certainly respond to the most asked questions and frequently voiced concerns.

Following are excerpts of the text; the full document is available from the ASA Office of Governmental Affairs or your state medical associa-



tion. Again, the following responses are from the AMA.

- *Will the AMA go to "war" over the Clinton proposal?*

We don't think anything would be accomplished by "going to war." If the plan adequately serves our patients' interests, we'll be supportive. But if the plan falls short of what is needed to guarantee patients' quality care, we'll assume the role of the loyal opposition and work hard to change elements in the plan that don't benefit our patients.

- *Why is the AMA opposed to global budgets and spending caps?*

Because they're the wrong approach to costs. We believe that spending must be brought under control, but these kinds of controls are bad for patients. Global budgets and spending caps don't address the root causes of increased spending. Because these spending pressures still exist, appropriate medical care and infrastructure upkeep end up being cut to stay within the limits.

Global budgets and caps sacrifice good patient care just to stay within an arbitrarily set number.

- *How does the AMA plan to contain costs?*

We have to change the incentives in the health care system. All Americans must be able to choose from a variety of insurance plans. They must be able to purchase a standard benefit package. Physicians should be able to group together to negotiate rates — something that current antitrust laws prohibit.

We also believe that while strict

budget limits are not acceptable, it would be appropriate and beneficial for all the parties in the health care sector to come together to negotiate predictable spending.

- *Isn't physician income the engine that drives the cost problem? Haven't physicians been gouging the system for a long time? What would the AMA do to get a handle on physician fees?*

Physicians' incomes are not what is driving up health care spending. About 19 percent of the money spent in this country on health care pays for physician services. But this money doesn't just go in the physician's pocket as income. It pays for the physician's overhead expenses, including the salaries of everyone who works in the office, rent, liability insurance, office supplies and equipment. If you cut every doctor's income by 50 percent, you would only reduce health spending by about 6 percent.

Physicians undergo the most extensive and rigorous training of any profession. Eighty percent go in debt for their training, with the average debt being more than \$50,000. To encourage highly qualified young people to choose a career in medicine, it is necessary to offer a competitive income.

- *How do we get more physicians into primary care? Hasn't the AMA encouraged specialization?*

The AMA represents all physicians and does not favor one area of medical practice over another. Medical students choose their areas of practice based on a number of factors such as the student's personal preference and perceived area of natural

competence, the prestige of a specialty, the type of lifestyle or hours that a certain type of medical practice demands and the amount of income. For students with high educational debts, the amount of potential income may be a deciding factor . . .

We believe that patient care is at its best, and physicians perform their best, when physicians are in a specialty of their choice.

- *How does the AMA think health reform should be paid for?*

Health system reform should be funded through a combination of contributions from employers, employees and individuals, and the government. The government should help subsidize coverage for lower income people. And it should help out small businesses, either through tax policies or subsidies.

- *What does the AMA think of managed competition?*

Managed competition incorporates some of the elements that we think are crucial in health care reform: a continued role for the private sector in health care, consumer choice, broadened access, an employer mandate and economic competition. We can't support, however, government incentives under managed competition that steer patients and physicians toward managed care systems.

We believe that free-market competition means that all competitors are on a level playing field. The people in the market decide what's best, not the government.

For a copy of the complete AMA document, call the Office of Governmental Affairs at (202) 289-2222.



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## Why Visit the Wood Library-Museum of Anesthesiology?

*Elliott V. Miller, M.D., President*

*Wood Library-Museum of Anesthesiology Board of Trustees*

A visit to the Wood Library-Museum of Anesthesiology (WLM) will enrich your present practice of anesthesia. This is the first and foremost reason to visit.

Objects are on display that are not available anywhere else in the world. Laënnec invented the stethoscope, and you can see his very own displayed. You will also be able to trace the development of the modern anesthesia machine. The exhibit on curare contains a blow gun, poison arrows, crude curare and illustrative photographs.

Other exhibits provide a view of the evolution of vaporizers, the mobile units of anesthesia machines developed during World War II, the Korean and Vietnam Wars. There are innumerable artifacts and pieces of equipment, all of which provide an important picture of how anesthesia equipment has developed to the present day. John Snow's inhaler stands prominently among other historic displays.

When you enter the beautiful new ASA Executive Office building, you will meet the receptionist directly ahead of you. Immediately to your right is the entrance to the Museum. Paul M. Wood, M.D., who did much to foster the development of ASA and our Library-Museum, is represented prominently in the exhibit area. The story of his life and contributions is one of great interest.

Guided tours can be arranged by advance scheduling with Patrick P. Sim, WLM Librarian, or Sally S. Graham, Assistant Librarian. Occasionally, George S. Bause, M.D., (volunteer) Museum Curator, is in town, and you may be able to arrange a personally guided tour with him. Self-guided tours with audio cassette tapes are under consideration.

On the third floor is the world's best library in anesthesia-related holdings. The collection of rare books and current publications numbers approximately 9,000. There are photographs and paintings of people and important sites related to our specialty. The audiovisual room contains all of the videotapes in the "Living History of Anesthesiology" collection. You may select a tape and watch it right there — or select several to take home on loan.

A tour through the reading rooms also is of great interest. There are exhibits



*Elliott V. Miller, M.D. is affiliated with Massachusetts General Hospital and is Assistant Professor at Harvard Medical School, Boston, Massachusetts.*



in these rooms depicting the people in whose honor the rooms are named (e.g., John Adriani, Henry K. Beecher, Robert D. Dripps, K. Garth Huston, Sr., Emery A. Rovenstine and Ralph M. Waters).

The WLM archives are extensive. Among them are those of anesthesia societies and collections of the papers of important figures in anesthesia.

In addition to enriching your working experience, the WLM will be interesting to family members. There is a great deal to learn and much to enjoy by arranging your own visit there. The WLM is open Monday through Friday from 9:00 a.m. to 4:45 p.m. It is near and very convenient to the busiest airport in the world, being only a 15-minute taxi ride from O'Hare International Airport. You are welcome to spend a few minutes or many hours of enrichment. If you are unable to visit, however, our library staff can assist in your current or archive/history information needs by telephone, fax or mail. **ASA**

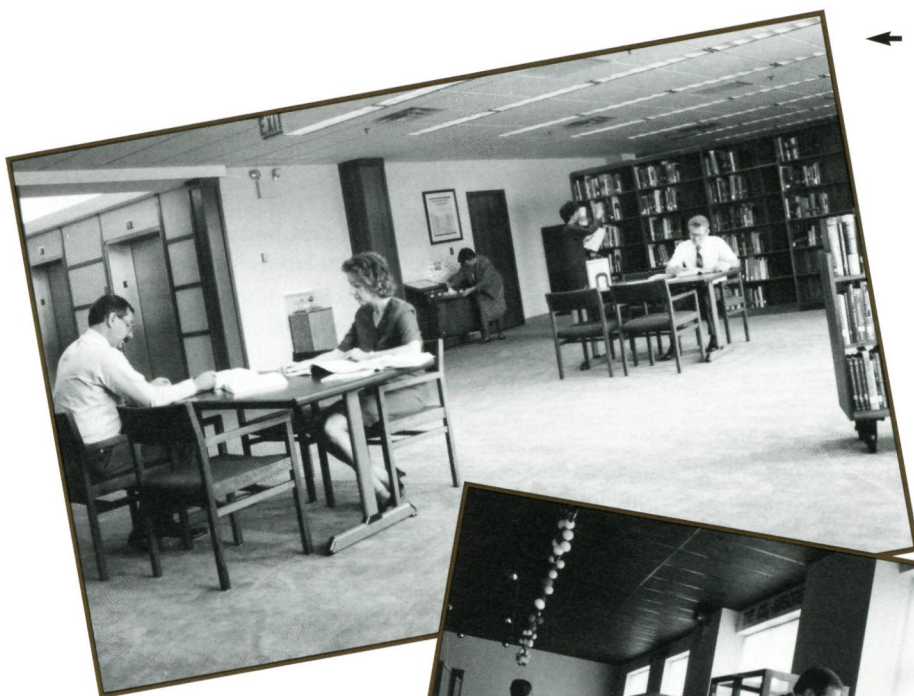


← The museum of the Wood Library-Museum of Anesthesiology is adjacent to the lobby at the ASA Executive Office in Park Ridge, Illinois.

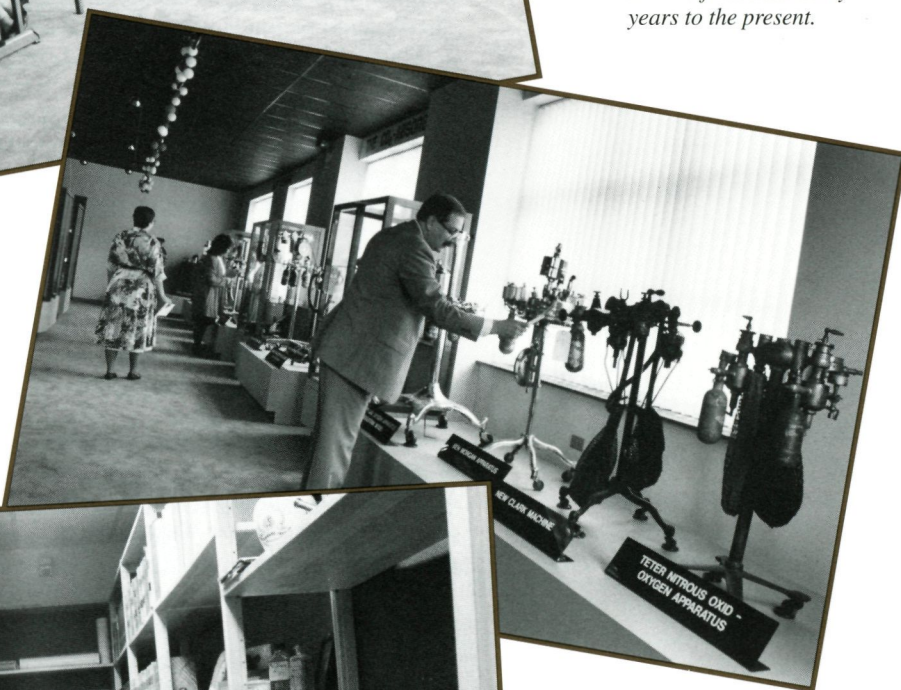
↓ Many treasures and artifacts important to the continuing development of anesthesiology are located inside the museum. Visitors are always welcome.







← In the heart of the library is the Emery A. Rovenstine main reading room. Open space and lots of light make researching in any of the 9,000 volumes housed here more enjoyable.



↓ A tour through the museum allows one to trace the evolution of anesthetic-inducing devices from their early years to the present.



← The K. Garth Huston, Sr. Rare Book Room houses more than 1,000 rare items, including books, pamphlets, journals and other anesthesia-related memorabilia.



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## The Waters-Morton House

*Leroy D. Vandam, M.D.*

William Thomas Green Morton (1819-1868), who was the first to successfully demonstrate ether anesthesia, was born in Charlton, Massachusetts, on August 9, 1819. (See "The Morton House" cover of the August, 1989 ASA NEWSLETTER.)

In 1827, when Morton was 8 years old, his father, James Morton, bought this house on Cemetery Road in old Charlton Center from the estate of Israel Waters, a prosperous tanner. The property was mortgaged at the same time to Leicester Academy.

The main house, a handsome 2-1/2-story, Georgian edifice with massive indoor chimneys at each end, was dedicated as a national monument in 1975. The Waters-Morton House is now owned by the Gilmore family.

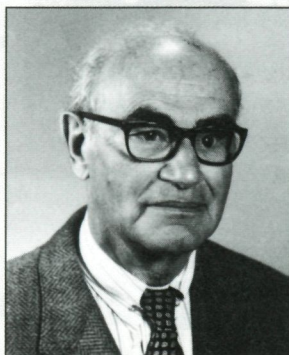
Young Morton attended the local public school, then Charlton Academy conducted by his father, and subsequently Leicester and Northfield academies. At age 16, he departed Charlton for Boston to work in a religious bookstore run by James Dow, publisher of the Christian Witness.

According to Benjamin Perley Poore in his 1856 preliminary biography of W.T.G. Morton, some time during the Charlton interval, Horace Wells (then an itinerant practitioner) took care of the dental needs of James Morton, the father. Perhaps this was the occasion that led to the younger Morton's future dental practice and his relationship with Wells, events which eventually led to the successful demonstration of ether anesthesia on October 16, 1846 at Massachusetts General Hospital.

### Editor's Note:

*The beautiful watercolor on the cover by Leroy D. Vandam, M.D. is one of several "Vandams" in the collection of artworks at the Wood Library-Museum. His paintings have won many blue ribbons at the ASA Art Exhibit and have appeared on the cover of the Journal of the American Medical Association.*

**ASA**



*Leroy D. Vandam, M.D., a former Trustee of the Wood Library-Museum, is Professor of Anesthesia Emeritus, Harvard Medical School and is affiliated with Brigham and Women's Hospital, Boston, Massachusetts.*



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## Put It There!

### An Invitation from Your Wood Library-Museum

*B. Raymond Fink, M.D., Chair  
Wood Library-Museum of Anesthesiology Publications Committee*

Can you, will you add a ray of sunshine to the WLM's three half-centuries of summer? Bestow fresh radiance with items selected from your own store of memorabilia?

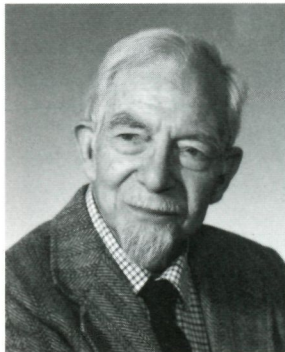
Whatever their period, they and you will gain Holocene recognition on the plaque placed by Museum Curator George S. Bause, M.D. next to every exhibit. Dr. Bause will warmly welcome all manner of relics: he suffers from painful gaps in regional anesthesia — ancient needles, syringes, connectors, prescriptions; he aches for vaporizers such as Drägers and has spasms of yearning for early laryngoscope blades.

Librarian Patrick P. Sim extends a comprehensive, scholarly hospitality to antiquarian books, archival journals, hospital records, billings, photographs, family albums, all manner of rarities reconditely aging on your shelves, your walls, in files, yea, even in your safe. Patrick will catalogue and lovingly annotate them for use within the Rare Book Room, where they will rub shoulders with prized editions of the airs men — Black, Priestly, Scheele, Lavoisier, Davy; and the vaporers — Morton, Bigelow, Snow, Simpson; or if ready access be more suitable, there are ample open shelves.

Donating items to a quasi-public institution is sometimes gratuitously belittled as a mere gesture to posterity. “We are always doing something for Posterity,” grumbled Addison; “I would fain see Posterity do something for us.” Anesthesiologists are as fain as anyone, but they see in the WLM far more than a collection of curiosities assembled for the edification of latter-day gawkers. The WLM receives your vigorous support because it enables ASA members to visualize and understand their work in a historical context worthy of and commensurate with their awesome responsibilities.

The founders of ASA were wedded to the notion that enjoyment of the WLM inheritance is a unique and essential part of being a complete anesthesiologist. It documents the evolution of a vital sector of human progress. The collections retell the exertions of successive posterities and relive many travails and ordeals that later perfectionists are apt to take for granted or forget.

Additions to the collection amortize the obligation we assume under the



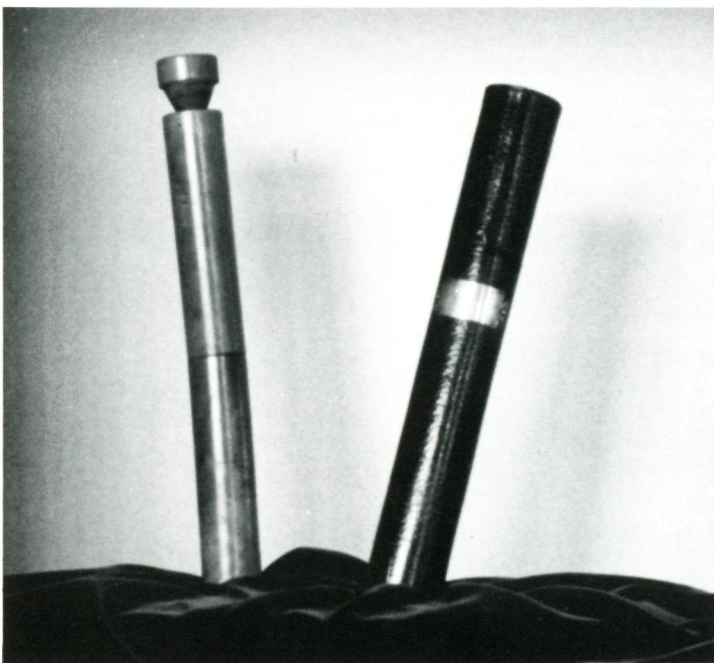
*B. Raymond Fink, M.D. is Professor Emeritus of Anesthesiology at the University of Washington, Seattle, Washington.*

ancient unwritten contract of Western civilization.<sup>1</sup> The debt is accepted on oath at graduation and repaid by enlarging it. The hallowed tradition, of course, sprang up in Hellas. Revitalized in Renaissance Europe, it has been zealously fostered on our shores. It honors teachers and cherishes the books and instruments used in their instruction and practice. It trains the learners to do likewise, that each generation may transmit to the next generation an ever goodlier inheritance, that improvement of the pupil, by the pupil and for the pupil may never cease!

This, in essence, is what motivated Paul Meyer Wood, M.D. to assemble and donate the nucleus of our Library-Museum, counting on following posterities to maintain and enhance it, in the conviction that concrete history deepens both our self-respect and understanding and the public's appreciation and confidence in its anesthesiologists.

Accordingly, the WLM does not set a narrow bound to anesthesiological vision but probes its origin and nature in manifold recesses. Like the Hubble space telescope, the instrument may not return an ideal image, but its imperfections cumulatively lessen with the improvements that result from appeals such as this.

Historical artifacts and books obviously acquire greater potential on display within our WLM than in the confines of a private collection. There is no doubt at all about that. They gain in numbers of viewers and users, and they add to the fund and force of ideas.



*Laënnec stethoscope, circa 1819. Courtesy of the Wood Library-Museum.*

Many join a sequence in which added meaning springs from the presence of predecessors and successors. A few stand out as starting points. Behold the first stethoscope, yes, Laënnec's, an antique wooden tube from the early 1800s that kept tuberculous rales and rhonchi at arm's length. Or admire a portrait by Sir Joshua Lawrence of the only known authentic likeness of Sir Humphry Davy (donated by our Curator, who is Davy's direct descendent), or go upstairs to read the original of Davy's undying book on nitrous oxide. Make your own additions to the collective of bequests. You gain, we gain, they gain from being placed in rightful sequence among their peers.

Thanks to farsighted nurture, the WLM has matured into a proud and distinctive expression of our professional identity. As already mentioned, it seeks to connect the problems of today to the visible, readable past, so that novelty may be recognized and honored as part of an ever-advancing flow.

Unquestionably, this approach is not merely instructive but also serves to emphasize the func-



tional beauty of many of the objects. The antique patina of the first stethoscope is there to see, maybe to feel and even to smell. Smell. I note that P. O. Fanger, an anti-pollutionist, recently proposed two new units of smell: the “decipol” and the “olf.”<sup>2</sup> A decipol is the pollution caused when one is resting and ventilating steadily at 10 liters per minute. Olfness is not measured electronically but by a panel of sniffing judges. A sedentary person apparently whiffs in at 1 olf, active people at between 5 and 11 olfs, a smoker not smoking at about 6 and a smoker smoking at 25. As for instruments, speaking for myself, I will admit to detecting a faint aroma around many an old one, for example, a pleasing 0.1 olf near the Laënnec stethoscope.

And why stop there? Let’s have other units surreptitiously serviceable in museums — a “palt” or “tang” for touch, say; and a “peep” for vision. The Laënnec might rate a cautious minitang, the Davy portrait a bold maxipeep. They have their rivals.

And that is not all. The holdings also embody something recalling the purification which Aldous Huxley regarded as a leading function of literature.<sup>3</sup> “*Donner un sens plus pur aux mots de la tribu*” is the exact quotation — “to give a purer sense to the words of the tribe.” There is many a hint of artistic clarification in the marshaled items, straining for truer application of physiology, pharmacology, biochemistry, anatomy — and melioration of the drugs and techniques of administration.

Thus, the WLM may adventitiously boast of overlapping the other culture, not altogether fortuitously blending quadrivium and trivium: science and art vibrating together in the primitive masks and the majestic compositions by Dräger and Ohmeda, with overtones from the quiet harmonies of Gerard Manley Hopkins:

Elected Silence, sing to me  
And beat upon my whorled ear,  
Pipe me to pastures still  
And be the music that I care to hear.

from: *The Habit of Perfection*

Just as in the operating room! Poetic fantasy, however, is not an admitted aim at our WLM. What we want is to construct an ever truer image of the past leading on into the future. That needs everybody’s help. Each gift sheds light on the bright fantastic story. You are invited to take a hand. Put it there!

#### References:

1. *The encyclopedia of philosophy*. Edwards P. ed. Toronto, Ontario: Collier-Macmillan; 1967; 7:466.
2. McCormick J. In praise of stinks. *Lancet* 1993; 341:1126-1127.
3. Huxley A. *Literature and science*. New York, NY: Ox Bow Press. 1963:114.



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gists.”

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## The Wood Library-Museum and the Future

*Donald Caton, M.D., Chair  
Wood Library-Museum of Anesthesiology  
Long-Range Planning Committee*

*"Some books are to be tasted, others to be swallowed, and some few to be chewed and digested."*

— Francis Bacon

Whatever your interests in medical literature, you will find something to suit your "taste" at the Wood Library-Museum of Anesthesiology (WLM). Our collection is unique. The founder, Paul M. Wood, M.D., envisioned an institution that would serve as a repository for papers, archives, artifacts and all other material relevant to the growth and maturation of our specialty. Through his efforts and those of many others, we now have a superb collection.

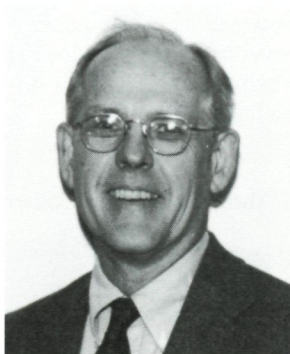
But the WLM is more than a museum and historical library. We also have papers, books and journals pertinent to all aspects of contemporary practice. The material, old and new, is meant to be used. Consider how we use it now, and then help us plan how best to use it in the future.

### Meeting Your Needs

At present, history buffs use the WLM the most. "Buffs" constitute a surprisingly heterogeneous group. Some are practitioners who want to know more about the origins and development of their specialty or the career of a favorite teacher. Others are officers of ASA or state societies who use the archives to resolve legal or administrative problems.

Professional historians constitute another group. Representatives from the Wellcome Medical History Library in London and the Smithsonian Institution in Washington, D.C. have used the WLM to prepare exhibits, books, papers or videotapes for public as well as professional distribution.

At the other extreme, we have a strong following among children, who request material for school projects or research papers. We even receive requests from newspaper reporters and from state and national legislators who want to know more about our specialty.



*Donald Caton, M.D. is Professor of Anesthesiology, Obstetrics and Gynecology, and Chief of Obstetric Anesthesia, University of Florida College of Medicine, Gainesville, Florida.*



For those who are new to medical history, we can help you to get started. We can provide you with a list of suitable reading materials. We can also direct you to people with similar interests who live in your geographic area. If you want a speaker for a lay audience or professional meeting, we can help you to find experts recognized for their work in the field of the history of anesthesiology (see the article on page 21).

The collections of the WLM may help even those who have no interest in medical history. For example, many of the artifacts collected over the years have been arranged into loan exhibits suitable for display for professional and lay organizations, county or state medical meetings or hospital exhibits. Members of ASA have used the material for public relations work for hospital administrators, legislators or members of the media.

Members of the Board of Trustees of the WLM have a strong commitment to the history of anesthesiology. We believe that the management of pain is one of the most significant developments in medicine during the past two centuries. The history of this effort may be particularly important in the next few years as social, economic and political forces alter clinical practice. We believe that critical examination of the past will enable us to identify those elements that will be most important to protect during this period of social upheaval.

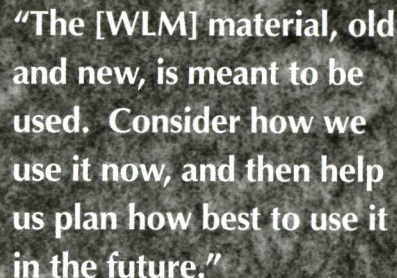
For the aforementioned reasons, the Board of Trustees will continue the traditional work of the WLM. We will collect artifacts, representative pieces of equipment, books, paintings and pictures. We will function as the primary repository for records and documents for the specialty. In addition, we will promote the history of anesthesiology by funding scholarly research, by offering reprints of important books and papers, by sponsoring the Lewis H. Wright Memorial Lecture at the ASA Annual Meeting and by collecting videotaped interviews of contemporary practitioners who have made significant contributions to the specialty.

### **Your Library — Your Priorities**

The space allocated to the Wood Library-Museum in the new ASA Executive Office building creates new opportunities. For the first time, we have resources to house, catalogue and exhibit the fine collection of artifacts donated by so many practitioners for so many years. In addition, we have shelves to hold all of our books and journals. The accessibility of the material gives us the opportunity to expand conventional library services. However, we do need to know what services you need and how we can best make them available to you.

The WLM differs from conventional libraries and, therefore, has special problems. It serves a group that has a very specific orientation, the practice of anesthesiology. Though well-defined, the group is widely dispersed. Many of those who need the library's services cannot come to the library to browse through shelves or thumb through books or journals. Members of ASA who have computers and modems have no problem because, with a subscription to the appropriate computer information service, they may search the literature and obtain the information they need.

At present, members of ASA who do not have a computer or do not know



**"The [WLM] material, old and new, is meant to be used. Consider how we use it now, and then help us plan how best to use it in the future."**

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how to use them may obtain help from the librarians of the WLM. They will search the literature and obtain copies of the appropriate material for you. We would like to know, however, how we could improve this service. For example, some have suggested that we have a "research librarian" who could provide technical advice for those who are "computer illiterate." Others have suggested that we develop new ways to distribute library material by "E-mail" or "electronic bulletin board."

We also have considered developing new services. For example, some members have noted that at least a dozen separate government and professional organizations publish guidelines pertinent to the safe practice of anesthesiology. They have suggested that the WLM collect, collate and help to distribute this material.

#### **Please Help Us to Plan**

The Trustees of the WLM recognize the need for change. For this reason, we have convened a Long-Range Planning Committee. We have sought advice about future work of the WLM from officers of ASA, directors of training programs and the presidents of Component Societies.

Many of the ideas mentioned above originated from members of these groups. However, we also want suggestions from individuals. The WLM exists to serve ASA members. Please send suggestions to Librarian, Wood Library-Museum, 520 N. Northwest Highway, Park Ridge, Illinois 60068-2573; or to Donald Caton, M.D., Department of Anesthesiology, University of Florida College of Medicine, P.O. Box 100254, Gainesville, Florida 32610-0254.





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## Care and Preservation of Videotapes

*John J. Leahy, M.D., Chair*

*Wood Library-Museum of Anesthesiology Living History Committee*

Since the introduction of videotape recording more than 25 years ago, the video cassette recorder (VCR) has become an important part of nearly every household, not only for entertainment but for archival purposes. The Wood Library-Museum of Anesthesiology (WLM) collection of video material is indeed priceless, and masters as well as duplicates are carefully preserved in a temperature- and humidity-controlled environment. But, for everyone who values their collection of videotapes, there are a few fundamental rules that ought to be remembered:

1. Recording tape is not permanent. It is a plastic strip to which metallic particles, capable of being magnetized, are attached by cement. Tapes can remain in good condition for long periods of time under environments similar to those that are hospitable for humans. They dislike extreme cold, heat, humidity or dryness. Storage temperatures of 15-25°C and relative humidity of 40-60 percent are ideal. Properly stored and maintained magnetic tape should last for many years, possibly as long as motion picture film. Unfortunately, we have received some valuable tapes at the WLM that were useless because they had been improperly stored for 15 or 20 years.
2. The cement used to hold the metallic particles to the backing have been greatly improved over the years, and tape presently available is much more resistant to deterioration than that used 20, 10 or even five years ago. It is recommended that any old tapes which you wish to preserve be redubbed (copied) onto new tape periodically. Regrettably, there will always be a slight loss in quality with each generation of copying a tape, yet that is preferable to losing the contents entirely! But, keep the original recording, too.
3. Tapes like to be "exercised" or ventilated. If not played frequently, they should be fast-forwarded and rewound at least once every three years. Tape should be neatly wound before storage. Avoid storing tapes that are not

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*John J. Leahy, M.D., now retired, was on the faculties of Georgetown University, Washington, D.C., Northwestern University, Chicago, Illinois and Thomas Jefferson University, Philadelphia, Pennsylvania. For the past 20 years, he has served as Director, Wills Eye Hospital, Philadelphia, Pennsylvania.*



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fully and smoothly wound onto either the take-up or supply reel. This procedure also should be followed for any tapes you plan to copy or rerecord. There are inexpensive devices available for this purpose to save time and wear and tear on your VCR. It is recommended that you use some system to remind yourself and to place a mark (such as a red dot) on the cassette whenever this is done.

4. Placing of tapes or, in other words, how you place them on your shelf is very important. They are intended to be stored upright in their protective cases (like books on a shelf) and never laid or stacked on their sides. Never leave a cassette out of its case when not in use as they must be protected from dust, which is harmful to the tape as well as to your VCR.
5. Keep tapes away from stray magnetic fields. Do not leave near electrical equipment (e.g., speakers, electric motors, television receivers) which generate strong magnetic fields. Many a valuable recording has been damaged severely by lying on its side atop a television receiver. Be particularly aware of desktop items that have magnets and may cause damage to recorded tapes.
6. Do not play your original (master) tapes on equipment that may not have been properly maintained. Playback heads and tape paths that have become contaminated with dust or oxide particles or have become magnetized permanently can damage or totally destroy a recorded tape.

Great advances are being made in recording techniques, and it is likely that at some future time, all recording will be done on optical disks (similar to compact disks) which will have a virtually unlimited life span. Such processes now exist but are prohibitive in cost. Also, digital video recording already exists (but again, it is extremely expensive). With it, multiple-generation copies are possible with no loss of quality (as in copying computer disks).

But these are in the future and, for now, we must do the best we can to preserve whatever visual heritage we have been able to collect in the best manner possible with the hope that, at some time, we can transfer it to a more permanent medium.





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## From the WLM Archives: Ansel M. Caine, M.D., Pioneer Anesthesiologist

*Patrick P. Sim, M.L.S., Librarian  
Wood Library-Museum of Anesthesiology*

By definition, archives pertain to public records and historical documents that are collected and preserved for posterity. They are firsthand records of individual and group activities, behavior, happenstance and all other social interactions that accurately reflect events of a given era.

Such records are precious evidence that allows historians to study and reconstruct the history of a given era accurately and objectively, with perspectives of the historian's own era from a distance made possible by the passage of time and by the proximity of events that occurred in yesteryear. In a very broad sense, archives are historical records in many forms and media such as official documents, artifacts, oral records, manuscripts, photographs, video recordings, personal correspondence, impressions, reminiscence, memorabilia, keepsakes and numerous other materials.

The institution that houses such relevant historical documents and artifacts pertaining to a given discipline is called the archive of that discipline. True to every aspect of the term, the Wood Library-Museum of Anesthesiology (WLM) is the official and bona fide archive of anesthesiology.

This article introduces the WLM archives with dual purpose. It will illustrate a small aspect of its archival role as a national treasure house to reflect the rich and colorful heritage of the specialty of anesthesiology. It will also demonstrate to anesthesia historians the practical application of archival records for research.

Additionally, there is perhaps a third purpose, which is more subtle and a little self-serving. It is hoped this article will win the confidence of its readers to encourage further donations to expand the WLM archival holdings. This can be achieved by donations of personal files and artifacts or by directions for the WLM to reach potential archival sources. After all, the collection of the WLM began with a single-minded individual who, in his unique role as ASA Secretary-Treasurer and WLM Librarian-Curator, single-handedly amassed priceless treasures since the third decade of the 20th century.

The subsequent enrichment of the WLM archives came from individuals and institutions sharing the same value that Paul Meyer Wood, M.D. cherished



*Ansel M. Caine, M.D.*



*Patrick P. Sim, M.L.S. has served as Librarian of the  
Wood Library-Museum of Anesthesiology for 22  
years.*

**Figure 1**

NEW ORLEANS, *July 31, 1918.*

*Mrs. Jennie Husson*

TO ANSEL M. CAINE, M. D., DR.  
ANESTHETIST

1528 LOUISIANA AVENUE PHONE UPTOWN 2935

<i>July 26</i>	ADMINISTERING NITROUS OXIDE		
	ADMINISTERING ETHER		<i>5 00</i>
	CONSULTATION		

RECEIVED PAYMENT.  
*Irene G. Higgins*  
*8-12-18.*

*Billing receipt for anesthesia service provided by Ansel M. Caine, M.D. gives historians a glimpse of anesthesiology practices in the earlier part of this century. Courtesy of the Wood Library-Museum.*

throughout his entire life.

Recently, a very rare and valuable artifact was sent, unsolicited, on February 25, 1993, to the WLM Librarian from Anthony G. Poché, M.D. of Metairie, Louisiana, a suburb of New Orleans. It was a slightly foxed, original billing statement for anesthesia service to a patient issued three-quarters of a century ago in New Orleans [Figure 1]. The ink on the letters, though slightly faded, renders a legible record of anesthesia practice in the first quarter of the century.

The dispenser of medical anesthesia service was none other than well-known American pioneer anesthesiologist, Ansel Marion Caine, M.D. (1882-1961), who led a distinguished family of three generations of anesthesiologists. The bill simply recorded the patient's name, service rendered, the dates of service, billing and receipt of payment. The evidence on the statement, however, is quite revealing.

First, Dr. Caine identified himself as a medical doctor and physician anesthesiologist in the formative era of the specialty. The practice of anesthesia 75 years



ago involved simply the administration of nitrous oxide, the administration of ether and the rendering of professional consultation.

In the case of Mrs. Jennie Husson, the patient to whom the bill was sent, she was treated on July 26, 1918 for the administration of ether for a fee of \$5. Billing was prepared by a member of Dr. Caine's office staff, Irene G. Higgins on July 31, 1918. Payment was received in less than two weeks on August 12, 1918.

The billing statement also allows a research historian to locate Dr. Caine's practice address, which was 1528 Louisiana Avenue in uptown New Orleans as indicated on the statement by his telephone number. It provides a glimpse of the demography of the time and place as well as the turnabout period of service reimbursement for a medical doctor from service rendered to payment received.

Anesthesiology certainly has come a long way, from the administration of only two inhalation anesthetics during the first quarter of the century to the present technologically sophisticated anesthesia patient care system in the last quarter of the century. By comparing the present to the past, this simple document provides a great appreciation for the dedicated service of a medical specialty which was born less than one and one-half centuries ago. The year 1918, as the mid-point of the 150-year history of anesthesiology, yields interesting observations. The first 75 years saw little progress in the specialty. Ether and nitrous oxide administration continued to dominate the anesthetist's armamentarium. In drastic contrast, the last 75 years witnessed an exponential growth of this specialty in all directions.

A further exploration of the personal archives of this American pioneer anesthesiologist reveals that Dr. Caine was born in 1882 in Perry County, Alabama. He received his undergraduate education from Howard College in Birmingham, Alabama. He went on to study medicine at Tulane University in New Orleans where he was awarded his medical degree in 1907, at about the same time when anesthetists began to organize themselves in Long Island, New York.

The archival record on Dr. Caine does not reveal the origins of his anesthetic interest. In his own handwriting, however, Dr. Caine indicated that he had begun full-time clinical anesthesia practice in 1909, two years after he had graduated from medical school. This developed into a lifetime medical career based at the Touro Infirmary and Southern Baptist Hospital in New Orleans.

The record further reveals that anesthesiologist Curtis W. Caine, M.D. was his fourth child (who had a son, Curtis W. Caine, Jr., M.D., also an anesthesiologist). It also discloses the lighter and humorous aspects of this pioneer anesthesiologist. He enjoyed fishing, pronounced himself "a late Rotarian" and indicated his political affiliation as "Democrat or Republican."<sup>1</sup>

In addition to his personal dedication to his chosen medical specialty, Dr. Caine was a leader in organized and academic anesthesia of his time. As a full-time pioneer anesthetist, he is credited posthumously for providing "spade-work" in promoting physician anesthesia in New Orleans. Together with a group of physicians whom he had personally trained, he promoted medical

**"The year 1918, as the mid-point of the 150-year history of anesthesiology, yields interesting observations. The first 75 years saw little progress in the specialty. . . In drastic contrast, the last 75 years witnessed an exponential growth of this specialty in all directions."**

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anesthesia in New Orleans and Louisiana for decades. He was also the first to administer warmed ether vapor by passing warm air through liquid ether to prevent anesthesia-induced pneumonia.

Dr. Caine and his junior associate, Wilmer Baker, M.D., joined John S. Lundy, M.D. and Ralph M. Waters, M.D. in the formation of the Anesthesia Travel Club in 1929. This group met periodically to exchange information and establish a professional network for the advancement of the medical specialty of anesthesia. The tradition he had established in New Orleans was further developed and perpetuated by another prominent modern anesthesiologist, John Adriani, M.D., who came from New York to head the development of modern anesthesiology at Charity Hospital. Among Dr. Adriani's early residents was Dr. Curtis W. Caine.<sup>2</sup>

This biographical account of Dr. Ansel Caine, based on the archives of the WLM, is necessarily sketchy. It is an attempt to illustrate the role of the national archival repository for anesthesiology. Without the awareness of its role in the minds of the ASA membership, the WLM would not have been the beneficiary to a rare artifact of an early anesthesia service billing statement. Through the receipt of this artifact, a segment of the history of American anesthesia is elicited in the life of a prominent pioneer.

Apparently, the resources of Dr. Caine's biography have not been exhausted. There are other archival resources in the WLM such as the oral history collection, official institutional records and other personal files of his friends and associates awaiting to be explored. We shall leave it to future historians to complete the story of Dr. Caine relative to the formative era of modern American anesthesiology.

#### References:

1. Ansel Marion Caine, M.D., Biographical File, 1946. Wood Library-Museum Archives.
2. Zepernick RG, Hyde EG, Naraghi MA. John Adriani: Contributions of Charity Hospital to the specialty of anesthesiology. In: Volpitto PP, Vandam LD. eds. *The genesis of contemporary American anesthesiology*. Springfield, IL: C. Thomas; 1982:133-137.





## WLM Speakers Bureau: Speaking Out for Anesthesiology

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

What do military surgery, anesthesia devices, Indian arrow poison, eye-witness accounts, secularization of pain, historical reviews and the development of anesthesia as a profession have to do with the way you practice anesthesiology today? Perhaps more than you realize.

The Wood Library-Museum of Anesthesiology (WLM) maintains a list of speakers who have published or lectured on these and other topics concerning the history of anesthesiology or related subjects. Referral of such speakers may be arranged for any recognized group or organization requesting a speaker appropriate for a local, regional or national meeting. The WLM does not book lectures, but the staff will assist in finding a speaker or topic for your meeting or event.

Since "history repeats itself," why not look back and discover the future? Consider a refreshing look back into the origins of anesthesia for your state society meeting, including the spouse program. Perhaps an upcoming anesthesiology department lecture or seminar for medical students or residents would be a forum for insights into the history of pain management or pharmacology.

Include historical vignettes in your after-dinner entertainment at meetings or as education for those who want to know more about the development of the specialty and its role in current social trends.

Members who are interested in creating a broader appreciation for the history of anesthesia and its contributions to current practice may consider using the WLM Speakers Bureau for a variety of audiences and events.

For further information, contact the library staff at (708) 825-5586 or WLM Trustee Donald Caton, M.D. at (904) 392-3441.



### You can use the WLM Speakers Bureau for:

- local, regional or national meetings
- state society meetings
- specialty society meetings
- refresher course lectures
- seminars
- clinical conferences
- departmental meetings
- community and civic group functions
- after-dinner speeches
- special events at medical schools
- public relations for local medical societies
- core lectures for students of medicine, nursing or public health
- education of government officials or legislators



*Sally S. Graham, M.L.S. has served as Assistant Librarian of the Wood Library-Museum of Anesthesiology for five years.*

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## Preview of ASA Exhibit at Annual Meeting

*John Byrne*

A few months ago, while working on preliminary plans for the exhibit at the ASA Annual Meeting in Washington, D.C., it was brought to my attention that there are many members who attend the meeting but are unaware that ASA, itself, is a major exhibitor. At that time, it was suggested that perhaps some advance publicity would stimulate interest and spread the word that the exhibit is informative, impressive and well worth visiting.

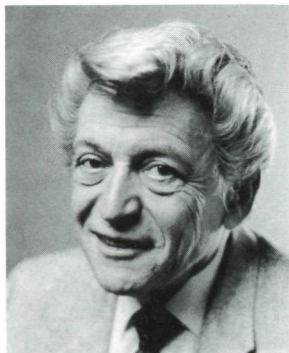
It would seem any ASA member could be so busy dealing with refresher courses, clinical update programs, meetings, seminars and serendipitous encounters with old and new friends, that there would be little time available to venture into the exhibit area. While one might be tempted to sneak off to some place not listed in any guide or program, kick off one's tired shoes and relax, one should resist temptation and venture forth to see the ASA exhibit.

This year, our exhibit will be located adjacent to the ASA hospitality area on the exhibit floor and will occupy a 20-foot-by-80-foot space. It will be divided into three sections with the Wood Library-Museum exhibit in the center flanked by an exhibit sponsored by the ASA Committee on Patient Safety and Risk Management with the Anesthesia Patient Safety Foundation and a separate exhibit by the Committee on Communications.

### **WLM Exhibit**

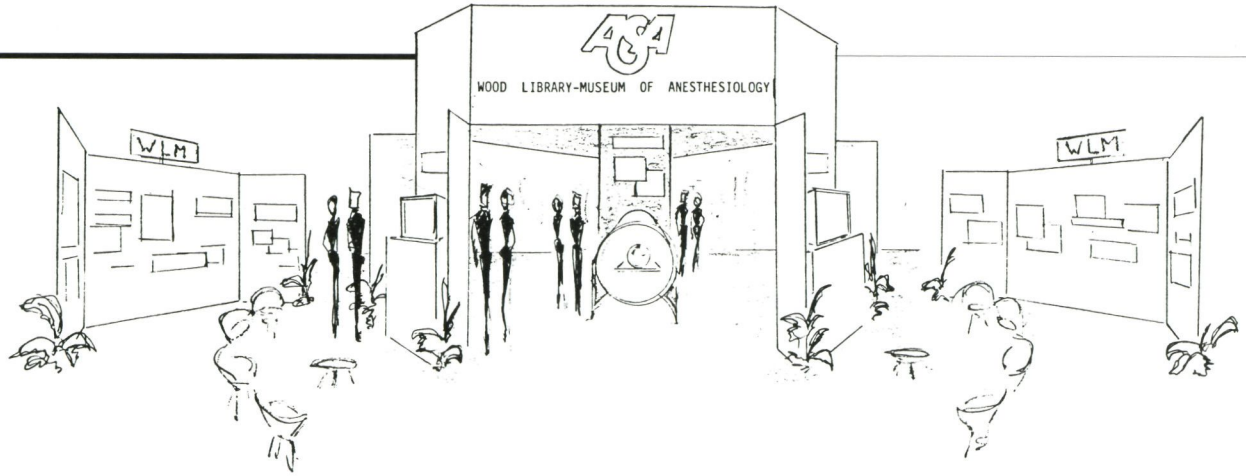
Beautifully planned and organized by Curator George S. Bause, M.D. and Librarian Patrick P. Sim and located in the spacious new ASA Executive Office building, the Wood Library-Museum (WLM) is not only a repository but also a resource.

In our fast-lane society with high-pressure lifestyles and stressful professionalism, we need the reassurance of continuity. The WLM, with its fascinating collection of well-displayed artifacts, rare books and current publications, provides that sense of attachment to a rich professional history while contributing to a vast future. Unfortunately, only a small sample of the continuity can be brought to the exhibit, but just enough to whet your appetite to visit the museum.



*John Byrne is an independent design consultant for exhibits and visual merchandising, East Corinth, Vermont.*





Plans for this year include:

- A display of an iron lung and an original Emerson ventilator with demonstrations of its use by its inventor, John (Jack) Emerson of Cambridge, Massachusetts.
- A "time line" display of the history of spinal anesthesia, which is being prepared by the American Society of Regional Anesthesia.
- Two audiovisual areas with seating for viewing selected tapes from the "Living History of Anesthesiology" collection.
- A display devoted to the history of hazards in the operating room. This section will relate to the adjacent patient safety area of the exhibit.



*Wood Library-Museum of Anesthesiology portion of the exhibit at the 1993 ASA Annual Meeting in Washington, D.C., as seen from the hospitality area. Sketch by John Byrne.*

### **Patient Safety Exhibit**

This area of the exhibit is part of a continuing program by the Committee on Patient Safety and Risk Management with the support of the Anesthesia Patient Safety Foundation to provide a forum in which health care professionals, manufacturers, insurance providers, government agencies and other interested parties can share information, ideas and concerns.

This year, the display and audiovisual programs will focus on hazards in the operating room, both violent and virulent — from fires and explosions to HIV and hepatitis. Special attention will be given to the difficult airway, pulmonary catheters, safe intravenous devices and infection control. Videotapes available for viewing will include "Fires in the Operating Room" and "The Difficult Airway," Parts I, II and III.

### **Communications Exhibit**

To quote Terry L. Dodge, M.D., Chair of the Committee on Communications, "... We have messages to deliver. We must communicate! ... Anesthesiologists have a number of different audiences, including but not limited to our patients, our surgical colleagues, hospital administrators, hospital employees, legislators, third-party carriers and the public at large." [ASA NEWSLETTER, April, 1993, pages 6-8]

This section of the ASA exhibit will be devoted to the ongoing process of improving our members' individual and collective communication skills. Plans for the Communications Exhibit include: an audiovisual area for comfortably viewing selected tapes; a section for inspecting slide presentations for patient education; information on ASA's Media Network activities; and an area for Resident Component information and communication. This exhibit is another example of our efforts to address the continuing need for communication among ourselves. We need for you to express your needs so that we can create even more meaningful communications programs.

Please seek out booth 1338 on your way to a coffee break in the ASA hospitality area of the exhibit hall. This combined exhibit is intended for the benefit of the ASA membership. Don't miss a real opportunity to vent your ideas and share some of ours.



# Fools Rush in Where Angels Fear to Tread<sup>1</sup>

Gerald L. Zeitlin, M.D., Immediate Past President  
Massachusetts Society of Anesthesiologists

## Editor's Note:

In the August issue of the ASA NEWSLETTER, Alan W. Grogano, M.D. pondered the "whys and wherefores" of an apparent reduction in the number of medical students selecting anesthesia as a career choice. The following article by Gerald L. Zeitlin, M.D. opines, "Are we training too many anesthesia residents?"

My guess, probably not. — E.L.

Are we training too many anesthesia residents? The Graduate Medical Education National Advisory Committee (GMENAC) study of the early 1980s attempted to project manpower needs; the effort appears to have been a fool's errand.<sup>2</sup> The continuing increase in enrollment in anesthesiology residency programs, however, requires an analysis of the situation.

Economic theory often raises the concept of supply and demand. On the supply side, the number of trained anesthesiologists in the United States is growing rapidly [Tables 1, 2, 3]. The number of American Board of Anesthesiology diplomates approximately doubled between 1980 and 1991.

In 1983, GMENAC published its second report on a needs-based model for predicting physician requirements in various specialties, including anesthesiology.

The GMENAC members projected anesthesia needs based on procedure rates estimated for 1990. The projected need for anesthesiologists was determined by estimating the length of time of anesthesia care for each operative procedure. Since much anesthesia care is provided by nurse anesthetists, GMENAC next estimated the propor-

Table 1

### ASA members (to the nearest 500).

1950:	5,000
1960:	7,000
1970:	11,000
1980:	15,000
1990:	27,000
1992:	29,500

Table 2

### Total number of anesthesiology trainees.

1970:	1,704
1975:	2,307
1980:	2,522
1985:	3,981
1990:	5,246
1991:	5,965

tions of each procedure that required an anesthesiologist's involvement.

The potential for inaccuracy with this approach was demonstrated recently in a study by the Battelle Medical Policy Research Institute. The study found significant variations in the time taken by different surgeons for the same operation.

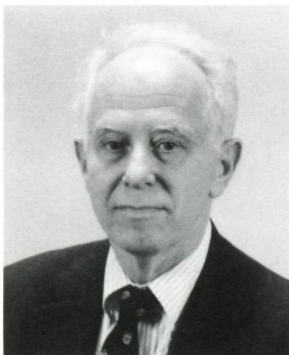
GMENAC assumed that anesthesiologists would be involved in 80 to 85 percent of anesthesia procedures when utilizing a team approach; it is not clear what was thought to be happening in the other 15 to 20 percent of cases. GMENAC also recognized that one anesthesiologist could be medically directing two nurse anesthetists.

At the time the advisory panel reviewed these estimates, it was thought the number of nurse anesthetists was unlikely to increase quickly enough to support their estimates. This prediction was correct. In 1981, schools of nurse anesthesia trained 1,400-1,500 graduates annually; this figure decreased to 600-750 by 1992.

The requirements for anesthesiologists in 1990 as projected by GMENAC were 22,143 full-time equivalents [Table 4].

On June 30, 1990, there were 27,034 members of ASA; of this number, 4,526 were residents. It is not clear whether the GMENAC report considered residents as part of the total anesthesiologists required in 1990. If residents were not considered, then the projection of 22,143 for 1990 was remarkably accurate (27,034 minus 4,526 = 22,508).

A recent article about manpower needs by Kronick et al. suggests that the total need for anesthesiologists would be 12,435 if managed competition should become the predom-



Gerald L. Zeitlin, M.D. is affiliated with Brigham and Women's Hospital and is an instructor of anesthesia at Harvard Medical School, Boston, Massachusetts.



**Table 3**

**Diplomates of the American Board of Anesthesiology.**

Total number of certificates issued 1938 to 1991 = 19,988

Total number of Diplomates alive in 1991 = 18,982

Certificates issued 1981 to 1991 = 9,986

**Table 4**

**Estimates made by GMENAC in 1983 of the number of anesthesiologists required in the United States in 1990. (FTE = full-time equivalent)**

Surgery-related needs	16,491
Obstetric-related needs	811
Intensive care	827
Pain therapy	198
Nonfaculty teaching, administration and research	2,950
Faculty (2,475 less 1,609 FTE for faculty patient care)	866
Total estimated 1990 required FTE =	22,143

inant system of health care delivery in the United States. There is no explanation for the source of this figure.

It is not unreasonable to equate roughly the number of ASA Active members with the number of practicing anesthesiologists. In Massachusetts, we know there are approximately 30 practicing anesthesiologists who are not members of our state Component Society compared to the 690 who are; this is a 4.3-percent difference.

The GMENAC projections could not foresee the dramatic changes in our specialty which make future manpower needs uncertain.

In 1992, Congress appointed a Council on Graduate Medical Education (COGME). This body proposed a system of coordinated planning by which 50 percent of medical school graduates would be forced to enter "primary care" specialties. The implementation of the proposal, if even par-

tially enforced, would decrease the number of physicians entering anesthesiology training programs. According to one news source, the growth in the total number of physicians from 1965 to 1990 was 111 percent. Gastroenterologists, cardiologists, neurologists and plastic surgeons have grown by 1,083 percent, 734 percent, 324 percent and 325 percent, respectively. One might argue that our numbers should mirror the growth in the number of surgeons (39 percent).

In the United States, there are approximately 74 practicing anesthesiologists per 100,000 of population (19,388/260,000,000). Similar numbers from other advanced industrialized nations might serve as useful comparisons. The professional anaesthesia associations in both the United Kingdom and Canada are currently collecting these figures.

Even such a comparison might well be invalid if the 1970 findings of Bunker are germane. He showed that there were twice as many surgeons in the United States as in England and Wales (in relation to the population) and that they performed twice as many operations. The indications for surgery were not sufficiently precise enough to allow a determination of whether American surgeons operate too often or the British too infrequently. What is known is that in 1992, there were nearly 1.5 million patients in the United Kingdom who had waited more than one year for elective surgery.

An article by Schwartz et al. in 1988<sup>3</sup> contradicts the conclusion of the GMENAC study. They support their article, "Why there will be little or no physician surplus between now and the year 2000," with the following arguments:

1. New technological advances promise to increase the demand by requiring physician involvement; further, the newer technology is unlikely to replace existing techniques to any significant degree. Advances such as heart, liver, pancreas and lung transplantation, the use of artificial hearts and implantable defibrillators and the treatment of metastatic tumors will require anesthesia participation.
2. Demographic and social changes such as the aging of the population, increased health insurance coverage, the improved availability of specialized physicians in smaller communities and increases in real personal income will increase the need for anesthesia participation.

3. The growth in the numbers of physicians engaged in teaching, administration and research and a decline in the number of hours per week that residents work will also constrain the supply of physicians for direct patient care. It is increasingly uncommon for anesthesiologists who were on "first call" at night to be obliged to work the next day.

If one assumes that one-quarter of all medical services may be unnecessary, the demand for services will still continue to grow at 1.3 percent per annum. Schwartz et al.<sup>3</sup> conclude that a surplus of physicians is only possible "if concern over rising costs leads to a sharp limitation on the provision of beneficial services"; in short, rationing.

Recently, Fuchs<sup>4</sup> suggested that there is great uncertainty whether American patients will accept rationing. He debunks the commonly held view that high health care costs are making American industry uncompetitive. He says that employer-paid insurance premiums are just a part of a compensation package and, as long as total compensation is paralleled by productivity, competitiveness is unaffected.

Other factors might make a surplus of anesthesiologists unlikely.

The geographic maldistribution of physicians applies as much to anesthesiologists as it does to other specialties. Hospitals in small communities perceive the need to provide a wide spectrum of services to market themselves for survival. Examples of such services requiring anesthesiologists are obstetrics, the treatment of acute and chronic pain and same-day surgery.

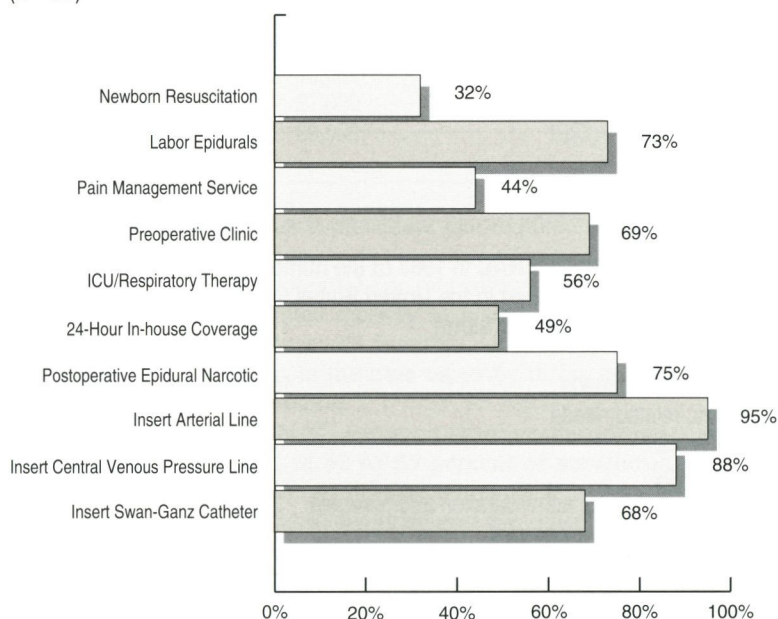
The study of anesthesia practice patterns in North Carolina by Vaughn et al.<sup>5</sup> showed a 27-percent increase in the number of community practitioners for the period 1984 to 1987. They concluded that this growth seemed largely to be filling an unmet need in anesthesiology subspecialties. Figure 1 displays the wide variety of activities undertaken by 63 anesthesiology departments that replied to the recent

**Figure 1**

### Massachusetts Anesthesiology Department Services

November, 1991 Survey

(n = 63)



From Massachusetts Society of Anesthesiologists Annual Practice Pattern Survey. Scope of services provided by 63 anesthesiology departments. Courtesy of Edward R. Roaf, M.D.

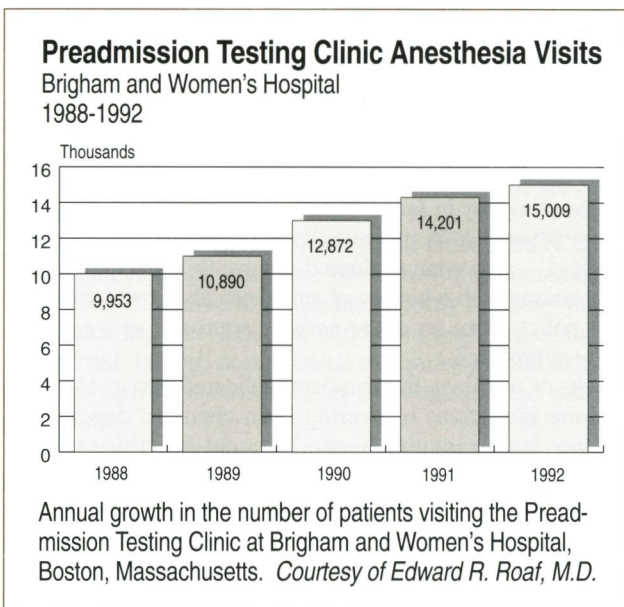
Massachusetts Society of Anesthesiologists' practice pattern survey.

Anesthesiologists who join the staffs of previously undermanned departments in community hospitals are in a uniquely influential position if they participate in hospital management activities; good relationships with hospital administrators and one's colleagues also tend to increase demands for anesthesia services.

Anesthesiologists are also increasingly involved in "primary" care. Figure 2 reveals the growth in the number of visits by patients to the Preadmission Testing Clinic at Brigham and Women's Hospital, Boston, Massachusetts.



**Figure 2**



The days when surgeons referred patients to internists for preoperative assessment ("keep the blood pressure up and give plenty of oxygen") are gone, thankfully.

The decline in the number of nurse anesthetists in training was cited previously. There are now political pressures extant that threaten the very concept of the anesthesia care team. However, some anesthesiologists believe that we should indeed be training more nurse anesthetists. They believe that because of the overall growth in demand, nurse anesthetists are not, and are unlikely to become, our competitors. It should be pointed out here that we are only one of two Western industrialized countries that allow anesthesia to be administered by nonmedical personnel. Some years ago, despite an apparent shortage of anesthesiologists, the concept of developing a corps of nurse anesthetists in the United Kingdom was rejected.

The opportunities for anesthesiologists to subspecialize are growing. Historically, subspecialization has always led to growth in demand in manpower.<sup>5</sup> On the other hand, the recent survey by Reves et al.<sup>6</sup> of anesthesiology residency programs for the period 1987 to 1991 showed a decline in the number of residents spending an extended

time (six to 12 months) in one subspecialty.

If one *assumes* that most anesthesiologists wish to retire from the work force at age 65 on average, then of the 1,700 residents entering the work force annually, approximately 300 would be replacing retiring physicians.

With all this uncertainty, perhaps it is now time for this question to be studied again. ASA might consider setting up a study commission with input from the Resident Component.

Special thanks to Alexander A. Hannenberg, M.D., Fredrick K. Orkin, M.D. and Edward R. Roaf, M.D. for advice and information.

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A complete list of references is available from the author upon request.

## Insurance Company Refusal to Contract with Recovering Physicians: Is This Still Happening?

William P. Arnold III, M.D., Chair  
Committee on Occupational Health of Operating Room Personnel

Over a year ago, a health insurance company refused to credential an anesthesiologist with a remote history of chemical dependence. That company's policy was "to accept and maintain as providers . . . only those physicians free from a history of substance abuse." The company subsequently modified its policy in response to actions taken by ASA and the American Medical Association (AMA), the details of which appear below.

In October, 1992, the ASA House of Delegates passed the following resolution:

**RESOLVED:** *That ASA introduce a resolution to the House of Delegates of the American Medical Association seeking its support and active participation in eliminating any discriminatory policy toward physicians recovering from substance abuse.*

The AMA strongly supported the ASA's position at the December, 1992 meeting of the AMA House during which it adopted three resolutions.

**RESOLVED:** *That the American Medical Association (AMA) study the extent of the practice by insurance companies of excluding participation by physicians in managed care or other provider plans, based solely on a history of substance abuse, and be it further*

**RESOLVED:** *That the AMA study the legality of such a policy based on current federal and state statutes; and be it further*

**RESOLVED:** *That based on the results of its study, the AMA take appropriate actions regarding the practice of insurance companies that exclude participation by physicians in managed care or other provider plans, based solely on a history of substance abuse.*

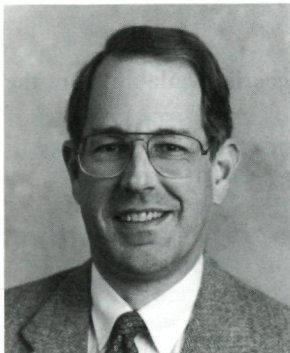
These resolutions, along with a legal memorandum suggesting that the insurance company's policy was a violation of the Americans with Disabilities Act, were furnished to the company in January of this year. In March, the company advised ASA that after reviewing its substance abuse policy, ". . . we have adopted a more flexible approach to physicians with a history of substance abuse which moves the policy from an *all-or-nothing* approach to a *case-by-case* approach."

As of that date, the company indicated that it: 1) would require physicians recovering from chemical dependence to pay for an inquiry to the National Practitioner Data Bank, 2) request a letter from the organization responsible for monitoring the physician, and 3) request a current curriculum vitae from the physician, to include work history.

The company further noted that its guidelines for credentialing "were constantly being re-evaluated," but as of mid-July, it had not responded to ASA's request for a copy of its written implementation of the guidelines.

ASA will continue to challenge uncompromising policies against recovering physicians. Should you or a colleague be denied the opportunity to participate with a third-party payer for similar reasons, please advise either the ASA Executive Office or William P. Arnold III, M.D.

Your report will be held in strict confidence; we need not know your name. Our goal is to prevent similar occurrences.



William P. Arnold III, M.D. is Associate Professor, University of Virginia Health Sciences Center, Charlottesville, Virginia.



## Occupational Exposure to Bloodborne Pathogens: Prevention to be Discussed at National Meeting

Arnold J. Berry, M.D., Chair  
Task Force on Infection Control Policy

Over a year and a half ago, the Occupational Safety and Health Administration published its Standard on Occupational Exposure to Bloodborne Pathogens in the *Federal Register*. The provisions of this standard were to be implemented by all applicable employers by July, 1992.

In spite of the heightened awareness resulting from these activities, anesthesiologists and other anesthesia personnel continue to incur occupational exposures with blood and body fluids from patients carrying bloodborne pathogens.

The Centers for Disease Control and Prevention (CDC) has documented 32 health care workers with occupationally acquired HIV infection, with the majority resulting from needlestick injuries. The true number of health care workers infected through occupational exposures is undoubtedly larger with many cases under investigation and others not reported.

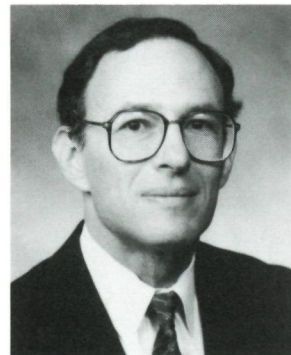
As the AIDS epidemic continues in the United States with an estimated one million HIV-infected individuals, clinicians and researchers have been working to develop strategies to prevent occupational exposures to infected blood and body fluids. Because of the tasks that they perform, anesthesiologists are included in the groups of health care workers at high risk for occupational exposure through bloodborne pathogens.

The ASA Committee on Occupational Health of Operating Room Personnel has published *Recommendations for*

*Infection Control for the Practice of Anesthesiology*, which addresses measures that can be taken by anesthesiologists to lessen the risk of occupational blood exposures. In addition to practicing universal precautions, many anesthesiologists have incorporated the use of available needleless or protected needle devices into their practice. In spite of these measures, accidental occupational exposures unfortunately continue to occur.

Research in the area continues to address practitioners' needs. To provide current information on the risk of transmission of bloodborne pathogens during surgical and obstetric procedures and to address new methods and ongoing research aimed at reducing the risk, the CDC and the American College of Surgeons are sponsoring a conference on "Prevention of Transmission of Bloodborne Pathogens in Surgery and Obstetrics." The meeting will be held in Atlanta, Georgia on February 13-15, 1994.

In addition to plenary sessions covering general information, specifics regarding problems relevant to the practice of anesthesiology will be included. Information including registration forms and requirements for submission of abstracts (due October 31, 1993) can be obtained by contacting John P. Lynch, Organization Department, American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611-2797; (312) 664-4050.



Arnold J. Berry, M.D. is Associate Professor of Anesthesiology, Emory University School of Medicine, Atlanta, Georgia.

## Redesigning ASA for the 1990s

*John B. Neeld, Jr., M.D., Chair  
Task Force on Structure and Function*

As part of the Administrative Council's strategic planning processes, five task forces were appointed to formulate reports on various areas of major importance to the Society.

The Task Force on Structure and Function met on January 9-10, 1993 in Atlanta. Members of the task force were: John B. Neeld, Jr., M.D., Chair; H. Jerrel Fontenot, M.D., Orin F. Guidry, M.D., William D. Owens, M.D. and Betty P. Stephenson, M.D.

The charge to the task force was to examine the present structure and function of ASA in light of anticipated future demands upon the Society and to recommend changes that would strengthen the Society, increase its value to members and improve its function.

Among the topics evaluated were the duties of the President and the Administrative Council; the structure and function of the Board of Directors and its committees; the organization, oversight, interaction and function of the committees of the Society; and the role of the ASA Executive Office staff.

In approaching our task, there was a remarkable unanimity of opinion among the task force members regarding a major concern that underlies our recommendations: the maintenance and enhancement of the strength of ASA and its ability to represent all anesthesiologists regardless of practice style, geographic location or subspecialty interest. There was a concern that the Society should not be lulled into a sense of complacency by years of seemingly effortless growth.

As all of medicine becomes uneasy over initiatives in Washington and as reimbursement levels are reduced by

managed care contracts and government regulation, some members may believe that ASA is not as relevant to their particular needs as subspecialty societies. (Simply put, we cannot assume that ASA is immune to the problems that beset the American Medical Association and other large medical societies.)

Our report will recommend initiatives in five major areas.

### Board of Directors

A strong, functional, fully participatory Board is critical to the Society's health. The appointment process for Board committees has appeared to be somewhat restrictive, resulting in the failure of some Directors to ever serve on a Board committee. In addition, the Board has not been active in assisting Section chairs in the oversight of the ASA's committees. Our report recommends the formation of a fifth Board committee, an increase in committee size to six members, a term limit for committee chairs and an alteration in the current process of committee nominations.

The fifth Board committee would be the Committee on Organization and would provide oversight and assistance to Section and Committee chairs. A primary goal of the committee would be coordination among various committees and the review and revision of committee charges to avoid overlap or duplication of effort.

### Member Services

In order to maintain and enhance the value of ASA membership, we must make a continuing effort to identify and meet the changing needs of our membership. Our report recommends a new Committee on Member Services and major educational initiatives in management, contracting, leadership development and institutional relationships.

In addition, the Section on Education and Research will be requested to continue efforts to improve the convenience of its offerings through the use of emerging technologies such as interactive digital video, simulators, etc.

### Subspecialty Relations

The ability of ASA to effectively represent the specialty would be threatened if our members were to perceive that subspecialty organizations offered more relevant benefits and services than ASA at lesser cost. Our report recommends various proposals to strengthen our relationship with the subspecialty societies.



*John B. Neeld, Jr., M.D. is Chair, Northside Anesthesiology Consultants and Vice-Chair of the Board of Directors, Northside Hospital, Atlanta, Georgia. He is also ASA Assistant Treasurer.*



### ASA Committees

A review of the existing committee structure reveals that some committees are relatively inactive, others overlap or duplicate one another, and some appear uncertain as to their charge.

Our report recommends formation of certain new committees (such as the Committee on Member Services), consolidation of certain committees with similar duties and assignment of other committees to sections that appear to afford better coordination of activities.

A restructuring, coupled with the enhanced oversight and coordination provided by the new Board Committee on Organization, should improve the overall function of the committees and their service to the membership.

### ASA Staff

Increased levels of activity by the Board, increased oversight of committees and implementation of new member services and educational programs cannot be as dependent upon physician volunteerism as we have been in the past. ASA senior officers and staff should evaluate the staff support provided to officers and committees by comparable organizations with a report and recommendations to be presented to the Board in March, 1994.

The challenges facing ASA are immense; so are the talents of our membership. Our task force believes its recommendations, along with those of the other working groups, will assure that ASA continues to well represent and serve its entire membership.

## Changing Times in Anesthesia Research and Education: How Do We Respond?

*Phillip O. Bridenbaugh, M.D., Chair  
Task Force on Research and Education*

The Task Force on Research and Education was charged with identifying the educational needs of the ASA membership to coordinate those needs with current educational offerings and to address future requirements. Special attention needs to be given not only to new technology in anesthesia practice, but also to the technology now available for education, e.g., simulators, interactive computer programs, CD-ROM, etc.

The task force was also charged to evaluate the possibility of creating a national consensus on anesthesia research, the establishment of priorities in resource development and the allocation of those resources. After extensive discussion of a broad array of current and future research and educational issues of importance to anesthesiologists, the task force will offer recommendations and comments in select areas.

### Research

All anesthesiologists need to remind themselves that it is research that ultimately provides us with new knowledge, drugs and technology and which separates us as consultant anesthesiologists from other physicians and other members of the anesthesia care team.

ASA needs to increase its awareness of the activities and

potential resources of a variety of research-related agencies, not only the National Institutes of Health, National Safety Foundation and the Food and Drug Administration, but also the Foundation for Anesthesia Education and Research (FAER), Anesthesia Patient Safety Foundation, Society of Academic Anesthesiology Chairs, Association of Anesthesiology Program Directors, Association of American Medical Colleges and other specialty and subspecialty societies of medicine. The ASA Committee on Research works very closely with FAER to encourage and circulate research grants submitted for funding.

The task force will recommend that the Committee on

*Phillip O. Bridenbaugh, M.D.  
is Professor and Chair, Department of Anesthesiology, University of Cincinnati, Cincinnati, Ohio. He is also ASA Vice-President for Scientific Affairs.*



Research and FAER develop a "white paper" on anesthesia research for the next decade. It will also recommend a series of articles in the *ASA NEWSLETTER*, informing the membership of the clinical benefits emanating from basic and clinical research and the significant support ASA gives to anesthesia research.

### **Education**

Significant time and effort were spent analyzing the current continuing medical education (CME) offerings of ASA, including not only annual and regional meetings, but also the journal, *Anesthesiology*, the Self-Education and Evaluation (SEE) Program and refresher course publications. With recertification and continuing competence programs becoming more common, the task force discussed the role of ASA in focusing educational offerings to members toward successful participation in these activities.

Another area of perceived educational need of the membership is in the acquisition of new skills, e.g., transesophageal echocardiography and fiberoptic endoscopy. Hands-on workshops using simulators, interactive video and models are being used by other specialties with apparent success.

As a result of these discussions, the task force will recommend that ASA work with subspecialty societies in the presentation of workshops teaching new technology and techniques. ASA should explore opportunities to present educational programs focused on continuing demonstration of qualifications and other continuing competence type examinations.

### **Wood Library-Museum of Anesthesiology (WLM)**

It should be noted that the WLM Board of Trustees has also created a long-range planning committee to evaluate its current programs and to consider areas for new and expanded activities. There is interest in the potential use of the CD-ROM technology, both for archival and educational programs. The two groups have had dialogues to determine new roles for WLM in ASA's educational programs. Efforts will be made to explore a reference service to members participating in the SEE Program.

### **Overseas Anesthesia Teaching Program**

The task force acclaimed the success of the Overseas Anesthesia Teaching Program under the direction of Nicholas M. Greene, M.D. ASA President Peter L. McDer-

mott, M.D. has appointed another group to look at the future directions of that program. Our task force discussed ASA's potential for teaching in underserved areas in a more global fashion through collaboration with outside agencies such as the World Federation of Societies of Anaesthesiologists and Project HOPE.

### **CME Needs Assessment**

In order for ASA to sponsor courses for CME credit for its members, it must meet certain standards as defined by the Accreditation Council for Continuing Medical Education (ACCME). Included in those standards are such requirements as statements of course objectives, course evaluations and needs assessment of the membership. The last membership survey for educational needs was apparently done around 1985. As noted in the report of the Task Force on Communications [*ASA NEWSLETTER*, April, 1993], a membership needs assessment survey relating to communications and other ASA programs is being conducted.

The Task Force on Research and Education will recommend that an "educational needs" survey of the membership also be conducted.

### **ASA's Role in Retraining Programs**

The special educational needs of a very small segment of our membership were discussed. This includes people wanting to return to practice after prolonged absences and people wishing to learn or retrain in select subspecialty practices or new techniques. It was felt that residency training programs, rather than our national Society, were better able to deal with these needs on an individual and statewide basis.

### **Summary**

The Task Force on Research and Education has engaged in a broad but in-depth discussion of many areas relating to ASA's programs, current and projected. Members on the task force represented most of the agencies currently involved in anesthesia research and education. The Chair wishes to acknowledge and thank the task force members: David E. Longnecker, M.D., John R. Moyers, M.D., Philip-pa Newfield, M.D., Susan L. Polk, M.D., Lawrence J. Saidman, M.D. and Donald R. Stanski, M.D. for their contributions and efforts in preparing the task force report.



## ASA Resident Component 1993 Preview and Review

*Diann H. Bridenbaugh, M.D., Chair  
Resident Component Governing Council*

The Resident Component House of Delegates will convene on Saturday, October 9, 1993 in the North Salon of the Grand Ballroom in the Washington, DC Renaissance Hotel.

This year, in particular, will see changes in format that more closely mirror those of the "big House." For example, seating of delegates will be in alphabetical order followed by a rotating sequence in future years. The House will open with the Chair's "call to order" and an invocation led this year by the Rev. Richard Ward, M.D. (a retired anesthesiologist who was recently ordained a Catholic priest), followed by the pledge of allegiance.

The nomination and election of officers also have been changed. Names must be submitted prior to the call to order, and each person must declare the office for which he or she is a candidate. We are no longer cascading the nominations because our component has grown large enough so that there are many people interested in and qualified for each position.

The Governing Council's opinion is that these changes must occur to move the Resident Component forward in a manner befitting the emulation of our parent Society.

The Governing Council has attended to particular issues this year that we felt would benefit our entire component.

1. A concerted effort has been made by all to encourage and help establish state resident component societies. Without our delegates, there would be no ASA Resident Component nor would there be an avenue to represent all residents and resident issues to ASA.
2. A newly revised and updated "Resident's Guide to the ASA" has been written and awaits publication. It is hoped that it will be distributed at the ASA Annual Meeting.
3. A Task Force on Resident Practice Management has been formed under the guidance and leadership of Bernard V. Wetchler, M.D., ASA First Vice-President. The impact from the outcome of this group will concern each and every resident as they address issues of future employment and survival into the 21st century.
4. Residents will have representation for 1993-94 on many ASA committees, including Geriatric Anesthesia, Patient Safety and Risk Management, Occupational Health, Standards of Care, Manpower, Surgical Anesthesia, Communications and Acute Medicine. (Our thanks to Wilson C. Wilhite, Jr., M.D., ASA President-

Elect, who graciously made these appointments.)

5. We continue to be represented at the American Medical Association by Ronald L. Harter, M.D., Delegate, and John R. Warren, M.D., Alternate Delegate.

While we are only four years into our formal organization, the Resident Component has been blessed with strong support from our parent Society and with people who have shared their time and talents to support this organization. It has been my privilege to work with a wonderful Governing Council, and I am most grateful for their time and energy which helped make this a most rewarding and productive year. Special thanks goes to Michael P. Smith, M.D., Vice-Chair; Renee A. Pitner, M.D., Secretary; Ronald L. Harter, M.D., Delegate; and John R. Warren, M.D., Alternate Delegate.

This year at the ASA Annual Meeting, we are fortunate to have been given the opportunity to share space with the Committee on Communications in the ASA Booth in the exhibit hall. Do stop by and say hello, meet the new officers and learn more about the Resident Component and how you can become involved. See you there!



*Diann H. Bridenbaugh, M.D. is an anesthesiology resident in her third year at the University of Cincinnati College of Medicine, Cincinnati, Ohio.*



## Helping to Preserve Our Past and Plan Our Future

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Vincent J. Collins, M.D. Winnetka, IL	Arthur S. Keats, M.D. Houston, TX	North American Dräger Telford, PA	Gerald J. Savage, M.D. Wilmington, DE	Department of Anesthesiology Yale University School of Medicine New Haven, CT
Lyle W. Cook, D.O. Kansas City, MO	Elliott H. Klain, D.O. Las Vegas, NV	Ohmeda Madison, WI	Ole V. Secher, M.D. Hellerup, Denmark	Myron Yaster, M.D. Baltimore, MD
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Gianfranco Dal Santo, M.D. El Paso, TX	Erwin Lear, M.D. Sands Point, NY	Irving M. Pallin, M.D. Sun City, AZ	South African Society of Anaesthetists Bergvliet, South Africa	



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## Keyword Program Search Again Offered at Annual Meeting

The Keyword Program Search (KPS) services will again be offered at the ASA Annual Meeting scheduled in Washington, D.C. from October 9-13, 1993. KPS is available free to all ASA Annual Meeting registrants.

KPS is a computerized database that will enable meeting registrants to select keywords and subjects of interest via on-site computer terminals. The Keyword Program Search for the ASA Annual Meeting in Washington is supported through a grant from Ohmeda — Subsidiary of The BOC Group.

### Custom-Designed Keywords

Annual Meeting participants select the keywords that best describe their specific area(s) of interest in anesthesiology. Then a computer search of a database containing scientific presentations scheduled for this year's ASA Annual Meeting is performed.

### Complete Program

The personal KPS program integrates any combination of unrelated keywords into a complete program that coor-

dinates an individual's interests in one handy source. This program provides a listing of relevant presentations without the necessity of reading the entire Annual Meeting Program book to locate specific areas of interest.

### Easy-to-Read Schedule

The presentations contained in an individualized KPS program are arranged in chronological order. Each presentation listing includes the title of the presentation, the authors, the date, time and site of the presentation.

To receive a KPS program at the ASA Annual Meeting:

- Pick up a KPS program order form and Keyword List in the ASA registration area.
- Complete the KPS order form and present it to KPS program personnel.

A personal KPS program will be prepared while you wait or can be picked up later at your convenience.

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## Journal Sponsors Symposium on Perioperative Pain Mechanisms

Gary R. Strichartz, Ph.D.

Editorial Board of Anesthesiology

The second scientific symposium sponsored by the Editorial Board of the journal, *Anesthesiology*, will be held at the ASA Annual Meeting in Washington, D.C. on Tuesday, October 12, 1993. The symposium's theme is "Basic and Clinical Aspects of Perioperative Pain."

The symposium will start at 9:00 a.m. with one hour to view posters representing 13 selected abstracts. From 10:00 a.m. to 11:00 a.m., there will be two formal lectures: "Basic Mechanisms: An Overview," presented by Tony L. Yaksh, Ph.D., University of California-San Diego, and "Clinical Considerations: Insights and Possibilities," presented by Igor Kissin, M.D., Ph.D., Brigham and Women's Hospital, Harvard Medical School.

The next 90 minutes will be devoted to a discussion of the posters and the lectures, moderated by Charles B. Berde, M.D., Ph.D., Boston Children's Hospital, Harvard Medical School.

Active audience participation is encouraged at this symposium. The Editorial Board seeks to advance the scientific content of the ASA Annual Meeting and to establish a forum for discussing the relevance of basic research to clinical realities. We look forward to the attendance and participation of all interested.

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Gary R. Strichartz, Ph.D. is Vice-Chair for Research, Brigham and Women's Hospital and Professor of Anesthesia (Pharmacology), Harvard Medical School, Boston, Massachusetts.



## Workshop to Focus on Quality Assurance and Standards Issues

Stimulated by health insurers, health management organizations, accrediting agencies, and regulators, quality assurance has become an important component of hospital practice in the United States.

ASA offers a Workshop on Quality Assurance and Standards of Care to be held on November 20-21, 1993 at Marriott's Camelback Inn in Scottsdale, Arizona.

This workshop will look at the growth of quality assurance (QA) from its early, practitioner-based approach to current concepts of total quality management of an entire organization, as well as the emergence of standards of care.

These programs have important legal and medical practice implications that the practicing anesthesiologist should understand, especially when called on to represent the anesthesiology department in a hospital-wide quality management effort.

The workshop will provide a forum for discussion of QA and standards of care in the setting of anesthesia practice, the implications for credentialing, licensing, malpractice litigation, malpractice insurance rates, and the future of independent medical practice.

Sean K. Kennedy, M.D. is the program chair. He will speak on "Quality Assurance and Standards of Care: Background and Introduction" and "Third Parties and Quality Assurance — Standards of Care." The other speakers and their topics are:

- John H. Eichhorn, M.D., "Standards of Care in Anesthesia" and "ASA and the Development of Quality Assurance in Anesthesia";

- Edward Hirshfeld, Esquire, "Practice Parameters vs. Outcome Measurements: How Will Prospective and Retrospective Approaches to Quality Management Fit Together?" and "Survey of Legislative Efforts to Implement Practice Parameters and Outcome Measurement";

- James Ziegenfuss, Ph.D., "Quality Assurance and Whole Organization Improvement" and "Continuous Quality Improvement — Startup and Implementation."

Panel discussions will address "Implementing a Quality Assurance Program in Your Institution" and "Controversies and Problems in Quality Management Programs — Law,

Ethics and Medical Practice."

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

ASA designates this continuing medical education program for 10 credit hours in category 1 of the Physician's Recognition Award of the American Medical Association.

Registration fees are \$160 of Active members, \$85 for Resident members and \$185 for nonmembers.

A block of rooms has been reserved at Marriott's Camelback Inn. A reservation card will be sent upon registration for the meeting. The form should be returned directly to the hotel by October 22, 1993.

The Camelback Inn is approximately 15 minutes from Sky Harbor Airport in Phoenix. The resort and spa offers golf, tennis, swimming, Jacuzzi and a gym and health club.

## ABA Announces . . .

### ABA to Conduct Written CDQ Exam

The American Board of Anesthesiology (ABA) will administer its written examination for certification of Continued Demonstration of Qualifications (CDQ) on Saturday, May 14, 1994.

Diplomates of the ABA who are interested in participating in the *voluntary* CDQ program may request an application by writing to

the Secretary, American Board of Anesthesiology, 100 Constitution Plaza, Hartford, Connecticut 06103-1796.

The deadline for receipt of completed applications in the Board office is **November 15, 1993**.

## Candidates Announce for Elected Office

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

- **President-Elect**  
Bernard V. Wetchler, M.D.
- **First Vice-President**  
Bertram W. Coffey, M.D.  
Norig Ellison, M.D.
- **Vice-President for Scientific Affairs**  
Phillip O. Bridenbaugh, M.D.

- **Secretary**  
Ronald A. MacKenzie, D.O.
- **Treasurer**  
John B. Neeld, Jr., M.D.  
Charles J. Vacanti, M.D.
- **Assistant Secretary**  
Richard G. Zepernick, M.D.
- **Assistant Treasurer**  
Neil Swissman, M.D.
- **Vice-Speaker, House of Delegates**  
Barry M. Glazer, M.D.

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

of candidacies for elected office.

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

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

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

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

## In Memoriam

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

Harry E. Burkett, M.D.  
Temple, Texas  
June 11, 1993

A. Keith Callender, M.D.  
Centerville, Ohio  
June 10, 1993

George H. Ham, M.D.  
Angwin, California  
May 14, 1993

James P. Hensen, M.D.  
Colorado Springs, Colorado  
June 23, 1993

Mervyn S. Isaacs, M.D.  
La Canada, California  
July 9, 1993

Riaz Mahboubi, M.D.  
Doylestown, Pennsylvania  
April 19, 1993

Stanford E. Mermelstein, M.D.  
North Miami Beach, Florida  
March 22, 1993

William E. Murry, M.D.  
Northridge, California  
May 16, 1993

Richard A. Patrone, M.D.  
Norristown, Pennsylvania  
April 19, 1993

Hans S. Roe, M.D.  
Carlisle, Pennsylvania  
June 3, 1993

Michael R. Seidel, M.D.  
Pelham, New York  
February 7, 1993

Arturo C. Uy, M.D.  
Potomac, Maryland  
April 23, 1993

Dan E. Woodson, M.D.  
Oklahoma City, Oklahoma  
June 4, 1993



## Shame

"Fetal distress in Room D," everyone screamed. I ran as quickly as I could from my office to the room, a few yards across the hall. The anesthesiology resident was at the head of the table, the patient scrubbed and the surgeon gowned with scalpel in hand. The resident asked my permission to start the anesthesia by administering thiopental and succinylcholine. I nodded, affirming the induction.

The drugs were injected and the mother rendered asleep and paralyzed. She put her life, and her son's, in my hands. But the anesthesia machine failed to deliver oxygen as it is supposed to do. I placed a tube into the patient's trachea and started ventilating her . . . taking deep breaths and blowing through the tube into her lungs. She and I were one unit. I was breathing, not for my life, but for her and her son as well. The three of us were kept alive by one ventilating force.

As I began to feel dizzy from hyperventilation, the resident succeeded in repairing the anesthesia machine, which then took over the ventilation. The cesarean section was performed, and the baby, vigorous and crying, was delivered.

My pleasure of triumph was shattered by the surgeon announcing that the patient was HIV positive! Everyone in the room had known this fact except me. I became furious with all of them because I was not warned. They all witnessed my performance of mouth-to-tube resuscitation, yet no one uttered a word. They were all so preoccupied with the care of the patient that the possibility of transmission of the virus to me had been overlooked. But how could they have no concern for a fellow physician — me? How could they put the life of an unknown patient ahead of mine? They all felt remorseful, sorry and deeply apologetic. Some cried, because while I had been trying to save the patients' lives, they failed to try to save mine.

That evening, while alone at my home, I replayed the incident in my mind. "What a shame . . ." I said to myself, ". . . to blame my team for what they had done! This patient and her baby were helpless — at least I made them so by administering the anesthesia. I took the responsibility of looking after them. Had I known beforehand that the patient was HIV positive, would I have jeopardized their lives? How could I dare to blame my coworkers for being so absorbed in caring for the patient

that they did not think of the risk to me? How selfish I could be!

"Haven't I always taught my students, for over 40 years, to put the patient ahead of us? Did I forget the doctors who succumbed to plague while treating their patients? Did I forget how many times I had given anesthesia to patients with perforated typhoid ulcers at a time when we had no treatment for the disease? Did I forget how many times I had given anesthesia to patients with ruptured amoebic abscess of the liver at a time when we were helpless against the disease? Did I forget how many times I gave anesthesia to patients who had poor personal hygiene while typhus epidemic blanketed the country? Did I forget how many times I took care of diphtheritic laryngitis at a time and place where sanitary rules were not followed?"

I looked back at the incident and said, "Shame! shame!"

To the mother and her son, to the doctors and the nurses in the room that day, I say, "Please accept my apology for getting upset." To my colleagues who were there, "I am sorry to blame you for fulfilling your duty toward your patient. Please forgive me. God bless you for what you have done."

Ezzat Abouleish, M.D.  
Houston, Texas

## Editor's Note:

*While the NEWSLETTER does not usually accept clinical material for publication, the preceding article highlights some issues worthy of consideration. The ethical and philosophical issues related to the clinical situation are timely.*

*There are also two more basic issues to be considered: the failure to carry out any protocol to check out the anesthesia machine before the case started and a failure in communication preoperatively among members of the anesthesia team, surgical team and nursing team. — E.L.*





## FOUNDATION FOR ANESTHESIA

EDUCATION ■ RESEARCH

### Resident Scholars Program Enters Fifth Year

In 1989, the Foundation for Anesthesia Education and Research (FAER) received an educational grant from Burroughs Wellcome Company to support a Resident Scholars Program in anesthesiology.

The program will complete its first five-year cycle with this year's ASA Annual Meeting. It has been remarkably successful in meeting its intended goal of encouraging resident participation in the educational, scientific and political affairs of ASA by active attendance at the ASA Annual Meeting.

As in the past, a grant in the amount of \$1,000 will be awarded to each participating program to help defray the cost of sending one resident to the meeting. Up to 32 grants

will be offered each year so that over a five-year period, funding will be provided for one resident from each accredited anesthesiology program in the United States. Strong positive feedback from former residents who attended and their program directors has resulted in the renewal of this annual activity on a year-to-year basis.

In addition to the broad variety of scheduled activities during the Annual Meeting, several special events are planned to permit interaction among resident scholars and between the residents and the ASA leadership. Programs are selected each year on a random basis, except that an effort is made to provide broad geographic distribution. The residents nominated by their program directors for 1993 are:

Daniel R. Balch, M.D.  
Children's Hospital  
Columbus, Ohio

Jeff L. Fuqua, M.D.  
University of Tennessee  
Knoxville, Tennessee

Oscar Mendoza-Calix, M.D.  
Cook County Hospital  
Chicago, Illinois

Grace E. Park, M.D.  
St. Elizabeth's Hospital  
of Boston  
Brighton, Massachusetts

Chris Chen, M.D.,  
Meridia Huron Hospital,  
Cleveland, Ohio

Robert E. Grady, M.D.  
Western Pennsylvania Hospital  
Pittsburgh, Pennsylvania

Chris J. Miciotto, M.D.  
University of Texas  
Southwestern, Dallas, Texas

William Peterson, M.D.  
University of New Mexico  
Albuquerque, New Mexico

R. Lee Cheng, M.D.  
Harbor-UCLA Medical Center  
Torrance, California

John Grillo, M.D.  
Brookdale Hospital  
Brooklyn, New York

Howard J. Miller, M.D.  
University of Colorado  
Denver, Colorado

Janet L. Phelan, M.D.  
Northwestern University  
Chicago, Illinois

Teralynn S. Clark, M.D.  
University of Arizona  
Tucson, Arizona

John L. Jimenez, M.D.  
Boston University  
Boston, Massachusetts

Joseph Moreno, M.D.  
Texas Tech University  
El Paso, Texas

David N. Pippins, M.D.  
Louisiana State University  
Shreveport, Louisiana

Mark R. Ezekiel, M.D.  
University of California  
Irvine, California

David R. Kassing, M.D.  
Indiana University  
Indianapolis, Indiana

Timothy F. Murray, M.D.  
University of Iowa  
Iowa City, Iowa

Michael Pylman, M.D.  
Madigan Army Medical  
Center  
Tacoma, Washington

Dennis E. Feierman, M.D.,  
Ph.D.  
Mount Sinai Medical Center  
New York, New York

Shanin Keramati, M.D.  
University of California  
San Diego, California

Sheldon Newman, M.D.  
Long Island Jewish  
Medical Center  
New Hyde Park, New York

Jack Ralston, M.D.  
Baylor College of Medicine  
Houston, Texas

Roderick R. Fernandez, M.D.  
Western Reserve Care System  
Youngstown, Ohio

John D. Lang, M.D.  
University of Texas  
Galveston, Texas

Steven A. Paganessi, M.D.  
Yale-New Haven Hospital  
New Haven, Connecticut

Thomas Ware, M.D.  
University of Cincinnati  
Cincinnati, Ohio

W. Rodger Funderburg, Jr.,  
M.D.  
University of Kansas  
Kansas City, Kansas

Daniel R. Meenan, M.D.  
MetroHealth Medical Center  
Cleveland, Ohio

Kenneth Papier, M.D.  
Wilford Hall USAF  
San Antonio, Texas

Mark A. Weech, M.D.  
University of Michigan  
Ann Arbor, Michigan





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WASHINGTON, D.C.

**1993 ASA Annual Meeting  
October 9-13**

*Registration opens at 3:00 p.m. Friday,  
October 8, 1993 in the Washington, D.C.  
Convention Center.*