



AMERICAN SOCIETY OF ANESTHESIOLOGISTS



# NEWSLETTER

SEPTEMBER, 1995

VOLUME 59 NUMBER 9

Fellowships of Discovery

*C. W. Long.*







Portrait courtesy of the Crawford W. Long Museum

Not only are the researchers of today discovering newer, safer ways to administer anesthesia, but there is still much to be learned from those earlier discoverers who pioneered the use of drugs and technology. The evolution of the specialty continues to be a work in progress.

#### EDITORIAL BOARD

##### Editor

Erwin Lear, M.D.

##### Associate Editors

Lawrence S. Berman, M.D.

Paula M. Bokesch, M.D.

David E. Byer, M.D.

James W. Cottingham, M.D.

Terry L. Dodge, M.D.

Ronald W. Dunbar, M.D.

Noel W. Lawson, M.D.

Jessie A. Leak, M.D.

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

Arthur O. McGowan, M.D.

##### Editorial Staff

Denise M. Jones

Kimberly S. Kallas

The **ASA NEWSLETTER** (USPS 033-200) is published monthly for ASA members by the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, Illinois 60068-2573. Second-class postage paid at Park Ridge, Illinois and additional mailing offices.

**POSTMASTER:** Send address changes to the **ASA NEWSLETTER**, 520 N. Northwest Highway, Park Ridge, Illinois 60068-2573, (708) 825-5586.

©1995 American Society of Anesthesiologists, all rights reserved. Contents may not be reproduced without prior written permission of the publisher.

## FEATURES

### Fellowships of Discovery

#### Fellowships a Vital Part of Wood Library-Museum

5

*Selma Harrison Calmes, M.D.*

#### The Art of Anesthesiology: Dr. Crawford W. Long

8

*Frederick J. Spielman, M.D.*

#### In Gwathmey's Own Words: Administration of an Anesthetic

11

*Doris K. Cope, M.D.*

#### Mesmer, Mozart and Music in Anesthesiology

15

*Gale E. Thompson, M.D.*

## ARTICLES

#### Helping to Preserve Our Past and Plan Our Future

18

#### ASA Gains E-mail, Spins Web Page

25

*N. Ty Smith, M.D.*

#### Value-Based Anesthesia: Operating Room and PACU Management

21

*Patricia A. Kapur, M.D.*

#### How You Can Help ASA Make Its Decisions

26

*Barry M. Glazer, M.D.*

#### ABA Announces...

34

## DEPARTMENTS

#### To the Membership

1

#### Residents' Review

33

#### President's Page

2

#### ASA News

34

#### Washington Report

3

#### In Memoriam

36

#### Professional Diversity

28

#### Letters to the Editor

37

#### Practice Management

31

#### FAER Report

40

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 that assist impaired physicians.



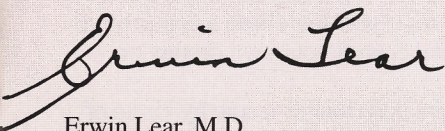
## Musing of a Novice

**R**egarding the article on James Tayloe Gwathmey, M.D. (page 11), this author is reminded of a kinship, though remote. Dr. Gwathmey was one of the original members of the Long Island Society of Anesthetists, which was based at the Long Island College Hospital, Brooklyn, New York. The author was a medical student at the Long Island College of Medicine and interned at the Long Island College Hospital barely six years after Dr. Gwathmey's death.

The anesthesia department at the hospital had no medical leadership prior to the ultimate arrival of Merel H. Harmel, M.D. as the first full-time Chair. Open-drop chloroform was the anesthetic of choice for vaginal deliveries. As a medical student, this author was "taught" the administration of chloroform by the obstetrical charge nurse. Cesarean sections were initiated under field block administered by the resident and intern. Only after delivery was the patient anesthetized.

It was not uncommon for neurosurgical patients to receive ether as part of their anesthetic management. Precautions for the use of cautery during gastrectomy under cyclopropane consisted of placing wet towels over the conductive tubing to include the patient's face. We were also required to wear conductive strips in their shoes. Medical students received two lectures in anesthesia; both related to the pulmonary complications associated with ether anesthesia.

Dr. Harmel, along with Benton D. King, M.D., Sylvan N. Surks, M.D. and John D. Elder, Jr., M.D., finally created a formal department of anesthesiology as the Long Island College of Medicine was taken over by the State University of New York in 1950.



Erwin Lear, M.D.  
Editor



*Erwin Lear, M.D.*



## Control Your Destiny

*Bernard V. Wetchler, M.D., President*

*"Man must cease attributing his problems to his environment, and learn again to exercise his will — his personal responsibility."*

— Albert Schweitzer

We can remember the way it was; we are acutely aware of how it is; as we prepare for the future, are these the best of times or the worst of times?

We have seen the integrity of our specialty eroding: nurse anesthetists moving to attain equal status, reduction of reimbursement for our services, exclusive contracts and economic credentialing upheld by the courts, managed care affecting practices, and residents having a difficult time finding the type of practice opportunity they were expecting when they began their training program.

When I finished my anesthesiology residency, I felt like many others did — fully prepared to manage any patient, any procedure, any problem that occurred in the operating room. I was not taught the importance of public relations and public education. There was no need to understand the complexities of practice management. There were an abundance of practice opportunities from which to pick and choose. Nurse anesthetists had not yet begun to envision independent practice.

So much has changed and so many of us have not been prepared to face today's changes. We must be ready for tomorrow's challenges. Academic departments are adjusting curricula to better prepare residents for their role as practitioners. For those of us in practice, a regular paradigm tune-up appears to be a must to stay competitive in the 21st century.

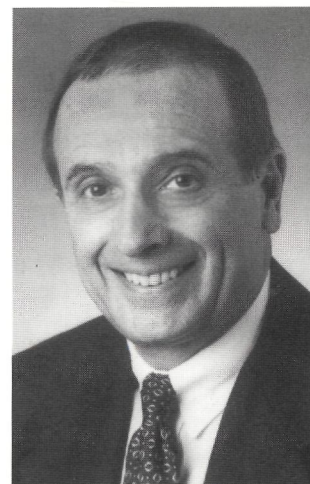
Anesthesiologists have been called the internists in the operating room. We must use our knowledge of pain management and cardiovascular and respiratory medicine to expand our area of activity and visibility. We must assume our role as the anesthesiologist consultant to other physicians and as the patients' perioperative physician. Lawrence J. Saidman, M.D., immediate Past President of the American Board of Anesthesiology, recently wrote, "In my opinion, it is time for the Anesthesiologist Consultant to perform preoperative assessment without the need to obtain 'clearance' from those having no clue as to what the impact of anesthesia and surgery are upon a patient with complex systemic disease. Increasing the breadth of the specialty should, by combining the best of primary

care medicine with the best of hospital specialty medicine, restore the attractiveness of the specialty to what it was just a few years ago."

In a highly managed health care environment, we are uniquely positioned to provide both the primary care "gatekeeper" and the operating physician with a complete preanesthesia assessment timed to limit procedure postponement or cancellation. This is only one of several ways in which we can contribute to an efficiently run operating room. By exercising our responsibilities — by consulting on preanesthesia and postanesthesia care, by educating our patients' health care plans on the role anesthesiologists can play in cost-effective care and by our choice of preprocedure testing, appropriate anesthesia techniques, technologies, agents and drugs — we can make an impact on procedural cost. We must be seen as valued participants in today's and tomorrow's health care, regardless of how the system is structured. We surely will face difficult times if we continue to limit our involvement to providing operating room services only.

Today, the game is played by Jack Welch's rules. As Chief Executive Officer of General Electric, he said: "Face reality as it is, not as it was or as you wish it were; change before you have to; if you don't have a competitive advantage, don't compete; control your own destiny or someone else will."

Our role in patient care is no longer secure by virtue of our "being physicians." Patients, health care plans and facility administrators must be made aware that we have a great deal more to offer than nonphysician providers who seek to unseat us. This is our competitive advantage.



*Bernard V. Wetchler, M.D.*



## HCFA Issues Proposed Teaching, "Two-on-One" Regulations

Michael Scott, Director  
Governmental and Legal Affairs

On July 26, the Health Care Financing Administration (HCFA) issued its long-heralded proposed regulations regarding payment for physician services in the teaching setting as well as a number of other matters, including a proposed change in its payment rules for the situation in which an anesthesiologist and a nurse anesthetist provide services to a single patient.

### Teaching Rules

Medicare Part B reimbursement of teaching physicians, including anesthesiologists, is currently governed by a document known as Intermediary Letter No. 372, which fundamentally requires that the teaching physician establish an "attending physician" relationship with the patient as a condition of reimbursement.

In general, there are no limitations in I.L. 372 as to the number of concurrent cases in which a physician can be said to have established an attending physician relationship. Such limitations have existed for anesthesiologists, however. Prior to 1994, HCFA permitted carriers to determine whether an anesthesiologist had established an "attending" relationship for up to two concurrent cases involving residents, and most carriers routinely reimbursed a full "personally performed" fee for each of two concurrent cases.

Beginning in 1994, however, HCFA effectively integrated the teaching of residents into the structure for medical direction of nurse anesthetists, permitting the teaching/directing anesthesiologist essentially one-half the "personally performed" fee for each of up to four concurrent cases involving either residents or

nurse anesthetists, assuming that in each case the anesthesiologist performed or participated in certain defined portions of the procedure. If an anesthesiologist involved himself or herself in only one case involving a resident or nurse anesthetist, the anesthesiologist could collect a full "personally performed" fee.

Teaching anesthesiologists have stridently objected, both before and after implementation of the current rule, to the elimination of full fee payment for each of two concurrent cases involving residents and have sought a return to the more liberal pre-1994 reimbursement standard.

ASA-initiated discussions took place with HCFA officials several months ago, and these discussions gave rise to some hope that HCFA might temper this restriction in the context of new proposed generic rules on reimbursement of teaching physicians. Those rules have now been issued and, instead of providing relief, appear actually to *tighten* reimbursement requirements for teaching anesthesiologists.

The new proposed generic teaching rule requires that the teaching physician "must be present for a key portion of the time during the performance of the service for which payment is sought"; in the case of "surgery or a dangerous or complex procedure, ... must be present during all the critical portion of the procedure and must be immediately available to furnish services during the entire service or procedure." As proposed, the rule also specifies that the teaching physician presence requirement is *not* met when the presence of a teaching physician is required in two places for concurrent surgery.

For evaluation and management services for which there are several levels of service available for reporting purposes, the appropriate payment level "must reflect the extent and complexity of the service if the service had been fully furnished by the teaching physician." Special rules are proposed for certain specialties (e.g., family practice and psychiatry) to reflect teaching methods in those areas.

As to anesthesiology, the preamble to the proposed rule merely makes reference to the current rules for payment of teaching anesthesiologists discussed previously (full fee for one case, half fee for concurrent cases up to four). In the new proposed teaching regulations, however, the following is provided:

### § 415.178 Anesthesia services.

(a) *General rule:* An unreduced physician fee schedule payment may be made if an anesthesiologist is not involved in directing concurrent services with more than one resident or with a resident and a nonphysician anesthetist....

(b) *Documentation:* Documentation must indicate the physician's presence or participation in the administration of the anesthetic *and a preoperative and postoperative visit by the physician* (italics supplied).

To our knowledge, no HCFA document has ever specified the requirement of a preoperative or postoperative visit. A similar requirement is not applied to other specialties under the proposed rules. The italicized phrase seems to suggest that the teaching anesthesiologist cannot rely



upon the resident to perform either of the visits.

### **Two Anesthesia Providers Involved in One Procedure**

Under current regulations, if both an anesthesiologist and a nurse anesthetist provide care to a single patient, and if Medicare does not deem the presence of two providers to be medically necessary, HCFA will pay a "personally performed" fee to the anesthesiologist and nothing to the nurse anesthetist.

The American Association of Nurse Anesthetists has claimed that this policy is unfair, that it does not recognize the contribution of the nurse anesthetist and that it has a negative impact on the salaries that hospitals are prepared to pay nurse anesthetists.

HCFA proposes that, effective January 1, 1998, the allowance for the medically directed nurse anesthetist and the medical-direction service of the anesthesiologist will be equivalent to 50 percent of the anesthesiologist's "personally performed" rate. The proposal to defer this change until 1998 results from a concern that if implemented before then, federal expenditures would increase because fees in the medical direction context will not be fully phased down to the 50-percent level until that year.

### **Use of Category-Specific Volume and Intensity Growth Allowances for Default MVPS**

For 1996 and subsequent years, HCFA proposes to calculate the

default Medicare volume performance standard (MVPS) based on estimates of the average growth in volume and intensity of services specific to each of the current update categories, i.e., surgery, primary care and nonsurgical.

Notwithstanding this proposal, HCFA also states its intention to move toward development of a legislative proposal, as recently recommended by the Physician Payment Review Commission and supported by the American Medical Association (AMA), to implement a single volume performance standard for all Medicare Fee Schedule services.

### **RUC Reviews Abt Associates Survey of Anesthesiology Work Values**

On July 30, ASA representatives appeared before a subcommittee of the AMA/Specialty Society Relative Value Update Committee (RUC) to present the findings of a survey of double-boarded anesthesiologists as to anesthesiology work values under the Medicare Fee Schedule. The survey had been suggested in late April by the full RUC as a potential means for validating anesthesiology work values developed by a multispecialty physician panel in January, using a valuation method based upon work intensity developed by Abt Associates Inc. as a consultant to ASA.

The survey, also conducted by Abt under contract to ASA, produced

anesthesiology work values that on average were 30.3 percent higher than those contained in the report of the multispecialty physician panel. This suggested that the panel had acted rather conservatively when it met in January and concluded that current anesthesiology work values were approximately 35 percent too low in comparison with other physician services.

In mid-July, the Abt multispecialty panel met again to refine its original conclusion and also to consider the results of the survey. In general, the panel concluded that the survey values were too high and that all that was required were some relatively minor changes in assessment of anesthesiology time and intensity, based principally on information disclosed by median values under the survey. As a result of this refinement process, the panel ultimately concluded that anesthesiology work values were currently about 40 percent too low — an increase of 5 percentage points from its earlier report.

Representatives from ASA and Abt Associates presented this data to an RUC work group of four physicians on July 30. After rather lengthy consideration, the work group determined that ASA had not presented "compelling evidence" (the RUC standard for action) that anesthesiology work values should be changed by the proposed 40 percent. The work group invited ASA, however, to develop further data as to the compatibility

*Continued on page 24*



---

## Fellowships a Vital Part of Wood Library-Museum

*Selma Harrison Calmes, M.D.*

*Wood Library-Museum of Anesthesiology Fellowship Committee*

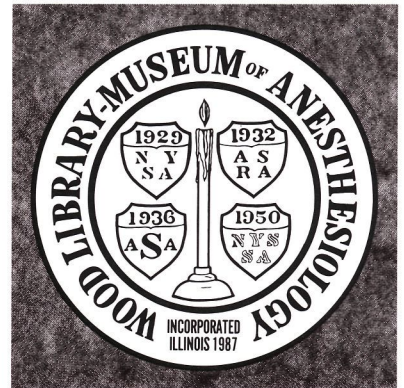
*This article is in memory of the late Roderick K. Calverley, M.D., former Chair of the Wood Library-Museum of Anesthesiology Fellowship Committee.*

The Wood Library-Museum of Anesthesiology (WLM), located in splendid quarters at the ASA Executive Office in Park Ridge, Illinois, contains the history of our specialty: records of our early organizations, examples of early equipment, an outstanding rare book collection, complete collections of important early journals and videotaped interviews of the leaders of our specialty. Under the leadership of Elliott V. Miller, M.D., Chair of the WLM Board of Trustees, and with strong, continuous ASA support, the WLM has evolved into a truly superior library and museum.

In the mid-1980s, the WLM Board of Trustees felt the need to make the collections better known, increase the use of the materials and stimulate interest in the history of anesthesiology. This timing was not by chance; interest in anesthesia history clearly was developing internationally at the time. The First International Symposium on the History of Anesthesia held in 1982 in Rotterdam, The Netherlands, brought together those working in this area and accelerated interest among American anesthesiologists.

WLM Trustee Roderick K. Calverley, M.D. had the idea of funding research fellowships at the WLM. The financial support of a fellowship would allow people to come to the WLM, use its materials and produce studies on anesthesia history. A committee composed of then WLM Trustees Edward A. Ernst, M.D. and Selma H. Calmes, M.D., with Dr. Calverley as Chair, was formed to develop the concept. The committee reported at the March, 1987 WLM Board meeting. After discussion, the WLM Board approved the concept of the Paul M. Wood Fellowship in the History of Anesthesiology. In October, 1987, the name of the fellowship officially became the Wood Library-Museum Fellowship in Anesthesiology; however, it continues to be known popularly as the Paul Wood fellowship, after the founder of the WLM.

The committee developed the application process for the fellowship program using guidelines from the Anesthesiology Young Investigator Awards of the



*Selma Harrison Calmes, M.D. is Chair of the Department of Anesthesiology at Olive View Medical Center, Sylmar, California, affiliated with the University of California at Los Angeles.*



**"The purpose of the WLM fellowships is to increase use of the library-museum's collections and stimulate interest in the history of our specialty."**

Foundation for Anesthesia Education and Research. It was also decided that Fellows must submit a written report of their project to the WLM Board. To attract history of medicine scholars, it was decided that Fellows need not be ASA members or even anesthesiologists; WLM Trustees are not eligible unless there are no non-Trustee applicants. An announcement on how to apply for fellowships was published in the October, 1987 *ASA NEWSLETTER*, the fall bulletin of the American Association for the History of Medicine (a national group of medical historians composed of M.D.s and Ph.D.s) and the *Anesthesia History Association Newsletter*.

The purpose of the WLM fellowships is to increase use of the library-museum's collections and stimulate interest in the history of our specialty. Fellows are awarded a stipend to work at the WLM to use its resources for a historical project related to the history of anesthesiology. A \$500 honorarium is paid as well as a per diem for periods of study up to three weeks. Fellows living more than 100 miles from the WLM in Park Ridge, Illinois, are reimbursed for one round-trip domestic, economy-class airline ticket. Needed library materials are photocopied free of charge for Fellows working in the library.

Application forms are available from Patrick P. Sim, WLM Librarian, throughout the year. Completed applications must be received by the Librarian on or before January 31. Applications are then circulated to the WLM Board of Trustees Fellowship Committee, which is chaired by C. Ronald Stephen, M.D. of St. Louis, Missouri. The current committee members are Dr. Calmes, Stephen Slogoff, M.D. and Charles C. Tandy, M.D.

Committee members evaluate the applications and then rank them in order of preference, giving consideration to the originality of the research idea, whether the WLM has the needed materials for the project and whether the applicant has been able to complete other projects. The Fellowship Committee reports its recommendations to the full Board of Trustees at the WLM Board meeting in March, and the Trustees make a final selection. Awards are announced shortly after the March Board meeting.

The first four Wood Library-Museum Fellowships in Anesthesiology were awarded in March, 1988 to David L. Brown, M.D. of Rochester, Minnesota, to study the development of the concept of risk in anesthesia; Eugene H. Conner, M.D. of Louisville, Kentucky, to study the 19th-century congressional investigation into who discovered anesthesia; B. Raymond Fink, M.D. of Seattle, Washington, to study the events leading to Claude Bernard's interest in anesthetics; and A. J. Wright III, Librarian at the University of Alabama at Birmingham, Alabama, to study examples of self-experimentation with anesthesia.

Twenty-four additional fellowships have been awarded since 1988. International interest has even developed, reflecting the high quality of the WLM's collections. Four Canadians have received fellowships: Joan C. Bevan, M.B. of West Vancouver, British Columbia, and Maria Pacelli of Montreal, Quebec, who researched the lives of Wesley Bourne, M.D. and M. Digby Leigh, M.D.; Richard I. Bodman, M.B. of Dartmouth, Nova Scotia, who researched the life of Harold R. Griffith, M.D.; and David A. Shephard, M.B. of Charlottetown, Prince Edward Island, who received two fellowships, one to examine the influ-



ence of American anesthesiology on Canadian-organized anesthesiology and the other to study the influence of John Snow's work on the development of anesthesia.

Two British physicians have received fellowship awards: David J. Wilkinson, M.B. of Essex, England, who researched the development of Trilene™ (trichloroethylene) in the United States, and Christopher Lawrence, M.B. of the Wellcome Institute in London, who researched two areas of possible differences in American and British anesthesia practice. Applications from other foreign countries have been received as well.

Fellowship topics have ranged widely, illustrating that there is still much to be studied in anesthesia history. This year, the first fellowship to study an early time period was awarded to Massimo Ferrigno, M.D. of the University of South Alabama, Mobile, Alabama, who will study the treatment of pain according to Dioscorides, a first-century botanist and pharmacologist who published a widely used encyclopedia of materia medica. Other 1995 Fellows are Danial O. Laird, M.D. of Seattle, Washington, for a project on the contributions of Nathan Cooley Keep, M.D. to American obstetric anesthesia, and Vincent J. Kopp, M.D. of the University of North Carolina, Chapel Hill, North Carolina, for a historical review of ethical issues in anesthesiology.

This issue of the *ASA NEWSLETTER* showcases the results of some WLM Fellows' work from 1989-93. Additionally, Fellows' work has appeared in other *ASA NEWSLETTER* issues and will continue to appear in future issues. In the September, 1994 *NEWSLETTER*, Stephen D. Small, M.D. of Boston, Massachusetts wrote on the death mask of Horace Wells. In the October, 1994 *NEWSLETTER*, Harry Wollman, M.D. of Philadelphia, Pennsylvania discussed why Crawford W. Long, M.D. probably did not publish his work with ether as an anesthetic until seven years after the initial discovery, and Jonathan C. Berman, M.D. of Denver, Colorado reported his work on the history of oral airways.

Seven years and 32 WLM fellowships after the implementation of the Wood Library-Museum Fellowship in Anesthesiology, Dr. Calverley's idea has developed as planned. The WLM fellowships clearly have increased the use of the WLM's resources by serious researchers. Also, new researchers have been stimulated to begin scholarly activities in the area of anesthesia history. These projects center around ASA's outstanding institution, the Wood Library-Museum of Anesthesiology. The fellowships serve as a lasting memorial for Dr. Calverley, who conceived the idea, carried the process of development of the fellowships to completion and chaired the WLM Fellowship Committee until his recent death.

For more information or an application for the Wood Library-Museum Fellowships in Anesthesiology, contact: Patrick P. Sim, Librarian, Wood Library-Museum of Anesthesiology, 520 N. Northwest Highway, Park Ridge, Illinois 60068-2573; (708) 825-5586. Deadline for applications for next year's fellowships is **January 31, 1996.**



"Seven years and 32 WLM fellowships after the implementation of the Wood Library-Museum Fellowship in Anesthesiology, Dr. Calverley's idea has developed as planned. The WLM fellowships clearly have increased the use of the WLM's resources by serious researchers."



## The Art of Anesthesiology: Dr. Crawford W. Long

*Frederick J. Spielman, M.D.*

*Wood Library-Museum of Anesthesiology Fellow (1993)*



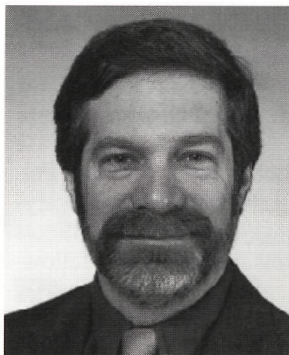
*Crawford W. Long, M.D. as portrayed by Lewis Crumley Gregg.*

After being awarded a Wood Library-Museum Fellowship, I began my research into the history of anesthesiology and pain control through art. My investigation identified media such as woodcuts, oils, watercolor and sculpture. I chose each work of art for both its content and beauty, then researched the history of anesthesiology and pain control depicted in the piece, the importance of the historic period upon medical practice and the impact of specific individuals upon the development of anesthesiology. Included were biographic notes about the artist and interpretations of the art from an aesthetic and artistic perspective.

The oil painting of Crawford W. Long, M.D. that graces the cover of this issue of the *NEWSLETTER* was one of many artistic representations I studied. I chose this picture because the ASA Annual Meeting will be held next month in Atlanta, Georgia, just 60 miles from Jefferson, Georgia, where Dr. Long administered the first ether anesthetic for surgery on March 30, 1842. This event occurred several years before the public demonstration of ether anesthesia by William Thomas Green Morton at Massachusetts General Hospital on October 16, 1846. Jefferson is also where the Crawford W. Long Museum is located. Opened in 1957, the museum displays documents supporting Dr. Long's discovery of anesthesia as well as personal items belonging to Dr. Long and his family. A highly detailed diorama depicting the first operation is the focal point of the museum, which also has exhibits on the development of modern anesthesia.

Crawford Williamson Long was born in Danielsville, Georgia on November 1, 1815. He received his medical degree from the University of Pennsylvania in 1839 and spent 18 months "walking the wards" in New York City. In 1841, at age 26, he returned to Jefferson where he bought the medical practice of George Grant, M.D.

Before the use of ether, surgery was rarely performed because adequate, secure, reliable methods of administering anesthesia had not been developed. Patients feared excruciating pain during the operation. Ether had been synthesized by Valerius Cordus in the middle of the 16th century, 300 years before its



*Frederick J. Spielman, M.D. is Professor of Anesthesiology, Obstetrics and Gynecology at the University of North Carolina, Chapel Hill, North Carolina.*



anesthetic properties were realized, and had been employed to relieve biliary and renal colic as well as bronchospasm.

Dr. Long used ether during medical school, not for anesthesia, but for amusement; it was the current recreational drug. As a practicing physician in need of a safe and effective anesthetic, Dr. Long recalled how breathing ether was associated with euphoria and how participants of ether parties discovered bruises and other injuries acquired while “under the influence,” but had no recollection of pain. A patient of Dr. Long’s, James M. Venable, had two cysts on his neck and presented Dr. Long with the opportunity to employ ether as an anesthetic. Knowing that Mr. Venable was afraid of the knife but fond of ether (he was an experienced “social sniffer”), Dr. Long suggested that Mr. Venable breathe ether before the operation.

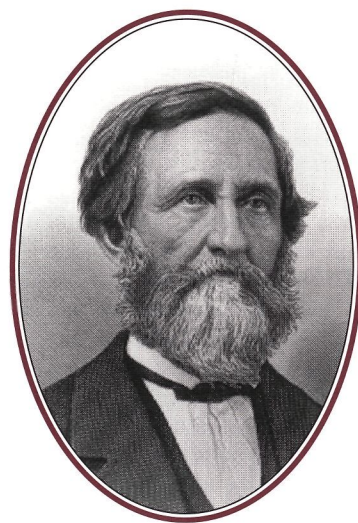
“The ether was given to Mr. Venable on a towel and, when [he was] fully under its influence, I extirpated the tumor. The patient continued to inhale the ether during the time of the operation, and when informed it was over, seemed incredulous until the tumor was shown him,” Dr. Long stated. The fee for the operation and anesthesia was \$2.

Dr. Long persisted in his desire to relieve pain for surgical patients and extended its use to obstetrics. He administered ether to his wife for the birth of their second child in 1845 and their 10 subsequent children. Some of Dr. Long’s friends urged him to stop administering ether during surgery because he might be assaulted or even killed by local townspeople who felt that the natural order was disturbed by the unnatural absence of pain during surgery.

Dr. Long was an introverted individual practicing in a rural area. His long, solitary working hours and the public’s general lack of acceptance of ether anesthesia created minimal publicity about his discovery. Not until 1849 did Crawford Long publish his research in the *Southern Medical Journal*. Dr. Long died in 1878 while delivering an infant; his death occurred just after the delivery. As he fell to the floor, the patient’s family rushed to help him, but he refused. His last words were: “Care for the mother and child first.”

When viewing a painting or photograph, we must ask ourselves how well the art has portrayed the character or person. How does it describe the culture at the time the art was created? Art is a window through which the past can be viewed with great accuracy. Artistic representation of medicine has been employed to publicize, advertise, instruct, create a personal or institutional record and, occasionally, to criticize or amuse. In the instance of Dr. Crawford Long’s portrait, art was used in celebration.

The portrait of Crawford Long was initiated and inspired by Mrs. Thomas K. Glenn, the wife of the President of the Trust Company of Georgia Bank. In 1936, she stated, “I have always felt that the average bank, with its marble and its general air of coldness, repels or even overawes the average person ... those marble walls are so cold.” She desired her husband’s bank to have warmth and color. Mrs. Glenn decided to fill the walls of the bank with portraits of 32 Georgians who had gained wide recognition as “builders of a state, and as leaders of its people.” In addition to Dr. Long, the portrait subjects included Button Gwinnett, Lyman Hall and George Walton, all of whom signed the



*Crawford W. Long, M.D. between the ages of 55 and 60.*

**Excursions to the Crawford W. Long Museum during the Annual Meeting will take place on Saturday, Sunday and Tuesday, October 21, 22 and 24. See the Social Activities Program for details.**



Declaration of Independence; James Edward Oglethorpe, the founder of Georgia; Josiah Meigs, the first president of Franklin College (now the University of Georgia); and Margaret Mitchell, author of *Gone With the Wind*.

Considerable thought was given to whom would paint the 32 portraits. Lewis Crumley Gregg, a native Atlantan, was given the charge. Mr. Gregg had studied at the Art Students League in New York and Paris and for 26 years was employed as a staff artist by the *Atlanta Constitution*. During this period, he gained considerable fame as a political cartoonist and an occasional writer of news events. After his departure from the newspaper, he became a noted portrait artist. The challenge that faced Mr. Gregg was that the vast majority of the individuals whom he was commissioned to paint were dead. Relying only on prior photographs, engravings and descriptions in old books and pamphlets as models, Mr. Gregg was concerned that facial expressions and the effects of light and shadow be accurate.

The "Court of Honor" graced the walls of the Trust Company headquarters in Atlanta for many years. In 1969, the Trust Company loaned Dr. Long's portrait by Mr. Gregg to the Atlanta Historical Society, which loaned it to the Crawford W. Long Museum in 1976. The portrait became a permanent exhibit at the museum in 1989.

Dr. Long is the subject of many and varied artistic representations (most of which show him with a full beard). His picture is on the cover of the book *The History of Anesthesia: Third International Symposium*, edited by B. Raymond Fink, M.D., Lucien E. Morris, M.D. and C. Ronald Stephen, M.D. That portrait is from the Crawford W. Long Hospital at Emory University, Atlanta, and was painted by one of his daughters.

A marble statue of the famous anesthesiologist was placed in Statuary Hall in the Capitol in Washington, D.C. on March 30, 1926. A bronze medallion honoring Dr. Long, designed by Professor R. Tait McKenzie in 1912,



*The 2-cent stamp of Crawford W. Long, M.D. was released in 1940.*

was unveiled at the University of Pennsylvania Medical School on March 30, 1942 to commemorate the 70th anniversary of the use of ether anesthesia. The medal shows Dr. Long administering ether to a patient. A larger version of the medallion was painted by Maurice Siegler in the 1930s for the Chicago Century of Progress Exposition. The June, 1951 *ASA NEWSLETTER* displayed a black-and-white drawing of Drs. Horace Wells, Morton and Long in profile.

The most widely used and circulated image of Dr. Long is on the 2-cent stamp released in 1940 and is an engraving made from a photograph from the 1870s. The

only other U.S. stamp honoring a physician related to anesthesiology is a 20-cent stamp of Virginia Apgar, M.D., released on October 24, 1994. The cover of the January, 1993 *Journal of the American Medical Association* displays a full-length picture of Dr. Long painted by Richard Lahey, courtesy of the University of Pennsylvania School of Medicine.

Art gives us a unique perspective on the history of medicine, rendering a subjective and personal view that cannot always be explained properly in words. Art and medicine belong together. Art in physicians' lives can be the antidote to the misery seen in the hospital. Artists and physicians share similar work methods; each one first observes, then interprets and synthesizes his or her observations, impressions and prior experiences. Subsequently, a statue, picture or therapeutic plan is created.

#### **Acknowledgment:**

Valuable information, encouragement and the photograph of Dr. Long's portrait were supplied by Susan B. Deaver, Director of the Crawford W. Long Museum, without whose support this article would not have been possible.

*References available by contacting the author.*





---

## In Gwathmey's Own Words: Administration of an Anesthetic

Doris K. Cope, M.D.

Wood Library-Museum of Anesthesiology Fellow (1990)

James Tayloe Gwathmey's life (1863-1944) spanned the Civil War through World War II. He trained as a surgical intern at the turn of the century, and his skill in anesthetizing patients and improvising anesthetic equipment led to one of the first full-time medical practices of anesthesiology. He was an original member of the Long Island Society of Anesthetists and was active in its transition to the New York Society of Anesthetists. In 1912, he was the prime initiator and the first president of the first national anesthesiology organization, which was founded as a medical specialty within the American Medical Association.

In addition, he wrote *Anesthesia*, the first comprehensive anesthesiology textbook, in 1914 and devised and upgraded the prototype of the modern anesthesia machine. He has been described as an elegant, self-possessed man whose opinions were valued highly by himself and others.<sup>1</sup> It is appropriate that he describe in his own words from his practice the beginnings of modern anesthesia. The following are abridged quotations directly from his works between 1905-14.



James Tayloe Gwathmey

### Preliminary Treatment

The preliminary preparation of a patient about to be anesthetized may be: 1) hygienic; 2) psychic; 3) medical.

#### Hygienic.

*Grooming of a Patient.* The patient should be as thoroughly prepared (as far as his or her condition permits) as if for an athletic event. A warm bath with thorough cleansing of the skin and a shampoo for the hair, followed by an alcohol rub, should precede *all* other treatment.

*The Mouth and Nose.* If possible, a dentist should cleanse the teeth thoroughly, removing loose and hopelessly decayed teeth and then giving the patient a suitable antiseptic mouthwash to be used every four or five hours until time for the operation.

*The Bladder.* Patients should either empty the bladder or be catheterized immediately before the operation.

If urine is scanty, bicarbonate of potash or citrate of potash in small quan-



Doris K. Cope, M.D. is Director of Research, Associate Professor of Anesthesiology and Adjunct Associate Professor of Physiology at the University of South Alabama Medical Center, Mobile, Alabama.



tities, not more than 20 or 30 grains within 24 hours, added to pure water should be given freely to flush the kidneys.

**Intestinal Tract.** No athlete is ever given a purge on the night immediately preceding a contest, and the time should be past when a patient is thus debilitated before entering the operating room.

**Diet.** While advantageous to have the stomach empty, it is not essential to starve the patient for 12 or 18 hours. Easily digested gruels of barley or rice can be given in small quantities up to within two or three hours of the operation with distinct advantage.

#### **Psychic.**

The expert anesthetist must be able to judge of the particular requirements of the individual case. Over 70 percent of cases, according to conservative estimates, require both mental and medical treatment in order to insure the best results.

Children and nervous and irritable adults require psychic preparation for the coming ordeal, and the anesthetist who ignores this factor runs the risk of having to deal with more or less serious difficulties during some portion of the time when the patient is under his care. In this connection, the Chapter on Hypnotism will be found helpful.

#### **Medical.**

Idiots and insane persons, as a rule, require only medical preparation.

Patients already in a state of coma require no preliminary treatment.<sup>2</sup>

#### **Induction**

*[Note: In this article, Dr. Gwathmey describes his vapor inhaler, which used three bottles that could be opened individually to allow for sequencing of anesthesia agents.]*

The induction stage is very pleasant (comparatively) for the patient. For a woman, I usually place in the third bottle her favorite cologne; for a man, a "highball" or something similar. The moral effect of the cologne on the one and the immoral effect of the "highball" on the other both have their usual quieting tendency, and the element of fear is reduced to a minimum. The anesthetic is started with a 1-percent vapor of this cologne or whiskey and, as soon as the mucous membranes have become accustomed to this, a fractional percent vapor of chloroform is added for the first minute, and this is changed gradually but as rapidly as pos-

sible, so that at the end of three minutes the patient is getting 1 percent vapor of chloroform and a fractional percent of cologne or highball, after which the latter is turned off entirely. The average time to induce surgical anesthesia is six minutes, varying with the patient.<sup>3</sup>

#### **Sequencing Anesthetic Agents**

We have already seen that the utilization of combinations and sequences was practically unknown until within recent years. This is one of the facts which renders the modern anaesthetist equal to almost any emergency and which has helped so materially in the reduction of the mortality statistics as applied to anaesthesia.

Ether, which was formerly given almost exclusively alone and very largely by the open or drop method, has been materially increased in value by preceding its administration with chloroform or nitrous oxide.

Chloroform, which has played so stormy a part in the drama of anaesthesia, was formerly used alone. It is now conceded that it should never be used alone, or as the terminal anesthetic, unless especially indicated. It is a safe initiatory anaesthetic to ether when, as preliminary medication, morphine has been administered, the immediate administration being preceded by the inhalation of a few drops of the oil of bitter orange peel.

Nitrous oxide, which was formerly used alone to the extent of asphyxiation and only in short operations, is now combined with oxygen whenever possible, rendering it safer and making its prolonged administration practical. The combination of nitrous oxide with oxygen, with preliminary small physiological doses of morphine and a few drops of ether when necessary, is applicable to over 90 percent of all surgical cases.<sup>4</sup>

#### **Advantages of Oxygen**

Oxygen should be used whenever possible, especially with chloroform, as it has now been proven beyond a doubt that this combination is safer than ether and air. [J.] Neudorfer, of Vienna, is credited with being the first to use this combination, about 1886; but a careful search on my part has failed to discover anything he may have written. The exact relation of chloroform and oxygen to other anesthetics was not absolutely established until my own experiments in 1904. It maintains a normal respiration and circulation; increases the limits of safety more than two-and-one-half times, as compared with chloroform and air; elim-





*Dr. Gwathmey administering a general anesthetic using his own apparatus.*

inates the mucous rale; and reduces the after-effects to a minimum. Sudden cessation of the vital processes, such as sometimes occurs with chloroform administered in the usual way, never takes place with oxygen and chloroform.<sup>5</sup>

### **Alternative Techniques**

The sequestration method consists of getting the patient under narcosis with some pulmonary anesthetic and then using the inner tire of an automobile, or preferably the cuff of some blood pressure apparatus, placed at the upper part of the thighs and also close to the armpits, making pressure, and thus cording off this amount of blood from the body. The anemia of the brain this produces is depended upon to continue the narcosis. The bands are gradually loosened and the anesthetic discontinued or only small amounts used. Anesthesia usually lasts from five to 15 minutes, without a reapplication. This method is safe, for if any untoward symptoms appear, a reversal of the patient's position immediately rectifies the trouble.

Rectal anesthesia is especially useful in all head surgery. This method has not made very great headway in the last few years. As the anesthetist is compelled to be at the head of the patient in order to note the reflexes, the writer of this article sees no advantage in this method over vapor anesthesia.

Spinal anesthesia seems to be slowly gaining favor. With the perfect technic that now obtains, it is comparatively safe. It is less available for head surgery than for other parts of the body. When the head is to be operated upon, the Trendelenburg posture is used to obtain the analgesia. In point of safety it cannot be compared with the best local and pulmonary methods.

Intratracheal anesthesia, as introduced by Dr. [Samuel J.] Meltzer of the Rockefeller Institute, should be encouraged and developed by those composing this association. This method consists in getting the subject under a pulmonary anesthetic and then passing a rubber catheter two-thirds the size of the trachea to its bifurcation and then alternately

passing the ether vapor and air through this tube. Upon the lower animals, the success of the method is unquestioned. Between 50 and 100 cases have been reported so far upon human beings. Unfortunately, one death has occurred through faulty technic. This method of anesthesia deserves every encouragement and a thorough trial; and in the meantime, a suspension of judgment and absence of criticism.

**Intravenous Anesthesia.** The first experiments were on animals with the different narcotics and analgesia. Ether in a 5-percent solution was finally selected as the best agent, used alone or in sequence with isopral. A special apparatus regulates the flow of the anesthetic drop by drop.

The objections stated are the long postanesthetic stage (seven to eight up to 24 hours) and incomplete anesthesia and relaxation, increased blood pressure and thrombosis formation in the veins; also lack of control over the dilution of ether.<sup>6</sup>

### **Fluids**

The unpleasant after-effects of inhalation anesthetic are materially modified by hypodermoclysis [*Note: subcutaneous injection*] begun with the anesthetic and continued throughout the operation. Saline solution introduced in this manner maintains the blood pressure, and this assists in



preventing shock either from the anaesthetic or the surgical procedure. When hypodermoclysis interferes with the surgical technic, an enema of one or two quarts of tap water with one or two ounces of glucose added, 10 to 15 minutes before the close of the operation, restores the glycogenic function of the liver, fills out the veins, dilutes any anaesthetic which may remain in the blood and assists in bringing the patient out of the anaesthetic in the best possible condition.<sup>7</sup>

### Anesthetic Record

In order to facilitate the acquirements of more exact knowledge by everyone concerned, an anaesthetic chart should be in every hospital, regardless of the method or anaesthetic used.

In all chloroform anaesthesia, the pulse should be taken every five minutes, the time recorded at the top of the chart and the rate by a dot on its respective line. During ether narcosis, the pulse-taking would depend entirely upon the patient's condition and the nature of the operation.<sup>8</sup>

### Postoperative Course

At the close of every operation, the patient should have from one to two pints of warm saline with one ounce of glucose per rectum, to restore the glycogenic function of the liver and to relieve the thirst and fill out the veins; as the operation is closing or a little later, an enema of three to six ounces of warm olive oil should be given in order to restore the opposing index. With these precautions and additions, not one patient in 10 will have any nausea or vomiting, or any unpleasant recollections of the work of the surgeon and his assistants.

In all major operations, the injection of normal saline solution per rectum before the patient is taken from the table and inhalations of oxygen for 30 minutes, after the operation is concluded, are measures intended to assist in getting rid of all of the anesthetic that may still remain in the blood, thus preventing postoperative shock.

The patient should be able to answer questions intelligently within 15 minutes after the conclusion of the operation. But even with the anesthesia properly induced and maintained, we must remember that a tremendous strain has been placed upon all of the vital functions; therefore, to avoid all shock after the operation, the room should be darkened, quiet maintained and the patient allowed to sleep until he awakens naturally.<sup>9</sup>

### Professionalism

There is no more reason why a nurse, an undergraduate medical student or an untrained hospital intern should be entrusted with the life of the patient, as is the case in the giving of an anaesthetic, than that such individual should be allowed to perform a surgical operation which endangers the life of the patient, or to treat a disease the successful culmination of which entails the ability to meet exigencies as they arise.

It should be, and is, the purpose of the American Association of Anaesthetists to combat this state of affairs and to demonstrate, by fact and figure, by experiment and practice, that it is the inalienable right of the patient who entrusts his or her life to a surgeon to have that life safeguarded in every way possible. The anaesthetist, even more than the surgeon, holds the thread of life in his hands. He should have at his command every facility known to modern science whereby to carry the patient easily into and safely out of the state which has been called that borderland in which life in many respects so simulates death.<sup>10</sup>

### References:

1. Cope DK. James Tayloe Gwathmey: Seeds of a developing specialty. *Anesth Analg.* 1993; 76:642-647.
2. Gwathmey JT. *Anesthesia*. New York, NY: D. Appleton and Company; 1914:364-366.
3. Gwathmey JT. The vapor method of anesthesia. *Med Rec.* 1905; 70:611.
4. Gwathmey JT. The American Association of Anaesthetists, President's Address. *Am Surg Anesth Suppl.* 1913; 58:869.
5. Gwathmey JT. The vapor method of anesthesia. *Med Rec.* 1905; 70:612.
6. Gwathmey JT. Methods of giving anesthesia in operations upon the upper respiratory tract. *Ann Otol Rhinol Laryngol.* 1911; 20:842-844.
7. Gwathmey JT. The American Association of Anaesthetists, President's Address. *Am Surg Anesth Suppl.* 1913; 58:870.
8. Gwathmey JT. Improvements in anaesthetic apparatus and technique. *Med Rec.* 1904; 69:92.
9. Gwathmey JT. Shock from anesthesia. *Int J Surg.* 1907; 70:46-47.
10. Gwathmey JT. The American Association of Anaesthetists, President's Address. *Am Surg Anesth Suppl.* 1913; 58:869-870.





## Mesmer, Mozart and Music in Anesthesiology

Gale E. Thompson, M.D.

Wood Library-Museum of Anesthesiology Fellow (1989)

This author was the recipient of a Wood Library-Museum Fellowship in Anesthesiology. The Wood Library-Museum of Anesthesiology (WLM), Park Ridge, Illinois, has more than 300 books referenced directly or indirectly to Franz Anton Mesmer, M.D. Many of these rare books are in French or German and still await translation and future research by scholars. In addition to the book collection, the WLM has acquired a great number of letters of personal correspondence written by Dr. Mesmer.

### Mesmeric Origins of Anesthesiology

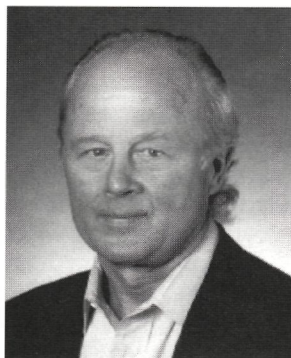
The origins of anesthesiology lie shrouded in antiquity, but the focal point of its modern history was in Boston, Massachusetts on October 16, 1846 when William T.G. Morton publicly demonstrated the efficacy of ether. After that time, the public's expectation was that patients should not feel pain during a surgical procedure. Simultaneously, the surgeons' expectation was to be able to operate on a quiet, immobile patient. Many surgeons likely experienced great emotional relief by shedding the attitude of "pitilessness" that had been encouraged since the days of Celsus!<sup>1</sup>

This change from operating on a writhing, complaining patient so impressed the famous London surgeon Robert L. Liston, M.D. that he uttered the now famous phrase, "This Yankee Dodge, gentlemen, beats mesmerism hollow."<sup>2</sup> Upon closer examination of this quotation, one is struck by the fact that Dr. Liston chose "mesmerism" as the antithesis against which the discovery of ether anesthesia should be compared. Indeed, in his remark, there were elements of a long-smoldering antagonism. Dr. Liston also wrote to a surgical colleague in Edinburgh, "Hurrah! Rejoice! Mesmerism and its professors, have met with a heavy blow and great discouragement."<sup>3</sup>

However, the advocates of mesmeric anesthesia did not give up easily. John Elliotson was the leading spokesperson for mesmeric anesthesia and editor of *The Zoist: A Journal of Cerebral Physiology and Mesmerism and Their Applications to Human Welfare*. The motto of the journal was "This is the Truth, though opposed to the Philosophy of the Ages." The last of its 13 vol-



Franz Anton Mesmer, M.D.



Gale E. Thompson, M.D. is Staff Anesthesiologist at Virginia Mason Medical Center, Seattle, Washington.



umes was published in 1855. *The Zoist* decried the dangers of ether and chloroform while regularly reporting “painless” mesmeric operations.

### Evolution of Mesmerism

Much about the personal life of Franz Anton Mesmer, M.D. remains an enigma despite numerous biographers.<sup>4,5</sup> Few would describe him as having great intelligence or as an original thinker. More appropriate descriptors would be stubborn and secretive, opportunist and plagiarist.

By the mid-1700s, there were a large number of writings on the subjects of magnetism, electricity and the possible effects of heavenly bodies on man; Galen, Hippocrates, Descartes and Paracelsus all reflected on this relationship. Dr. Mesmer’s early practice in Vienna evolved in an increasingly mystical way as he adopted various means and methods to place himself as an intermediary between the energizing heavenly “fluidism” and human disease. His concept of the specific nature of this fluid still remains ill-defined, but terms like electricity, magnetism, emanations or vibrations might serve to guide our understanding.

The pre-Revolutionary period in France was especially conducive to fostering Mesmer’s success. Indeed, mesmerism was the most fashionable topic of interest in France in the decade prior to the Revolution:

“It was debated in the academies, salons and cafés. It was investigated by the police, patronized by the queen, ridiculed several times on stage, burlesqued in popular songs, doggerels, and cartoons, practiced in a network of masonic-like secret societies, and publicized by a flood of pamphlets and books. It even found its way into *Così fan tutte* by Mesmer’s friend from his days in Vienna, Wolfgang Amadeus Mozart.”<sup>6</sup>

It was an age trying to escape from the ignorance and witchcraft of the past while exploring the new world of science. Dr. Mesmer would enter his treatment room in a purple or yellow robe, to the strains of music played live by musicians in the background. He was convinced that the magnetic properties of this therapy could be communicated, propagated and intensified by sound. Dr. Mesmer was probably aware of the rich history of interface between medicine and music, a history that had evolved from Egyptian, Greek and Roman times. This is best summa-

rized in a quotation from Francis Bacon, who wrote in 1606:

“[T]he [Greek] poets did well to conjoin music and medicine in Apollo, because the office of medicine is to tune this curious harp of man’s body and to reduce it to harmony.”<sup>7</sup>

As a youth, Mesmer learned to play the piano, the cello and an instrument referred to as the glass harmonica. A series of glass tumblers filled with water to various heights, the glass harmonica gave a distinctive sound when a finger was passed around the rim of the glass. Thus, he improvised various melodies. Later, composer Cristoph W. Gluck became his close personal friend and often encouraged him to produce such original instrumental sounds. Joseph Haydn was also a personal friend and frequent visitor to Mesmer’s home in Paris.

However, Mesmer’s most noteworthy alliance with a famous musician was that with Wolfgang Amadeus Mozart. The two first had met in Vienna, where Wolfgang’s father, Leopold, had brought the 12-year-old prodigy on tour. Although successful in obtaining audiences with Empress Maria Theresa and other aristocracy, Leopold was not finding ready financial support. He complained bitterly in a letter in January, 1768 about the “ridiculous, impossible madness” of those Viennese who failed to recognize the genius of Wolfgang as a composer. At that point, Mesmer took the opportunity to help, and this further encouraged their lasting friendship.

“Emperor Joseph II, in a moment of enthusiasm, had urged Wolfgang to compose a whole opera, and the child had responded with *La Finta Semplice*. Joseph, always posing as a simple man of the people without high-brow predilections, was not as deeply interested in music as was his mother, Maria Theresa. But, nonetheless, Joseph had instructed Affligio, the director of the Viennese Opera House, that young Mozart’s opera was to be produced. Affligio was jealous and annoyed, but he could not refuse. He could and did, however, encourage malicious intrigues against Leopold at the Court, so that the production of *La Finta Semplice* was indefinitely postponed. Realizing the young composer’s profound disappointment, Mesmer immediately took steps to compensate him for Affligio’s antagonism.

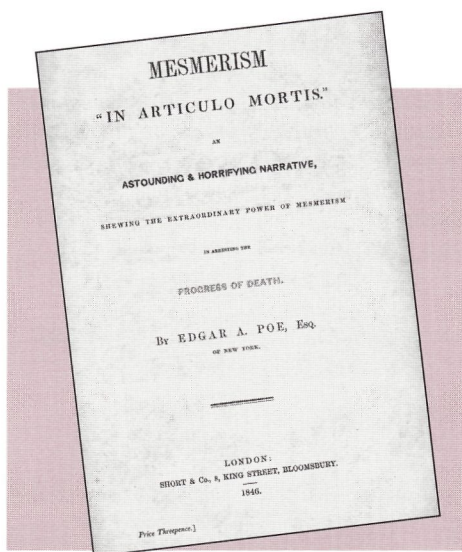


Mesmer now ordered a small opera from Mozart, *Bastien and Bastienne*, and this, the first of Mozart's operas ever to be produced, was given at Mesmer's home in September of the same year, 1768."<sup>8</sup>

The field of literature also contains many references to Dr. Mesmer and mesmerism. As some might suspect, Edgar Allan Poe was among those whom it fascinated. The cover of one of his ghoulish tales [right] certainly demonstrates this. The story *Mesmerism* might be said to have pertinence to anesthesiology in that it includes commentary on death, dying and associated experiences. Mesmeric philosophy launched much of the ideation of Balzac and Victor Hugo; they, too, attacked traditional science as too guarded and prone to repress challenging new concepts.

For Charles Dickens, Rudyard Kipling and Mark Twain, the subject of mesmerism was an obvious source of material for jesting, derision and humor. Dr. Mesmer's critics tended to be polarized and to look upon him with either strong favor or contempt. R. B. Ince<sup>9</sup> pleaded for a non-judgmental attitude, and his book contains a particularly poignant story related to Mesmer's pet canary.

"This canary lived in an open cage in his room. Every morning the bird would fly out, perch on Mesmer's head while he slept, and waken him with its song — nor would the concert end until Mesmer arose and dressed himself. Always he had the power of putting the canary to sleep with a light stroke of the head and of awakening it by stroking the feathers in the reverse direction. On February 20, 1815, Mesmer, feeling unwell, did not visit the Casino as he was accustomed to do on Sundays. His illness gradually increased, and upon March 5th he begged that his friend, a young priest, Fessler by name, might be sent for. Before he arrived, however, Mesmer passed peacefully away. The body was left untouched until morning, but the canary did not, as usual, fly out of its cage to perch upon his head and awaken him. The



The title page from Edgar Allan Poe's short story *Mesmerism*.

bird neither sang nor ate any more, and very shortly afterwards was found dead in its cage."

Perhaps the story best emphasizes the sensitive, musical side of Dr. Mesmer's personality. There is certainly more than ample evidence of his iconoclastic controversial side. Was he a charlatan or savior? Quack or healer? Opportunist or purveyor of some truth? The debates go on, but it is nonetheless appropriate that we consider those roots of anesthesiology that might be ascribed to Franz Anton Mesmer.

#### References:

1. Calverley RK. Anesthesia as a specialty: Past, present and future. In: Barash PG, Cullen BF, Stoelting RK. eds. *Clinical Anesthesia*. Philadelphia, PA: J.B. Lippincott; 1989:3.
2. Cock FW. The first major operation under ether in England. *Am J Surg*. 1915; 29 (Anesthesia Suppl 7):98-106.
3. Liston RL. Mr. Liston's letter to Mr. Miller. *The Zoist*. 1849; 6:211.
4. Podmore F. *Mesmerism and Christian Science, a Short History of Mental Healing*. London: Methuen; 1909.
5. Goldsmith M. *Franz Anton Mesmer: The History of an Idea*. London: Arthur Barker; 1934.
6. Darnton R. *Mesmerism and the End of the Enlightenment in France*. Cambridge: Harvard University Press; 1968:22-41.
7. Thompson GE, McMahon DJ. Music and analgesia. In: Brown DL. ed. *Problems in Anesthesia*. Philadelphia, PA: J.B. Lippincott; 1988:376-385.
8. Lowenberg A. "Bastien and Bastienne" once more. *Music and Letters*. 1944; 25:176-181.
9. Ince RB. *Franz Anton Mesmer: His Life and Teaching*. London: William Rider & Son; 1920.



## Helping to Preserve Our Past and Plan Our Future

*The Board of Trustees of the Wood Library-Museum of Anesthesiology wishes to acknowledge and thank the following individuals and organizations who have made monetary contributions to the WLM from September, 1994 through August, 1995 (does not include endowment contributions):*

<b>Contributor(s)</b>	<b>In Honor of:</b>	<b>Contributor(s)</b>	<b>In Honor of:</b>
Ezzat I. Abouleish, M.D. Houston, TX	Roderick K. Calverley, M.D.	John S. Hattox, M.D. San Diego, CA	Roderick K. Calverley, M.D. Mrs. Catherine Pender
Dr. and Mrs. Terry Ambus Chandler, AZ	Roderick K. Calverley, M.D.	Carol A. Hirshman, M.D. Baltimore, MD	Roderick K. Calverley, M.D.
Richard Ament, M.D. Williamsville, NY	M.T. Pepper Jenkins, M.D.	Joanne Jene, M.D. Portland, OR	M.T. Pepper Jenkins, M.D.
Dr. and Mrs. Douglas R. Bacon East Amherst, NY	Roderick K. Calverley, M.D.	Drs. Sara T. and James Jones Winston-Salem, NC	Mrs. Jean Vandam
Paul G. Barash, M.D. Orange, CT	Roderick K. Calverley, M.D.	John J. Leahy, M.D. New Tripoli, PA	Roderick K. Calverley, M.D.
Dr. and Mrs. Louis S. Blancato Scarsdale, NY	M.T. Pepper Jenkins, M.D.	Dr. and Mrs. Ronald A. MacKenzie Rochester, MN	M.T. Pepper Jenkins, M.D.
Drs. Diann H. and Phillip O. Bridenbaugh Cincinnati, OH	M.T. Pepper Jenkins, M.D.	Kathryn E. McGoldrick, M.D. New Haven, CT	Roderick K. Calverley, M.D.
Dr. Seymour and Mrs. Rose Brown Chesterfield, MO	Dr. John and Mrs. Emma Bonica	Franklin B. McKechnie, M.D. Winter Park, FL	Roderick K. Calverley, M.D. M.T. Pepper Jenkins, M.D.
Selma H. Calmes, M.D. Culver City, CA	M.T. Pepper Jenkins, M.D.	Elliott V. Miller, M.D. and Mrs. Elizabeth M. Lee Arlington, MA	Roderick K. Calverley, M.D. M.T. Pepper Jenkins, M.D.
Roderick K. Calverley, M.D. San Diego, CA	Mrs. Catherine Pender M.T. Pepper Jenkins, M.D.	Lucien E. Morris, M.D. Bainbridge Island, WA	John J. Bonica, M.D. Robert W. Virtue, M.D.
Donald Caton, M.D. Gainesville, FL	Roderick K. Calverley, M.D. M.T. Pepper Jenkins, M.D. Mrs. Catherine Pender	Gerald G. Mullikin, M.D. Longview, TX	M.T. Pepper Jenkins, M.D.
Dr. and Mrs. Edward P. Didier Rochester, MN	M.T. Pepper Jenkins, M.D.	John B. Neeld, Jr., M.D. Atlanta, GA	Roderick K. Calverley, M.D. M.T. Pepper Jenkins, M.D.
Burdett S. Dunbar, M.D. Houston, TX	Roderick K. Calverley, M.D.	E.S. Siker, M.D. Pittsburgh, PA	M.T. Pepper Jenkins, M.D.
Norig Ellison, M.D. Ardmore, PA	M.T. Pepper Jenkins, M.D.	Leslie E. Soper, M.D. Las Vegas, NV	Marion A. Warpinski, M.D.
Florida Society of Anesthesiologists St. Petersburg, FL	Breckinridge W. Wing, M.D.	Edna M.H. Spillar, M.D. San Antonio, TX	M.T. Pepper Jenkins, M.D.



---

**Contributor(s)**

St. Joseph Hospital Medical Staff  
Lancaster, PA

John E. Steinhaus, M.D.  
Atlanta, GA

C. Ronald Stephen, M.D.  
Chesterfield, MO

Robert K. Stoelting, M.D.  
Carmel, IN

Dr. Shepard B. and Mrs. Marlene Stone  
Branford, CT

**In Honor of:**

Norman B. Kornfield, M.D.

M.T. Pepper Jenkins, M.D.

Roderick K. Calverley, M.D.  
M.T. Pepper Jenkins, M.D.

M.T. Pepper Jenkins, M.D.

Morris T.C. Stone

**Contributor(s)**

Texas Society of Anesthesiologists  
Austin, TX

Dr. Jess B. and Mrs. Shirley Weiss  
Pompano Beach, FL

Dr. and Mrs. Bernard V. Wetchler  
Peoria, IL

Bernard V. Wetchler, M.D.  
Peoria, IL

Marcelle M. Willock, M.D.  
Boston, MA

**In Honor of:**

M.T. Pepper Jenkins, M.D.  
Stephen A. Stern, D.O.

Dr. M.T. Pepper and  
Mrs. Betty Jenkins

I. Cary Andrews, M.D.  
M.T. Pepper Jenkins, M.D.

New England Society of  
Anesthesiologists

M.T. Pepper Jenkins, M.D.

---

*The Board of Trustees of the Wood Library-Museum of Anesthesiology wishes to acknowledge and thank the following individuals and organizations who have made donations other than monetary (e.g., books, equipment, manuscripts) to the WLM from September, 1994 through August, 1995:*

Ezzat I. Abouleish, M.D.  
Houston, TX

Karel B. Absolon, M.D.  
Rockville, MD

Ms. Charlotte Agree  
Deerfield Beach, FL

Maurice S. Albin, M.D.  
San Antonio, TX

James E. Albrecht, M.D.  
Jackson, WI

American Society of Regional  
Anesthesia  
Richmond, VA

Deepthi Attygalle, M.B., F.F.A.R.C.S.  
Sri Lanka

Richard J. Bailey, F.F.A.R.C.S.  
Sydney, Australia

Betty J. Bamforth, M.D.  
Madison, WI

Jan Baum, M.D.  
Damme, Germany

Baxter Healthcare Corporation  
Anesthesia Division  
Round Lake, IL

Mrs. Hope S. Beam  
Evanston, IL

Mr. Ronald R. Beer  
St. Louis, MO

Jonathan L. Benumof, M.D.  
San Diego, CA

Jonathan C. Berman, M.D.  
Denver, CO

Dorothy W. Betlach, M.D.  
Janesville, WI

Mr. Prall Bird  
Merrick, NY

James F. Black, M.D.  
Marshalltown, IA

Casey D. Blitt, M.D.  
Tucson, AZ

David L. Brown, M.D.  
Rochester, MN

Blackwell Brunner, M.D.  
Potomac, MD

Mrs. Janeen Calverley  
San Diego, CA

Donald Caton, M.D.  
Gainesville, GA

David H. Chestnut, M.D.  
Birmingham, AL

Miguel A. Colón-Morales, M.D.  
San Juan, Puerto Rico

Michael Cooper, F.F.A.R.C.S.  
Sydney, Australia

Randall C. Cork, M.D., Ph.D.  
New Orleans, LA

James E. Cottrell, M.D.  
Brooklyn, NY

Thomas J. DeKornfeld, M.D.  
Ann Arbor, MI

Hansel de Sousa, M.D.  
Pittsburgh, PA

B. Raymond Fink, M.D.  
Seattle, WA

Carl W. Fisher, M.D.  
Walnut Creek, CA

Simon Gelman, M.D., Ph.D.  
Newton, MA

Adolph H. Giesecke, Jr., M.D.  
Dallas, TX

Gina M. Glick, M.D.  
Carrollton, TX

Virgil P. Goodman, M.D.  
St. Clair Shores, MI



Hubert G. Gootee, M.D. San Antonio, TX	Loma Linda University Department of Anesthesiology Loma Linda, CA	New York State Society of Anesthesiologists, Inc. New York, NY	David S. Smith, M.D., Ph.D. Philadelphia, PA
Joachim S. Gravenstein, M.D. Gainesville, FL	Sam Lo Palo, CRNA Gainesville, FL	Morris J. Nicholson, M.D. Sun City, AZ	Penelope C. Smith, M.D. San Diego, CA
Nicholas M. Greene, M.D. North Haven, CT	Mr. John C. Lundy Orange, CA	E.M. Papper, M.D., Ph.D. Miami, FL	Mr. Dana Stetson Rockland, MA
Sidney W. Helperin, M.D. Tarzana, CA	Jacob Mainzer, Jr., M.D. Albuquerque, NM	Nagin P. Parbhoo, M.D. Bergvliet, South Africa	John E. Steinhaus, M.D. Atlanta, GA
Thomas L. Higgins, M.D. Cleveland, OH	Gertie F. Marx, M.D. Bronx, NY	Carlos P. Parsloe, M.D. São Paulo, SP, Brazil	David J. Steward, M.B., F.R.C.P. Pasadena, CA
Thomas F. Hornbein, M.D. Seattle, WA	Kathryn E. McGoldrick, M.D. New Haven, CT	John W. Pender, M.D. Palo Alto, CA	Rebecca S. Twersky, M.D. Brooklyn, NY
Wayne K. Jacobsen, M.D., F.C.C.M. Redlands, CA	MCP/Hahnemann University Department of Anesthesiology Philadelphia, PA	Stephen J. Prevoznik, M.D. Drexel Hill, PA	United States Pharmacopeial Convention, Inc. Rockville, MD
Family of M.T. Pepper Jenkins Denver, CO	David Mendelsohn, Jr., M.D. Chagrin Falls, OH	Albert W. Ray, Jr., M.D. Joliet, IL	Thomas E. Upton, M.D. Medford, OR
Paula Kaiser, M.D. Washington, DC	Elliott V. Miller, M.D. Boston, MA	Leslie Rendell-Baker, M.D. Redlands, CA	Gerard A. Vanderhaar, Ph.D. Memphis, TN
Donald Klopp, M.D. Portland, ME	Ronald D. Miller, M.D. Mill Valley, CA	James T. Roberts, M.D. Needham, MA	Alan Van Poznak, M.D. New York, NY
Carol L. Lake, M.D. Sacramento, CA	Michael Montagne, Ph.D. Boston, MA	Mark A. Rosen, M.D. Piedmont, CA	Mrs. Paula Vehrs Eugene, OR
Arthur M. Lam, M.D., F.R.C.P.C. Seattle, WA	Daniel C. Moore, M.D. Seattle, WA	Henry Rosenberg, M.D. Philadelphia, PA	Philip J. Villandry, M.D. Portland, ME
Erwin Lear, M.D. New York, NY	Lucien E. Morris, M.D. Bainbridge Island, WA	Theodore J. Sanford, Jr., M.D. Ann Arbor, MI	Paul F. White, M.D., Ph.D. Dallas, TX
Roy C. Levitt, M.D. Towson, MD	Mosby-Year Book, Inc. Philadelphia, PA	Wallace M. Shaw, M.D. Melville, NY	Mr. Richard J. Wolfe Boston, MA
J.B. Lippincott Company Philadelphia, PA	Alexander H. Nacht, M.D. New York, NY	E.S. Siker, M.D. Pittsburgh, PA	Howard L. Zauder, M.D. Scottsdale, AZ



# Value-Based Anesthesia: Operating Room and PACU Management

Patricia A. Kapur, M.D.

Task Force on Value-Based Anesthesia

*This is the sixth article in a series on value-based anesthesia topics.*

Patient care related to surgery and anesthesia has traditionally generated revenue proportional to the time and resources consumed. The advent of single global fees to cover all facility and provider charges, along with capitated care in which profitability is related to minimizing the resources expended for patient care, has rapidly transformed surgical suites from "revenue centers" to "cost centers."

This shift has provided an unparalleled emphasis on managing all aspects of the surgical process with the greatest efficiency and lowest cost. The traditional independent management of various departments, divisions and services that constitute the overall surgical process is changing to an integrated management of "surgical services" [Figure 1].

Therefore, contemporary management of the operating room and postanesthesia care unit (PACU) now demands a broader perspective, encompassing all elements of the perioperative process for which anesthesiologists are uniquely suited.

It is important, therefore, for anesthesiologists to be familiar with the facilities' issues in surgical care that impact resource availability and allocation. It is equally important that they learn to recognize the impact that choices in facility management have on the ultimate ability of the operating suite to deliver quality care to the greatest number of patients requiring it in the most efficient manner.



Patricia A. Kapur, M.D. is Associate Professor of Anesthesiology and Director of the Surgery Center at the University of California, Los Angeles, California.

## Customers

Perioperative customers who assess "value" are: surgeons, patients and third-party payers as well as the anesthesiology staff. Surgeons value timely starts, minimal turnover times, timely availability of instruments and equipment, and patient satisfaction with facility amenities and staff.

Patients value friendly, caring and competent staff, on-time procedures, a clean facility, and adequate preoperative and postoperative teaching. In addition, patients expect lack of operative complications, adequate pain relief, adequate treatment of nausea and emesis, and prompt return to preoperative well-being.

Third-party payers value patient satisfaction because satisfied patients will renew their affiliation with those payers who can provide access to successful facilities or, conversely, will exert pressure for alternative payer sources that provide access to better performing facilities. However, third-party payers basically value the financial bottom line, i.e., the provision of a satisfactory level of care for the best price.

Anesthesiologists value having well-prepared patients; being provided with well-maintained, reliable equipment and appropriate supplies and medications; having trained support personnel so they can concentrate their time on patient care; and having well-trained preoperative and postoperative staff to share in the care of the patients.

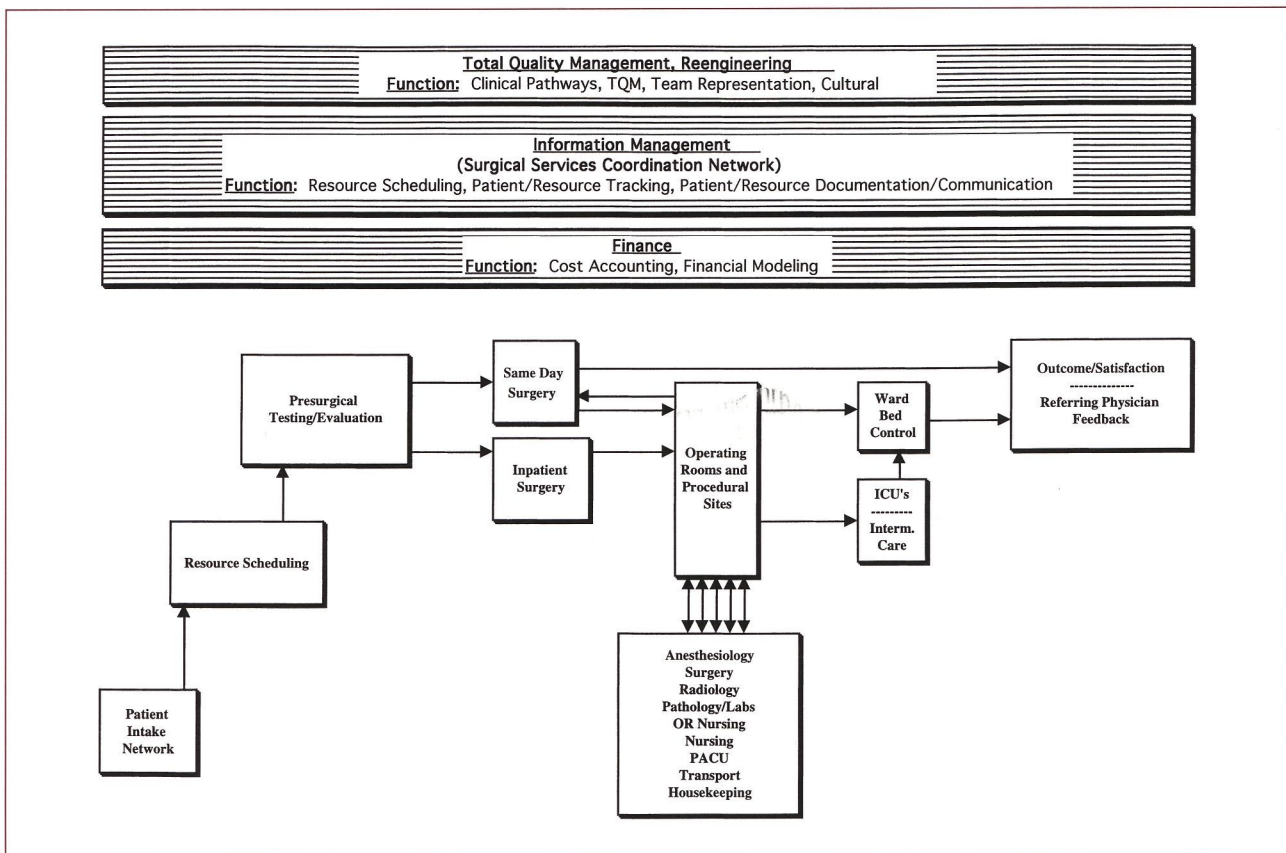
## Personnel

To maintain an efficient surgical facility in the new fiscal environment, employees must be willing to be very flexible in the approach of their daily work. They must possess multiple skills to cover various assignments as the type and amount of work fluctuates from day to day and within the day. In the past, nurses have specialized in either intraoperative or preoperative and recovery care; it is now becoming more common in surgery settings to cross-train nurses to care for patients in both areas.

Flexibility in staffing is gained and staff expenditures are controlled because recovery of late patients or small numbers of patients on low-volume days do not require additional specialized recovery staff to sit idle until surgeries are completed. Larger units can stratify duties and reduce staffing costs by instituting team care concepts in the preoperative and recovery areas, i.e., utilizing registered nurses with licensed vocational nurses and nursing



**Figure 1**



*Diagram of integrated perioperative management scheme, requiring coordinated, efficient, "value-based" management. Courtesy of W. D. Watkins, M.D., Ph.D.*

assistants to provide for the variety of needs of the perioperative patient in a cost-efficient manner.

The support staff is a valuable component to promote functional efficiency and achieve cost-containment in the surgical setting. Every staff member should be prepared to do whatever has to be done to help the work flow. Furthermore, whenever possible, lower salaried technical and support personnel should be used to the fullest extent of their capabilities whenever possible so the available professional personnel can concentrate on the duties that require their special talent, training and licensure.

The twin concept of cross-training and multitasking is

essential. Cross-training implies knowledge of more than one job so employees can fill in for one another during vacations, illness and periods of increased volume. Examples of cross-training, in addition to operating room and postanesthesia nurses, include operating room orderlies and anesthesia technicians who are trained to fill in for one another; scrub technicians who help with instrumentation sterilization and tray preparation; and reception and patient care/clerical personnel who cross-cover.

On the other hand, the multitasking employee is one who regularly carries out duties that overlap one or more job categories when all job titles are not simultaneously



active. For example, one employee may work at reception in the morning, assist the billing clerk at midday and provide support in the predischARGE area at day's end. Another example is the versatile, multitasking technician who may work as an anesthesia technician during the busy morning, help the operating room as a laser monitoring technician and then process instruments at day's end.

### **Scheduling**

The continual optimization and fine-tuning of the operating room schedule is a powerful tool that can result in near complete utilization of available time and space or contribute to serious discrepancies that undermine surgeon and staff morale.

A "block time" schedule is only effective if surgeons reliably and consistently fill their blocks; otherwise, unreimbursed operating room time results, and other (dissatisfied) surgeons see empty rooms too late to add cases.

An "open" schedule requires a skillful scheduler who can assemble surgical requests into a cohesive schedule, taking into account limited numbers of specialized instruments and/or equipment available at any given time. A combined approach — in which surgeons with large, reliable practices are granted appropriate block time while others utilize open rooms on a first-come, first-served basis — is often successful.

Once the surgical facility and the anesthesiology team have agreed to the daily schedule, the smooth flow of the surgical cases for that day will depend greatly on the last-minute decisions regarding when and where to start making room and/or time changes to accommodate late surgeons or patients, add-on cases, cancellations, staff shortages, etc. Close communication among perioperative personnel, anesthesiologists, surgeons and patients is required for this necessary micromanagement of the space, time and personnel resources in order to assure a favorable outcome and improved efficiency.

### **Materials Management**

Three components of materials management in surgical suites are equipment, instrumentation and supplies. The maximum utilization of these resources at the minimum capital outlay depends heavily on multiple managerial principles: 1) nonconflicting scheduling of cases with similar resource demands; 2) cost-effective procedures for turnaround of instruments; 3) timely replacement schemes for

consumable supplies that do not require maintaining excessive inventories; 4) prompt repair/preventive maintenance schemes to minimize equipment downtime; 5) prospective budgeting for replacement of capital items at the anticipated end of their useful lifetimes; and 6) anticipation of changes in case mix because of development of new surgeries, change of old surgeries to an ambulatory venue or additions/losses of particular surgeons.

Other methods to ensure sufficient (versus unutilized/unreimbursed) equipment availability include careful case scheduling, incentives for surgeons to take operating time on days with less demand for specialized equipment, shared utilization of equipment between inpatient and outpatient operating rooms, or rental options for rarely used equipment. Coordination among users of expensive equipment is required to make purchasing choices so as to avoid the expense of supporting multiple, competing equipment systems.

Cost-effective management of consumable supplies takes a variety of forms: 1) coordinated purchasing by a central source; 2) bulk purchasing discounts (storage considerations and commitment of capital outlay); and/or 3) intermediate vendors who purchase from primary sources in bulk and then deliver on a "just in time" basis.

Regardless of the acquisition methodology, outcome information is required to justify the cost versus benefit of the choice of any and all consumables, from sutures to pharmaceuticals.

### **Care Maps/Critical Paths**

Satisfactory outcomes for a reasonable cost are important as surgical facilities become positioned to offer a health care "product" at a package price with a high degree of consistency between the cost of delivering the care and the price charged. It is now recognized that the presence of "care maps," or case management by the critical path approach, can result in reduced variability in resources consumed.

The anesthesiologist per se can contribute valuable input regarding anesthetic and postoperative resource consumption by choosing agents and techniques that optimize overall patient care in an efficient manner. This, in turn, can result in improved patient satisfaction. For example, a smooth and short-duration recovery period may not only reduce overall costs incurred, but it also may be a key indicator of "good service" as viewed by patients and their



families, adding to the competitive edge enjoyed by a particular facility.

The viability of these concepts depends upon outcome information in order to make a determination that the overall cost of one alternative is less while achieving an equivalent or better outcome. The health care facility then can utilize historical data to devise a global facility fee based on the type of procedure to be performed. Important to this effort is a thorough understanding of the actual costs (versus current charges) for various procedures.

Surgery facilities that anticipate these trends by functioning efficiently and by developing a value to cost awareness will be better prepared for the eventual widespread application of a prospective payment system for perioperative care.

### Summary

The goals of anesthesiologists and surgical facility managers are acutely converging, and anesthesiologists themselves should be prepared to take a leadership role — from

the moment the decision to schedule surgery is made, to the determination of the timing and extent of the preoperative evaluation, through management of the intraoperative experience, efficient postoperative care and follow-up to resolve problems and improve future satisfaction.

Optimum selection, allocation, deployment and utilization of all resources (personnel, space, time, equipment and expendable supplies) is required to ensure that in the setting of high-quality care, all aspects of efficiency and service are maximized.

### Reference:

1. Kapur PA. Facilities management and staffing. In: White PF. ed. *Ambulatory Anesthesia and Surgery*. London: W.B. Saunders, Ltd. In press.

### Acknowledgment:

Special thanks to W. D. Watkins, M.D., Ph.D. for his review and comments.

---

## Washington Report

*Continued from page 4*

of anesthesiology values with work values for other physician services and procedures and to make a presentation to the full RUC in late August.

In early August, ASA undertook a review of some of the intensity values used in the Abt study and submitted a revised proposal to the RUC, calling for a 35-percent increase in work values.

### Senate Passes Lobbying, Entertainment Rules

On July 25, the Senate unanimously adopted new lobbyist registration requirements, increasing the number of persons who must register as lobbyists and expanding the detail of

information that lobbyists must disclose in their lobbying reports.

Under the new proposal, lobbyists must disclose information as to issues that prompt a lobbying effort and account for money spent on the effort. The House of Representatives has not yet enacted its bill with respect to lobby disclosure requirements.

Two days later, the Senate adopted internal rules (no House action required) limiting the value of any meal or other entertainment to \$20 that a Senator would be permitted to accept from a lobbyist or any other person, except friends or relatives. Also banned would be expense-paid travel and lodging for charitable events or other entertainment or recreational events.

### GOP Developing Medicare Legislation

Republicans in the House are expected to introduce sweeping Medicare reform legislation shortly after the end of the August recess. The bill is widely expected to rely heavily on a voucher system for Medicare beneficiaries and on managed care options as a means of achieving the necessary budget savings required by the House-Senate budget resolution adopted several weeks ago.

Of special interest to physicians, the bill will also likely contain a one-year freeze on payments under the Medicare Fee Schedule as well as adjustments to the formula by which such payments are allowed to rise.



## ASA Gains E-mail, Spins Web Page

*N. Ty Smith, M.D., Chair  
Committee on Electronic Media and Information Technology*

The ASA Executive Office is preparing for the 21st century by implementing a World Wide Web page as well as e-mail communications with its office in Park Ridge, Illinois. ASA is very pleased to offer these two services to its membership.

In cooperation with the Committee on Electronic Media and Information Technology (EMIT), the ASA Executive Office has implemented a direct Internet connection. Briefly, the Internet is an international network of networks connecting people who use computer systems. These networks use satellites and high-speed communication lines that allow users to transfer information in a variety of formats.

E-mail should enhance communications between the Executive Office and the membership by allowing a more rapid and direct exchange of information. Any member with a computer, a modem and an e-mail account may now reach individuals at the Park Ridge office directly. The addresses for departmental mailboxes are listed in Table 1.

ASA also has a World Wide Web site through which it will publish information of general usefulness to its members as well as patient education information for the general public. The Web page currently offers information about ASA itself and the practice of anesthesiology, the complete text of the ASA Bylaws and the text of the latest *NEWSLETTER*. Other items are still being readied, e.g., information about the 1995 Annual Meeting. The ultimate goal is to make ASA's home page a useful resource that professionals and the public will want to visit often.

The World Wide Web is a graphical, intuitive means of accessing information via the Internet. Entry points are called home pages. Each home page serves as a jumping-off point to the information contained at the Web site and sometimes offers links to other Web sites as well. To access the Web, you must have an Internet account, either through your company, your educational institution or a commercial service. You will need a computer, a modem and a browser program. Netscape and Mosaic are the two best known among the browser programs available. Navigating the Web is simply a point-and-click transaction, with each page containing buttons or "hot text" (underlined text) that lead to other pages.

You will also need to know the universal resource locator (URL), or address, for any page you wish to access. URLs for Web pages always begin with the indicator "http://".

**Table 1**

### ASA Executive Office E-Mail Addresses

Accounting Department . . . . . accounting@ASAhq.org  
Communications Department . . . communications@ASAhq.org  
Meetings and Conventions . . . . mtgs@ASAhq.org  
Membership Department . . . . . membership@ASAhq.org  
Publications Department . . . . . publications@ASAhq.org

American Society of Critical  
Care Anesthesiologists . . . . ascca@ASAhq.org  
Society for Ambulatory  
Anesthesia . . . . . samba@ASAhq.org  
Society for Pediatric  
Anesthesia . . . . . spa@ASAhq.org  
Wood Library-Museum of  
Anesthesiology . . . . . wlm@ASAhq.org

To reach a specific staff member, address messages using the individual's first initial, a period and the last name, followed by "@ASAhq.org". For example, to reach Frank W. Connell, Director of Scientific Affairs, address messages to: f.connell@ASAhq.org.

Send general questions to: **mail@ASAhq.org**

ASA's Web site URL is: **http://dewey.anes.ucla.edu.**

ASA's Web page was designed by EMIT Committee member Stanley W. Stead, M.D., Associate Professor of Ophthalmic Anesthesia, University of California-Los Angeles School of Medicine, Los Angeles, California. This is your site, and your comments and suggestions are welcome as we refine and expand the home page. Send any comments you may have to Janice L. Plack, ASA Systems Manager, at: j.plack@ASAhq.org.

The EMIT Committee is moving forward with goals established in 1994 and continues to embrace new challenges in the world of electronic information. The Internet connection and the World Wide Web site are first steps in a multiphase plan that will eventually include e-mail for the ASA Washington Office in Washington, D.C.



## How You Can Help ASA Make Its Decisions

Barry M. Glazer, M.D.  
*Speaker of the House of Delegates*

**THE MYTH:** Each year, tucked away in a corner of the headquarters hotel, a small group of anesthesiologists leaves the educational world of the ASA Annual Meeting to participate in the deliberations of the House of Delegates. ASA Officers, along with Delegates, District Directors and their alternates, comprise this esoteric session, making decisions in a small, closed circle that will affect anesthesiologists around the country.

**THE FACT:** These sessions are open to every member of ASA, and real opportunities exist for individual members to express opinions on the business items being considered and participate in the deliberations.

How does the ASA legislative process work?

The ASA House of Delegates includes voting members with constituencies who include the entire membership of ASA; there is approximately one voting member for every 100 ASA members. Almost all voting members are elected by their state or district. The legislative process permits these members of the House to hear the facts and give proper consideration to every item before the House and to debate and vote on these items in an open and democratic deliberative assembly.

Materials are sent to delegates and alternates in a Handbook for Delegates in advance of the meeting. These materials constitute the agenda for the House of Delegates. The sources of these business items include reports from the Officers, District Directors and committee chairs as well as resolutions from individual delegates. Each of these items is referred to a Reference Committee by the Speaker of the House of Delegates.

Lack of familiarity with the Handbook for Delegates is

probably the biggest obstacle to a member who is not familiar with the operations of the House to participate in these deliberations. ASA Officers, particularly the Speaker and Vice-Speaker, as well as ASA staff are eager to explain to any member how to use the Handbook to find the issues in which the member is interested. The House of Delegates Office, which will be located at the Atlanta Marriott Marquis during the 1995 Annual Meeting, is the best location to obtain such assistance.

The first meeting of the House at the 1995 Annual Meeting will be held on Sunday, October 22, at 9:00 a.m. in the Marquis Ballroom I-III, Atlanta Marriott Marquis Hotel.

At this meeting, ASA President Bernard V. Wetchler, M.D. and ASA President-Elect Norig Ellison, M.D. will present their addresses to the Society. Officers will be nominated at this meeting as well, and candidates for office will address the entire House at this time. Adjournment usually occurs by 11:00 a.m.

Sunday afternoon will provide the best opportunity for the individual member to provide input or comments on any issue coming before the House. Again, Officers and staff in the House of Delegates Office will assist members who wish to find out exactly where discussion on the issues in which they are interested will take place.

Four concomitant Reference Committee hearings will be held on Sunday beginning at 1:00 p.m., with issues being divided among these four committees. Reference Committees are composed of seven members, who are appointed by the President with consideration to geographical distribution as well as experience with the issues and processes of the House.

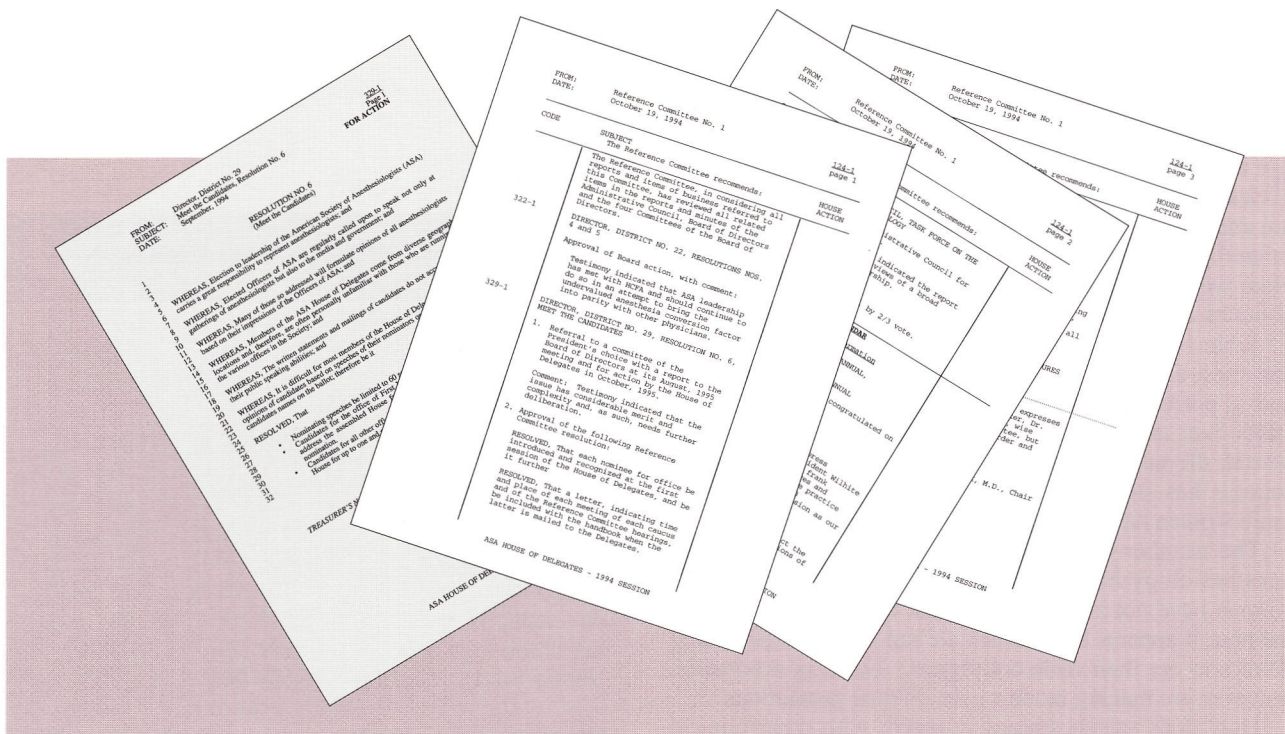
At these open hearings, when an issue of interest is discussed, any member may step to the microphone and provide his or her opinions. All members are welcome and are encouraged to attend and participate. Discussion is rarely curtailed, and limits will be imposed only when discussion is repetitive or if the extent of the committee's agenda demands it.

Open hearings will continue until 3:00 p.m. or until testimony has concluded, whichever is later. Hearings must adjourn or recess no later than 5:00 p.m., reconvening at 8:00 a.m. the next morning if (and only if) necessary. Then the Reference Committees go into closed (executive) session, at which time they will decide recommended action on each item of business that was assigned to the commit-



Barry M. Glazer, M.D. is Chair of the Department of Anesthesiology at Saint Francis Hospital, Beech Grove, Indiana.





tee. The written reports of the Reference Committees' recommendations are usually available by 5:00 p.m. Tuesday in the House of Delegates Office.

The second meeting of the House of Delegates will come to order at 8:00 a.m. on Wednesday, October 25, again in the Marquis Ballroom I-III, Atlanta Marriott Marquis Hotel. Elections will be conducted, and then the House will proceed to other business. Usually little debate occurs at this time because the Reference Committees will have provided ample opportunity for discussion and will have responded with appropriate and broadly acceptable recommendations for action, based on the testimony during the hearings.

Should members differ with the recommendations, however, debate is heard, limited only by order of the House itself. Motions are received and considered for amendment, referral to committees or such other action as the House may desire to take. Because of the size of the House of Delegates (nearly 300 voting members this year), formal parliamentary procedure guides the actions under the direction of the Speaker and Vice-Speaker, who chair these sessions.

Those who have never participated in such an assembly and who wish to do so might find the new Delegates' briefing, which will be held from 9:00 a.m. - 10:00 a.m. Satur-

day, of value. Conducted by the Speaker and Vice-Speaker and directed to new members of the House who are not familiar with how the House of Delegates and Reference Committee systems function, this briefing is open to all interested members. The hour consists of a very rapid introduction to ASA processes and a brief introduction to parliamentary procedure, especially as used by the House of Delegates.

Just as in public legislative bodies, much of the work of the House of Delegates is done outside of the formal process, but these sessions are not secret. They consist of the meetings of the caucuses. Five geographical areas have organized into unofficial but well-organized caucuses, which usually meet on Saturday and Tuesday afternoons at the Annual Meeting. At these caucuses, issues and candidates are discussed in free and open discussion (sometimes more open than in the House because of the smaller size and more informal atmosphere). Your District Director or Delegates can be of great assistance in helping you participate in caucuses, but the House of Delegates Office can also provide some guidance and location information.

**THE TRUTH:** Secret society? Not at all! ASA can take pride in having one of the most open and democratic processes of any organization of its size, allowing members to be involved in the important decisions that affect us all!



## A Crack in the Glass Ceiling?

Susan L. Polk, M.D.  
Committee on Professional Diversity

In the October, 1992 ASA NEWSLETTER, a series of articles on "Women in Anesthesiology" showed that women are under-represented in higher academic appointments and offered possible explanations and remedies for the future. Here we document the progress since then and speculate about its causes.

Table 1 compares statistical data on women in academic anesthesiology and shows a modest increase in numbers and in percentage at the professor and associate professor ranks over the past three years.<sup>1,2</sup> During the same time period, the number and percentage of women in medical schools has stayed about the same, but proportionately more women have entered anesthesiology residencies.

The number of women holding faculty positions in anesthesiology has increased; however, proportionately, women have not kept pace with the men. As was true in the past, it appears that women are not as interested in academics as are their male colleagues. Those in academics, however, are making modest gains in their promotions.

How does anesthesiology compare with other clinical specialties? Not very well. Table 2 lists the number and percent of faculty women, by medical specialty, who were full professors at the end of the 1993-94 academic year.<sup>3</sup> Almost 10 percent of all female medical school faculty hold the rank of full professor; in anesthesiology, only 4.4 percent of female faculty have achieved that rank. Only emergency medicine and orthopedics have a lower percentage. By contrast, 17.5 percent of male anesthesiology faculty hold the rank of full professor, while 32.3 percent of all male faculty members of American medical schools are professors.

Does this situation exist because few women have been on faculties long enough? Perhaps. The number of women medical faculty has nearly tripled since 1975; in anesthesiology, it has almost quadrupled. There was a 21-percent increase in the number of women who attained full professorships between 1992 and 1994 compared to a 13-percent increase for men. There are now five department chairs who are women.

My (optimistic) interpretation of these data is that women are being promoted at an increasing rate and will someday be represented equally at the higher ranks, should the most qualified remain in academics. We are still a relatively young specialty, and perhaps we have some catching up to do.

In 1992, Caryl J. Guth, M.D. suggested several actions

**Table 1**

### A Comparison of the Number of Women in Anesthesia

	1991 <sup>1</sup> n (%)	1994 <sup>2</sup> n (%)
All Anesthesia Faculty	664 (22.8)	928 (24.8)
Chair	4 (3.3)	5 (4.1)
Professor	33 (7.2)	40 (7.5)
Associate Professor	119 (20.2)	174 (22.8)
Assistant Professor	408 (27.1)	503 (26.9)
Instructor	104 (28.9)	211 (36.9)
All Anesthesiologists	5,518 (18)	5,585 (18.7)
Anesthesia Residents	1,241 (22)	1,303 (32)
Medical School Graduates	5,533 (36)	5,919 (38.1)

The numbers of women in anesthesiology have increased at all levels.

that could be taken to shatter the "glass ceiling" in academic programs. They included participating in medical organizations, re-examining the effectiveness of existing provisions, providing opportunities for shared or part-time positions, creating the freedom to develop flexible schedules and codifying parental-leave policies.<sup>4</sup> Philippa Newfield, M.D. elaborated on particular academic needs, including



Susan L. Polk, M.D. is Associate Professor of Clinical Anesthesia and Critical Care and Associate Chair for Education at the University of Chicago, Chicago, Illinois.



**Table 2****Women Faculty Who Were Full Professors in Medical Specialties in 1994<sup>3</sup>**

Department	Faculty Appointments		Full Professors
	Number	Percent	Percent
Anesthesiology	956	24.8	4.4
Dermatology	152	29.1	9.2
Emergency Medicine	108	21.2	3.7
Family Practice	631	30.5	5.4
Internal Medicine	3,767	21.3	7.1
Neurology	483	20.9	8.5
Obstetrics/Gynecology	1,059	33.1	5.5
Ophthalmology	293	20.4	7.8
Orthopedic Surgery	119	10.7	4.2
Otolaryngology	157	19.7	12.1
Pathology	1,156	25.6	15.0
Pediatrics	3,050	37.8	9.8
Physical Medicine	278	37.7	5.8
Psychiatry	2,001	30.6	7.0
Public Health	409	35.0	11.0
Radiology	1,010	20.4	9.3
Surgery	666	10.1	8.1
ALL MEDICAL FACULTY	19,052	24.4	9.9

Anesthesiology has the third lowest percentage of women full professors (4.4 percent) as compared with other clinical specialties and less than half the average percentage of women full professors in all specialties (9.9 percent).

appropriate and committed mentors, negotiating abilities, commitment of the department chair and willingness to do the hard work required for academic success.<sup>1</sup> Both of these anesthesiologists were on the mark in many respects, as evidenced by a recent article and accompanying editorial in the *Journal of the American Medical Association*<sup>5,6</sup> that quantitated the progress of women in academia.

Surveying 153 women and 263 men who were appointed to medical school faculty 11 years earlier, the authors were able to determine that 5 percent of women compared to 23 percent of men had been appointed to the rank of full professor; 59 percent of the women and 83 percent of the men had been promoted to a rank above assistant professor.

Controlling for productivity factors, women were less likely than men to be promoted.

The productivity factors that differed between the sexes were hours worked per week (women averaged 10 fewer), papers published and academic resources (office, lab space, protected time and grants) available at the beginning of the faculty appointment. There was no difference in academic preparation, availability of a secretary or lab assistants or availability of a mentor (although the quality of the mentoring was not explored). More of the men were married (93 percent versus 74.5 percent of women), and the men had more children (2.18 versus 1.52). There was no statistically significant correlation between number of children



and rank achieved for either gender. The attrition from academia was the same for both.

The conclusion of the study was that, as of 1991, even after controlling for fewer hours worked and fewer publications, women are still less likely to be promoted than men.

**“...published data now show that women can make progress in academia when consciousness is raised about the inequities, when processes for networking and personal improvement are put in place and when women become aware that they are lagging behind.”**

An accompanying editorial raised questions about the possible reasons for slower promotion. Those included time taken off for family during the 11 years of the study and the quality of the mentoring, which could have differed between the sexes. At Johns Hopkins University, Baltimore, Maryland, progress in equity has ensued since 1987, when a study showed that salaries and opportunities for promotion were unequal. It was most interesting to find that the inequity could be traced to the department level rather than the Promotions Committee. Fewer women were being recommended for promotion.

Efforts to advance women included annual gatherings and dissemination of statistics, formation of a Women's

Leadership Council to encourage participation in activities within the institution as well as outside and appointment of women to all faculty committees. Those efforts have been successful.

In other words, published data now show that women can make progress in academia when consciousness is raised about the inequities, when processes for networking and personal improvement are put in place and when women become aware that they are lagging behind. Effective and concerned role models and mentors remain the most important factors in developing successful academic careers. There obviously is also a place for encouraging and developing effective career planning and negotiating skills in our women residents.

#### **References:**

1. Newfield P. Women in research: Are opportunities equal? *ASA NEWSLETTER*. 1992; 56(10):27-29.
2. American Association of Medical Colleges Data Book: Statistical Information Related to Medical Education. American Association of Medical Colleges, 1995.
3. Bickel J, Galbraith A, Quinnie R. Women in U.S. Academic Medicine. American Association of Medical Colleges, 1995.
4. Guth CJ. Does medicine have a glass ceiling? *ASA NEWSLETTER*. 1992; 56(10):22-24.
5. Tesch BJ, Wood HM, Helwig AL, et al. Promotion of women physicians in academic medicine. Glass ceiling or sticky floor? *JAMA*. 1995; 273:1022-1025.
6. DeAngelis CD, Johns ME. Promotion of women in academic medicine. Shatter the ceilings, polish the floors. *JAMA*. 1995; 273:1056-1057.



At last year's ASA Annual Meeting, the House of Delegates approved a redefined policy permitting a member to seek the assistance of ASA legal counsel if the member believes that he or she has been denied the opportunity to provide anesthesia care in violation of contractual or other legal rights.

When a hospital awards an exclusive contract, as happens more and more frequently, some anesthesiologists may be displaced as a result. If the hospital revokes privileges in a way that is inconsistent with the medical staff bylaws, or if the exclusion of one set of anesthesiologists is based solely on the economic self-interest of other physicians, the hospital may be in violation of either contract law or antitrust rules, or both. Two cases filed recently by displaced anesthesiologists, one in Montana and the other in Pennsylvania, involve such important general principles that ASA leadership authorized counsel to submit *amicus curiae*, or "friend of the court," briefs supporting the plaintiffs' arguments.

In the Montana case, the defendant hospital decided to close its anesthesia department and award an exclusive contract to a single provider group. The professional corporation given the contract, also named as a defendant, offered every anesthesiologist then on staff the opportunity to participate in the new arrangement as an independent subcontractor. The plaintiff declined and thereafter was prevented from providing anesthesia services at the hospital.

His lawsuit, which originated in state court but was transferred to the federal district court at the defendant's behest, alleged breach of contract, interference with the plaintiff's contractual relationships and "expectancies," and violations of state and federal antitrust laws. The court held that the hospital had breached the medical staff bylaws but that no damage remedy was available. Further, it granted "summary judgment" for the defendants on all of the other issues, meaning that there were no genuine factual controversies to be resolved. The plaintiff anesthesiologist appealed the decision to the Ninth Circuit Court of Appeals, where it is now pending.

## ASA Files Amicus Curiae Briefs in Two Contract Lawsuits

Karin Bierstein,  
Practice Management Coordinator

While the appellant challenged every adverse ruling, ASA's *amicus curiae* letter to the Ninth Circuit focused on whether the exclusive contract amounted to a "tie-in" that would violate federal antitrust law. Tying arrangements involve conditioning the sale of one service (the tying product) upon the buyer's purchase of a second service (the tied product). They have long been considered *per se* violations of Section 1 of the Sherman Act, which prohibits agreements "in restraint of trade." The United States Supreme Court applied this doctrine to an exclu-

sive contract for anesthesiology services in a seminal 1984 decision, *Jefferson Parish Hospital v. Hyde*, where it was alleged that the hospital was tying the use of its operating rooms to the purchase of anesthesiology services from the group holding the exclusive contract. The Supreme Court held that the arrangement was lawful because the hospital did not have a very significant share of the market for operating room services, so that it could not compel patients to use the anesthesiology group with the exclusive contract or seriously hamper the ability of other anesthesiologists to compete in the community.

In contrast, the hospital in the current Montana litigation allegedly enjoys at least an 80-percent share of the market for anesthesia services in general and is the only facility in the area offering obstetrical services. The widely accepted dividing line between a safe level of market power and a market share that might raise antitrust problems is about 30 percent to 35 percent. The Montana hospital would therefore be on the suspect side of the line. Application of its market power has apparently resulted in a large increase in anesthesia fees and in the inability of obstetricians and patients to use the anesthesiologist of their choice.

This situation is in direct conflict with the policy adopted by the ASA House of Delegates in October, 1994 that states, "No contract or other practice arrangement should ... impede contractual or other legal rights to offer and deliver anesthesiology care." Thus, in its *amicus curiae*, ASA is urging the Ninth Circuit Court of Appeals to



reverse at least that part of the district court's decision rejecting the claim that the exclusive contract constituted an illegal tying arrangement.

As noted above, this case also involved a claim that the hospital had breached its contract with the plaintiff by denying him the hearing required by the medical staff bylaws in order to terminate privileges. That argument was initially successful in another lawsuit, this one brought by a Pennsylvania anesthesiologist. When, after the first trial, the hospital belatedly conducted the hearing and again decided to limit the anesthesiologist's privileges, he filed a new lawsuit and sought ASA's assistance.

In 1991, the hospital had terminated the plaintiff anesthesiologist's exclusive contract but allowed him to exercise his privileges by providing pain management services for another two years. Then the hospital terminated his pain service privileges without the due process hearing required by the medical staff bylaws, claiming that an "administrative decision" of this nature did not give rise to the protection of the bylaws. The trial court rejected this argument and enjoined the hospital from interfering with the plaintiff's privileges without complying with the due process provisions of its bylaws. The decision was upheld on appeal by the Pennsylvania Superior Court.

Meanwhile, before the Superior Court issued its opinion, the hospital again notified the anesthesiologist that his privileges were being curtailed and instituted hearing procedures to decide whether the award of an exclusive contract allowed the hospital to limit privileges. Predictably, the hearing and the administrative appeal resulted in an affirmation of the hospital's decision.

The anesthesiologist has now filed a new lawsuit, this time on the grounds that the bylaws spelled out all the reasons for which privileges might be revoked, and that execution of an exclusive contract was not among those reasons. ASA and the Pennsylvania Society of Anesthesiologists jointly have filed an amicus brief in support of these contentions.

In addition to demonstrating the contravention of the bylaws, the brief argues that the power of hospitals to award exclusive contracts and thus preclude the exercise of some anesthesiologists' privileges is not unlimited. Because of the anticompetitive potential of exclusive contracts, courts frequently will examine whether the hospital has acted in good faith to achieve a higher standard of patient care and "in furtherance of the common good." Since the hospital

has produced no evidence of objectives related to quality but appears simply to have reacted to a turf battle, its "administrative decision" to curtail the anesthesiologist's privileges was an abuse of power.

In lending its support to the plaintiff anesthesiologists in these two lawsuits, ASA is seeking to bolster the legal principles in issue, not to intervene in turf disputes. Recognizing that exclusive contracts are being awarded more and more frequently, however, ASA has an important role to play in keeping the process as fair to ASA members as possible.

If you believe that your opportunity to provide anesthesiology services is being abridged in violation of your due process, contractual or other legal rights, you are encouraged to solicit the assistance of ASA legal counsel through your Component Society.

## **Abt Reports Available**

This month's "Washington Report" (see page 4) discusses the most recent report of Abt Associates, as consultant to ASA, on undervaluation of anesthesia work values under the Medicare Fee Schedule (MFS). Some ASA members have found the Abt data valuable in discussing appropriate levels of reimbursement with third-party payers seeking to base anesthesiology fees on the MFS. Copies of the full report (Phases I and II) are available from the Washington Office at the cost of reproduction (\$25); interested members should contact Joan D. Heffernan at (202) 289-2222.

## **CSA Address Correction**

An incorrect address for the California Society of Anesthesiologists (CSA) appeared in this column in July, 1995, page 35, in a discussion about CSA's new publication called "A Working Guide to Capitation Contracting for Anesthesiology Services." For more information, contact: CSA, 1065 East Hillsdale Boulevard, Suite 410, Foster City, California 94404-1615; telephone (415) 345-3020; or fax (415) 345-3269.



## ASA Resident Component 1995 Preview and Review

Susan J. Brandt, M.D., Secretary  
Resident Component Governing Council

The ASA Annual Meeting equals an unequalled opportunity for residents. Research the opportunities for education (refresher courses, problem-based learning discussions, practical workshops, scientific papers and exhibits, panels for specialty anesthesia), *political involvement* (Resident Component House of Delegates, ASA House of Delegates), *networking* (check postings at the Georgia World Congress Center and co-headquarters hotels to find your state society and alumni meetings) and *equipment review* (exhibits open on Sunday afternoon).

Five formal ASA meetings and one American Board of Anesthesiology (ABA) meeting are scheduled for resident participation:

1. **Resident Reception:** Friday, October 20 from 8:00-10:00 p.m. in the Consulate Room, Atlanta Marriott Marquis Hotel.
2. **Resident House of Delegates:** Saturday, October 21 at 4:00 p.m. in the West Salon Grand Ballroom, Atlanta Hilton and Towers.
3. **Resident Forum:** Sunday, October 22 at 11:00 a.m. in the Consulate Room, Atlanta Marriott Marquis Hotel.
4. **ASA House of Delegates Opening Session:** Sunday, October 22 at 9:00 a.m. in the Marquis Ballroom I-III, Convention Level, Atlanta Marriott Marquis Hotel.
5. **ASA House of Delegates Closing Session:** Wednesday, October 25 at 8:00 a.m. in the Marquis Ballroom I-III, Convention Level, Atlanta Marriott Marquis Hotel.
6. **ABA Information Session:** Saturday, October 21 from 5:30-6:30 p.m. in Room 360-361, Georgia World Congress Center.



*Susan J. Brandt, M.D. recently completed her anesthesiology residency at the University of Medicine and Dentistry of New Jersey, Newark, New Jersey, and is employed at the Meadowlands Pain Center, Meadowlands Hospital, Secaucus, New Jersey.*

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

1. **Panel on Finding a New Job That You Can Keep: Where and How to Look:** Monday, October 23 from 2:00-5:00 p.m. in Room 201, Georgia World Congress Center.
2. **Special Meeting on Communication Skills with Media, Public and Peers:** Tuesday, October 24 from 9:00 a.m.-12:00 noon in Room 257, Georgia World Congress Center.
3. **Panel on Preparing for a Research Career:** Tuesday, October 24 from 2:00-5:00 p.m. in Room 202, Georgia World Congress Center.

For the second year in a row, there will be no job placement interview program at the meeting. Employers do not have enough positions to warrant more than a bulletin board. Survival in the field we have chosen will require involvement, knowledge, Board certification and an understanding of the changing health care environment.

The Resident Component extends its sincere thanks to all the past and present ASA and Resident Component leaders who have had the foresight and initiative to involve residents in the process of ASA's governance. Special thanks go to Bernard V. Wetchler, M.D., ASA President, and Norig Ellison, M.D., President-Elect, for their support of resident involvement and the invaluable appointments of residents as adjunct members of ASA committees. My personal thanks to the New Jersey leadership for their support and guidance during my year as state and national secretary. Thanks also to Ronald A. Bruns, ASA Executive Staff liaison to the Resident Component, and Michael L. Ault, M.D., who has edited this year's "Residents' Review" submissions to the ASA NEWSLETTER.

Congratulations to the ASA Resident Component Governing Council on a good year in trying times (John L. Jimenez, M.D., Chair-Elect; Sam L. Page, M.D., Delegate; and Steven J. Hattamer, M.D., Alternate Delegate). Special recognition goes to Governing Council Chair Richard J. Pollard, M.D. for his outstanding effort in leading us into the era of electronic information exchange and for his implementation of new residency communication avenues.

*Enjoy Atlanta!*



## Candidates Announce for Elected Office

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

- **President-Elect**  
Phillip O. Bridenbaugh, M.D.
- **First Vice-President**  
Casey D. Blitt, M.D.  
William D. Owens, M.D.
- **Vice-President for Scientific Affairs**  
Robert K. Stoelting, M.D.
- **Secretary**  
Ronald A. MacKenzie, D.O.
- **Treasurer**  
John B. Neeld, Jr., M.D.
- **Assistant Secretary**  
Joanne Jene, M.D.
- **Assistant Treasurer**  
Allen J. Hinkle, M.D.  
Neil Swissman, M.D.
- **Vice-Speaker, House of Delegates**  
Eugene P. Sinclair, M.D.

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

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

a list of candidates submitted to be published in the September issue of the *ASA NEWSLETTER* and the Handbook for Delegates;

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

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

## Bryan E. Marshall, M.D. to Receive 1995 Excellence in Research Award

The 1995 recipient of the ASA Excellence in Research Award is Bryan E. Marshall, M.D. Dr. Marshall is Professor of Anesthesiology at the University of Pennsylvania, Philadelphia, Pennsylvania.

In addition to being a skilled clinician, teacher, scientific reviewer and research administrator, Dr. Marshall has devoted more than a quarter century of his career to anesthesia research, covering such topics as perioperative hypoxemia, mitochondrial respiration, lung water balance and shock. More recently, he has been working on a series of studies on hypoxic pulmonary vasoconstriction.

Dr. Marshall will be honored in a presentation of the Excellence in Research Award at the ASA Annual Meeting on Monday, October 23 at 11:20 a.m. in Ballroom I-IV of the Georgia World Congress Center immediately preceding the E. A. Rovenstine Memorial Lecture.

## 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 18, 1996.

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, 4101 Lake Boone Trail, The Summit-Suite 510, Raleigh, North Carolina 27607-7506.

The deadline for receipt of completed applications in the Board office is **November 15, 1995**.

## 1995 Refresher Course Books Available

The 1995 *Annual Refresher Course Lectures* book is available at a cost of \$15 per copy (U.S. and Canada) or \$30 for foreign orders via air mail. The *Annual Refresher Course Lectures* book contains summaries of lectures that will be present-



ed at the ASA Annual Meeting in Atlanta, Georgia.

The book will be distributed free of charge at the Annual Meeting site to those who purchase three or more lecture tickets.

Anyone wishing to purchase additional copies should send a check payable to ASA to:

American Society of Anesthesiologists  
ATTN: Publications Department  
520 N. Northwest Highway  
Park Ridge, Illinois 60068-2573.

## Update on 1995 Annual Meeting Social Events

*Stanley R. Mogelnicki, M.D., Ph.D.,  
Chair, Committee on  
Local Arrangements*

In addition to the ASA Social Activities Program, attendees of the ASA 1995 Annual Meeting on October 21-25 may find the following performances of interest during their stay in Atlanta, Georgia:

- The musical play *Miss Saigon* will have performances beginning Friday, October 20 at the Atlanta Civic Center. For more information on performance times and to order tickets, call Ticketmaster at (404) 817-8700.
- The Atlanta Symphony Orchestra will perform on October 19, 20 and 21. Alicia DeLarocha will perform Mozart's *Piano Concerto No. 27* and Beethoven's *Symphony No. 7*. For more information and to order tickets, call the Atlanta Symphony Orchestra ticket office at (404) 733-5000.

## Scottsdale Workshop to Review Principles of Echocardiography

The ASA Workshop on Advanced Intraoperative Echocardiography will be held at Marriott's Camelback Inn in Scottsdale, Arizona on November 18-19, 1995. This program is designed for anesthesiologists with a basic understanding of the principles of echocardiographic technology and its diagnostic applications.

Intraoperative applications of ultrasound in the anesthetic management and surgical decision-making process of patients undergoing both cardiac and noncardiac surgical procedures will be highlighted.

Participants will be capable of understanding the application of advanced echocardiographic diagnostic principles in the surgical patient upon completion of this advanced workshop.

Robert M. Savage, M.D. is the program chair. He will speak on "Intraoperative Assessment of the Mitral Valve and LVOT Obstruction," "The Role of Intraoperative Echocardiography in High Risk Coronary Bypass Surgery," "Diastolic Function" and "Intraoperative Assessment of Diastolic Function." Other speakers and their topics are:

- Solomon Aronson, M.D., "Intraoperative Assessment of Hemodynamics," "Proficiency Determination and Credentialing in Intraoperative Echocardiography" and "Intraoperative Assessment of Myocardial Perfusion and Cardioplegia Administration";
- Michael K. Cahalan, M.D., "Assessment of Regional and Global

Ventricular Function," "Intraoperative Assessment of Congenital Heart Disease," "Intraoperative Echo in the Cardiac Patient Undergoing Noncardiac Surgery," "The Importance of Intraoperative Echocardiography for the Anesthesiologist" and "Aortic Valve Disease";

- Steven N. Konstadt, M.D., "Intraoperative Assessment of the Aortic Valve," "Aortic Valve Disease" and "Intraoperative Assessment of the Aorta";
- Michael G. Licina, M.D., "Intraoperative Echo TEE Examination: An Overview," "Intraoperative Assessment of Prosthetic Valve Dysfunction" and "Mitral Valve Assessment";
- Patrick M. McCarthy, M.D., "Mitral and Aortic Valvuloplasty LVOT Obstruction Management: A Surgeon's Perspective," "Mitral and Aortic Valve Replacement: A Surgeon's Perspective" and "Surgical Management of Thoracic Aortic Disease"; and
- Emad Mossad, M.D., "Congenital Heart Disease" and "Intraoperative Assessment of Congenital Heart Disease."

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

ASA designates this continuing medical education program for 15 credit hours in category 1 of the Physician's Recognition Award of the American Medical Association.

The program will last two full days. Registration fees include coffee breaks and lunches for both days. The fees are \$300 for Active members, \$125 for Resident members and \$650



for nonmembers. Registration is encouraged by October 18, 1995.

A block of rooms has been reserved at the Camelback Inn. A reservation form will be sent upon enrollment for the workshop. The form should be returned directly to the hotel by October 25, 1995.

## Regional Refresher Course Scheduled in San Antonio

The first ASA Regional Refresher Course of 1996 will be held in San Antonio, Texas on January 27-28, 1996 at the Plaza San Antonio. Coagulation for the anesthesiologist, pain management after ambulatory surgery, and regional anesthesia for outpatients are among the 20 sessions for which registrants may enroll.

Jeffery S. Vender, M.D. is the program chair. The faculty and their lecture topics are:

- Lois L. Bready, M.D., "Anesthesia for Laparoscopic Surgery" and "Anesthesia for the Patient with Renal Dysfunction";
- Charles P. Gibbs, M.D., "Is There a Place for General Anesthesia in Obstetrics?" and "Anesthesia for the Pregnant Patient Requiring Non-OB Surgery";
- Steven C. Hall, M.D., "The Difficult Pediatric Airway" and "Newborn Anesthesia";
- Roberta L. Hines, M.D., "Strategies for Managing Pulmonary Hypertension" and "Cardiothoracic Drugs for the Failing Heart";
- Michael F. Mulroy, M.D., "Does Post-op Analgesia Make a Differ-

ence?" and "Regional Anesthesia for Outpatients";

- Ronald G. Pearl, M.D., "New Treatments for ARDS" and "Recent Advances in Hemodynamic Monitoring";
- Robert N. Sladen, M.B., "Hyperactive Airway Management" and "Perioperative Management of Hypertension";
- Tod B. Sloan, M.D., "Anesthesia for Head Trauma" and "Monitoring for Neuroanesthesia";
- Kenneth J. Tuman, M.D., "Cost-Effective Anesthesia Care" and "Coagulation for the Anesthesiologist"; and
- Paul F. White, M.D., Ph.D., "Anesthetic Techniques for Ambulatory Anesthesia" and "Pain Management After Ambulatory Surgery."

ASA is approved by the Accreditation Council for Continuing Medical Education 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 \$250 for ASA Active members, \$125 for ASA Resident members and \$600 for nonmembers. For more information or to receive the meeting brochure, call the ASA Executive Office at (708) 825-5586. Registration is suggested by December 20, 1995.

A block of rooms has been reserved at the Plaza San Antonio. A room reservation form will be sent upon enrollment. The completed form should be returned to the hotel by January 4, 1996.

## In Memoriam

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

Vicente Chulia, M.D.  
Valencia, Spain  
April 23, 1995

Norman B. Kornfield, M.D.  
Lancaster, Pennsylvania  
January 28, 1995

Todd G. Miller, M.D.  
New York, New York  
April 15, 1995

Andrew E. Morrison, Jr., M.D.  
Seattle, Washington  
October 5, 1994

Louis H. Porter, M.D.  
Dallas, Texas  
May 19, 1995

Thomas A. Redlin, M.D.  
Elkhart, Indiana  
May 2, 1995

Stephen A. Stern, M.D.  
Eules, Texas  
April 1, 1995

Edward H. Stullken, Jr., M.D.  
Morgantown, West Virginia  
May 11, 1995

Stanley P. Wesolowski, M.D.  
St. Paul, Minnesota  
March 21, 1995



## Ivory Tower Existence

I have been exposed to your writings for some time now, and your comments in the May, 1995 *NEWSLETTER* ["To the Membership"] have exceeded my ability to quietly tolerate your monthly drivel.

You seem to have anxiety about the decreased interest on the part of medical students in the specialty of anesthesiology. These talented people completing medical school are actually behaving quite rationally due to the awful oversupply of anesthesiologists that has developed over the last several years. Individuals not selecting our specialty will not have to suffer the indignity, tragic disappointment and financial and emotional stress that is taking place among so many anesthesiologists these days.

Make no mistake about it: you and your ilk in academia are directly responsible for this sorry situation, and your comments in the May, 1995 *NEWSLETTER* show that you have no remorse for the mess for which you are directly responsible. You people sit comfortably in your cushy, secure, tenured jobs and for years have blatantly encouraged far too many people to be trained in anesthesia residencies and for the worst of reasons — so that you could financially profit off of them by using them as a cheap source of labor (and in the process minimize your time in the operating room) and increase the image and presence of individual anesthesia departments by this overly large number of residents.

Your ivory tower existence removes you from the obscene situation of residents completing training with no hope of employment. Their financial debts are usually huge, their families undergo great emotional stress, and there is no end in sight to their troubles.

In this day of hospital contracts, economic credentialing, capitation and managed care deciding how many doctors to hire (and fire), the excessive numbers of anesthesiologists render us mere commodities to be tossed around at will by hospital administrators and corporate executives. I and all the rest of us outside of the silly fantasy land of academia have worked hard in our hospitals, read actively to maintain our intellectual skills and do the best we can to

work with surgeons who, we all know, can be difficult and unpleasant to deal with. Your deliberate flooding of the "market" for anesthesiologists has made and will continue to make my life and the lives of all others in private practice more difficult than it already is and needs to be.

You consistently rail against government action and bureaucrats, but government planners would have done a much better job of matching the supply of us to the demand than did the malevolent staff in university settings.

I have come to believe that there needs to be a dramatic change in ASA with you academicians put out and those of us in practice who do the work put in. You have failed miserably and should be ashamed of yourselves.

Wayne Chamberlin, M.D.  
Helena, Montana

## Dr. Wetchler Responds

After reading your letter, I am fairly certain you do not live in a glass house. You have taken academic members of ASA to task for the perceived oversupply of anesthesiologists in today's market, and you equate academic leadership with ASA leadership. You want change in ASA; you want "academicians put out and those of us in practice, who do the work, put in." The facts are that of ASA's last 16 Presidents, eight are nonacademicians (I am one of them); of this year's 11 elected Officers, six are nonacademicians.

The membership of ASA is diverse — anesthesiologists in private practice who personally perform anesthesia care (I am part of this group); anesthesiologists who practice in a care team with nonphysician providers; anesthesiologists who practice and teach in an academic setting. Combined, we represent the strengths of ASA, united by a common interest, the medical specialty of anesthesiology.

We are concerned about the future of our specialty; we are concerned about work-force planning and public relations. Academic departments are decreasing training posi-

---

*The views and opinions expressed in the "Letters to the Editor" are those of the authors and do not necessarily reflect the views of ASA or the NEWSLETTER Editorial Board. The Editor has the authority to accept or reject any letter submitted for publication. Letters must be signed and are subject to editing and abridgment.*



tions, working with group practices and hospitals to develop practice opportunities for anesthesiologists and working with Component Society leadership and membership to develop public relations and public education programs.

Academicians are working to be part of the process of change. Where would our specialty be without the well-trained residents who are now in practice? Where would our specialty be without the research that has provided us with better drugs and safer anesthetic techniques? Blame, if you wish, but also give credit where and when it is due.

Ours is not the only specialty facing hospital contracts, economic credentialing, managed care and capitation. During these difficult times when our initial reaction is to lash out at others, we must stay focused. ASA will have a Manager of State Programs in our Executive Office in Park Ridge, Illinois, who will work with Component Societies on a state-by-state basis to improve practice opportunities and public relations. We must work together to address change. It does our specialty no good to blame one another for the problems of today and those of tomorrow; constructive criticism accompanied by a solution is always welcome.

ASA is responsive to the needs of all of its members. It is time for our members to be responsive to the needs of all anesthesiologists. Please help deliver our message; please help develop practice opportunities and a public relations/public education campaign in your state of Montana.

Bernard V. Wetchler, M.D.  
1995 ASA President  
Peoria, Illinois

## Mind Over Machine

The cover of the June, 1995 ASA NEWSLETTER seems to emphasize that the human brain, indeed, is better than an automated machine. The automated printout leads us to believe that among the events displayed, item No. 15, "End of Anesthesia Care," occurred *before* the abdomen was closed and *before* the end of surgery. Can this be possible?

Richard M. Berkman, M.D., Ph.D.  
Lake Isabella, California

## State-of-the-"Art" Practice?

The artwork on the cover of the June, 1995 NEWSLETTER shows clearly the neatness of the computerized record. I did note that the time from the incision to the delivery of the baby was 24 minutes, quite a prolonged time. Upon closer inspection of the computerized record, the problem for the delay was quickly discerned. The patient was turned prone prior to the incision. Modern medicine has brought about dramatic changes, but I doubt that doing a C-section in the prone position represents state-of-the art obstetrical practice.

James F. Arens, M.D.  
Galveston, Texas

## A Marvelous Piece of Work

The things that technology in anesthesia is able to accomplish simply boggle the mind! Imagine, as *documented* on the anesthesia record reproduced on the front cover of the June, 1995 ASA NEWSLETTER, the patient, positioned prone on her face, was able to have her abdomen opened through some wondrous surgical skills and then her uterus, giving up a child for removal to (another wonder of wonders) the neonatal ICU. Ours is not to wonder how — or *why* (the expense of the ICU). No, just to marvel in the technology should suffice. Indeed, the anesthesia care team walked off the premises a full four minutes before the patient left the operating room and even before the abdomen was closed. Was there an autopilot as an optional accessory on this automated record-keeping system?

Could there have been some error in recording? Hardly, since we are given italicized assurance (page 15) that we must "*accept what is documented as having occurred and what is omitted as not having occurred.*"

What a marvelous piece of work is the modern anesthesia care team!

John M.R. Bruner, M.D.  
Groton, Massachusetts



---

## Editor's Response

Thank you for your letters regarding the automated record. The form was a demonstration record, not an actual case, that the supplier had used in a 1992 operators' manual. The manual has since been updated, company sources inform us, using an actual automated anesthetic record, with only the names changed. (It's nice to know our readers do pay attention to the *NEWSLETTER* when it arrives in the mail each month!) — E.L.

## Anesthesiology's Worst Enemy

As an older anesthesiologist who can see the end of a career in the not too distant future, I have contemplated several things over the last few years as I have watched the changes in our profession and in medicine in general. This letter is prompted by the recent meeting I attended in Jackson Hole, Wyoming, where [ASA President] Bernard V. Wetchler, M.D. was the keynote speaker.

First I thought his comments were very thought-provoking and pertinent. I was very surprised at the response, or should I say lack of it, from the audience. Since I was a visitor to that Component Society, I did not feel it my place to enter into a discussion, but it served to reinforce what I have been thinking about. In a nutshell, anesthesiologists are anesthesiology's worst enemy.

Let me illustrate this with a personal story. I, like many others, started in another specialty, general surgery. When I began in practice as a general surgeon, I was on the bottom of the hospital totem pole. I had to work the odd hours in the operating room and take the cases that nobody else wanted and all the other usual adventures of getting started in practice. Like everyone else, the anesthesiologists ignored me, acted as if they were doing me a tremendous favor by staying to do a case for me and, in general, treated me with little respect and no accommodation. In contrast to that, Vera and Delaine, the resident nurse anesthetists, were accommodating, helpful and cheerful. They came at all hours and functioned well, and the patients did as well as with the anesthesiologists as far as I could tell. In fact, they were eager to discuss the cases with me and come to a

mutual understanding as to what was best for the patient.

It was soon after that I went off to do my anesthesia training. At the end of this training, I felt confident I had a great deal to offer. I had gone through a prestigious training program, and I thought I knew lots of valuable things that would contribute to the hospital I had previously worked in. When I suggested coming there, the same anesthesiologists cried foul.

"We're full!" they cried. "There's no room for you here."

"Tough bananas," I cried. "It is an open staff and I'm coming anyway."

I did the same thing I did as a general surgeon. I worked the odd hours. I took on the new surgeons who could not get help otherwise. I talked over the cases with internists and surgeons. It only took about six months to become the busiest anesthesiologist on the staff. Interestingly, Vera and Delaine were still there doing their thing. They were by far the greatest competition, but I respected them and was glad to work with them and have continued to do so for many years. They both have just recently retired.

With the changing times, the days of the lone horseman challenging the system as I did are over. In this day and age, we have a desperate need to work together. I still believe the principles are the same. Stick your nose in to show your value to associates and institutions. Support the local and national societies that are trying to help, and communicate to them the kind of things that need to be done. Provide service in such a way as to become indispensable, and find ways to generate more room to allow for additional colleagues.

Gerald L. Hayward, M.D.  
Midway, Utah





## FOUNDATION FOR ANESTHESIA

---

EDUCATION ■ RESEARCH

---

### FAER Grant Review — Just a Beginning

As this article is being written, the applications for 1995 Research Starter Grants are arriving in the Foundation for Anesthesia Education and Research (FAER) office. It seems to be a fitting time to recognize the effort and commitment of the reviewers of FAER grant applications.

The FAER Board of Directors and staff are grateful to the following ASA Committee on Research members, without whom high-quality reviews would not be possible: Julien F. Biebuyck, M.D., Chair, Thomas J. Blanck, M.D., James C. Eisenach, M.D., Leonard L. Firestone, M.D., Joseph C. Gabel, M.D., Simon Gelman, M.D., C. Alvin Head, M.D., Roger A. Johns, M.D., Paul R. Knight III, M.D., Sheila M. Muldoon, M.D., Donald S. Prough, M.D., Michael F. Roizen, M.D., Duane K. Rorie, M.D., Carl E. Rosow, M.D., Ben F. Rusy, M.D., Debra A. Schwinn, M.D., Steven L. Shafer, M.D., Ruth E. Wachtel, Ph.D., David C. Warltier, M.D. and Paul F. White, M.D., Ph.D.

The Committee on Research has served the important function of proposal review for FAER as part of its charge to improve research in anesthesiology. The committee meets for a whole day two times each year in addition to the countless hours spent reviewing and preparing critiques of the grant applications. All applicants receive carefully prepared comments on their work, whether or not the projects are funded. It is hoped that this feedback will be helpful in allowing them to understand the processes involved in grant review. This rigorous review allows applicants to construct better packaging and more lucid presentations of their research proposals and strengthens their skills for future applications.

A recent response to the survey asking former award recipients about the impact of FAER funding on their career development specifically addressed the importance of the review process. Roderic G. Eckenhoﬀ, M.D., University of Pennsylvania, Philadelphia, Pennsylvania, said:

“FAER funding was the crucial bridge between fellowship and government funding. It allowed continuation and focus of my fellowship research to evolve into questions of importance to the field of anesthesiology. This bridge was made all the more solid by the excellent and thorough critique of my FAER application provided by its review panel.

“While it is generally recognized that the current FAER grants are insufficient to fully support the research effort of young investigators, it does provide: a) practice at grant writing and rewriting; b) reasonable financial support for supplies and a technician; c) sufficient time/resources to generate the preliminary data necessary for successful NIH/NSF applications; d) evidence of ability and commitment to research; and e) a degree of name recognition in academic anesthesiology.

“A common mistake of FAER grant recipients, however, is not using this time effectively. Because the funding is designed for professional development, in addition to scientific and medical advancement, it is important that the awardee use this time — from the start — to construct and refine grant applications that will provide academic independence in the future. One cannot spend time only doing experiments. Abstracts, papers and grant applications are the currency of contemporary biomedical research and cannot be deferred to some future time. Should government or substantial private funding occur early on, FAER is not averse to redistributing funds to other deserving young investigators. Used wisely and efficiently, FAER review and funding of investigator-initiated research can provide the start to a rewarding academic career.”

FAER is the beneficiary of the work and dedication of the current and former chairs of the Committee on Research, who have been major proponents for investigation in the specialty. Records in the FAER office show recipients of ASA and FAER research awards since 1973.

Over the intervening years, the following distinguished anesthesiologists have served as Chair of the ASA Committee on Research: Evan L. Frederickson, M.D., 1972-74; Edmond I. Eger II, M.D., 1975; Robert G. Merin, M.D., 1976-80; Carl C. Hug, Jr., M.D., 1981-84; Donald R. Stanski, M.D., 1985-88; and David E. Longnecker, M.D., 1989-94. We owe each of them, their predecessors and their committee members our sincerest expressions of appreciation.





## Officers

---

### President

Bernard V. Wetchler, M.D., Peoria, Illinois

### President-Elect

Norig Ellison, M.D., Ardmore, Pennsylvania

### Immediate Past President

Wilson C. Wilhite, Jr., M.D., Los Angeles, California

### First Vice-President

Phillip O. Bridenbaugh, M.D., Cincinnati, Ohio

### Vice-President for Scientific Affairs

Robert K. Stoelting, M.D., Carmel, Indiana

### Secretary

Ronald A. MacKenzie, D.O., Rochester, Minnesota

### Treasurer

John B. Neeld, Jr., M.D., Atlanta, Georgia

### Assistant Secretary

Joanne Jene, M.D., Portland, Oregon

### Assistant Treasurer

Neil Swissman, M.D., Las Vegas, Nevada

### Speaker of House of Delegates

Barry M. Glazer, M.D., Indianapolis, Indiana

### Vice-Speaker of House of Delegates

Eugene P. Sinclair, M.D., Elm Grove, Wisconsin

## District Directors

---

### DISTRICT 1 - Maine, New Hampshire, Vermont

Allen J. Hinkle, M.D.

### DISTRICT 2 - Massachusetts

Marcelle M. Willock, M.D.

### DISTRICT 3 - Rhode Island, Connecticut

Jan Ehrenwerth, M.D.

### DISTRICT 4 - New York

Jared C. Barlow, M.D.

### DISTRICT 5 - New Jersey, Delaware

*Vacant*

### DISTRICT 6 - Pennsylvania

William D. Hetrick, M.D.

### DISTRICT 7 - Maryland, District of Columbia

Raafat S. Hannallah, M.D.

### DISTRICT 8 - Florida, Puerto Rico

James D. Beeson, M.D.

### DISTRICT 9 - Alabama, Mississippi, Louisiana

Orin F. Guidry, M.D.

### DISTRICT 10 - Tennessee

Bradley E. Smith, M.D.

### DISTRICT 11 - Ohio

John G. Poulos, M.D.

### DISTRICT 12 - Michigan

Charles R. Schmitter, Jr., M.D.

### DISTRICT 13 - Indiana

Larry G. Thompson, M.D.

### DISTRICT 14 - Illinois

Anthony D. Ivankovich, M.D.

### DISTRICT 15 - North Dakota, Minnesota, South Dakota

David E. Byer, M.D.

### DISTRICT 16 - Nebraska, Iowa

Charles D. Gregorius, M.D.

### DISTRICT 17 - Missouri, Kansas

William D. Owens, M.D.

### DISTRICT 18 - Arkansas, Oklahoma

Scott E. Ames, M.D.

### DISTRICT 19 - Texas

James W. Cottingham, M.D.

### DISTRICT 20 - Colorado, Wyoming

Bruce R. Brookens, M.D.

### DISTRICT 21 - Nevada, Arizona, New Mexico

Casey D. Blitt, M.D.

### DISTRICT 22 - California

Thomas H. Cromwell, M.D.

### DISTRICT 23 - Washington, Alaska

William L. Collins, M.D.

### DISTRICT 24 - Wisconsin

John F. Kreul, M.D.

### DISTRICT 25 - Georgia

Joseph F. Johnston, M.D.

### DISTRICT 26 - Hawaii, Oregon

Timothy E. Baldwin, M.D.

### DISTRICT 27 - North Carolina, South Carolina

Bertram W. Coffey, M.D.

### DISTRICT 28 - Virginia, West Virginia

Roger W. Litwiller, M.D.

### DISTRICT 29 - Idaho, Montana, Utah

William L. Hamilton, M.D.

### DISTRICT 30 - Kentucky

J. Dickinson McGavie, M.D.

## Executive Staff

---

Glenn W. Johnson, **Executive Director**

William S. Marinko, **Assistant Executive Director**

Frank W. Connell, **Director of Scientific Affairs**

Ronald A. Bruns, **Director of Administrative Affairs**

Denise M. Jones, **Director of Communications**

Michael Scott, **Director of Governmental and Legal Affairs**





City Hall

**1995 Annual Meeting  
October 21-25**

*Registration opens at 3:00 p.m. Friday,  
October 20, 1995 at the Georgia World  
Congress Center.*