



# NEWSLETTER

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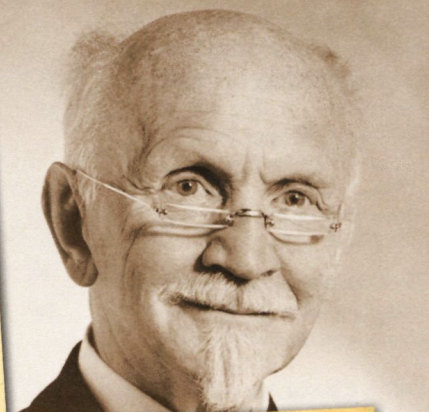
SEPTEMBER 2004

## Defining Moments for ASA

**A**tribute to the  
memory of  
**T. Densdale Buchanan**  
for his contribution to  
American Anesthesia, his  
ability, loyalty, kindness  
& encouragement - from  
his colleagues on the  
American Board of Anes-  
thesiology - March 29, 1941

J. M. Waters  
J. D. Ruth

John S. Lundy  
Charles F. McCuskey  
Edith...



RELATIVE  
VALUE  
GUIDE  
1975



**Fellow-in-Anesthesiology**  
THE AMERICAN COLLEGE OF  
ANESTHESIOLOGISTS, OF  
THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

This is to certify that  
**Paul M. Wood**

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THE AMERICAN COLLEGE OF ANESTHESIOLOGISTS,  
has demonstrated to its satisfaction an adequate preparation and experience  
in the knowledge of the art and science of Anesthesiology, and being  
in possession of this specialty is hereby admitted as a  
Fellow of The American College of Anesthesiologists

Charles F. McCuskey M.D.  
President, A.S.A.

M.D.

No. 9 - 1948

Secretary, A.C.A.

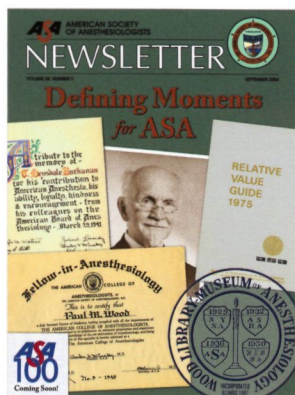
M.D.



**ASA  
100**

Coming Soon!





This issue presents ASA's "Defining Moments" on the eve of the Society's 100th anniversary (1905-2005). The new "ASA100" logo (bottom left) is but one highlight of our yearlong centennial celebration, which kicks off next month at the ASA Annual Meeting.

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### SUBSTANCE ABUSE HOTLINE:

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



## Countdown to the Centennial

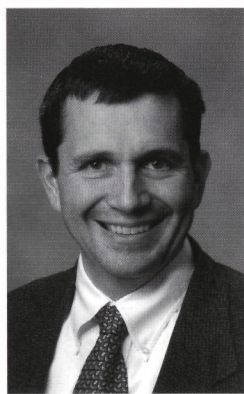
**A**s a teenager, I remember clearly my anticipation at the approach of the year 1976 and the 200th anniversary of the birth of the United States. There were bicentennial moments on television, and patriotism was rampant across the country. Special quarters were minted to commemorate the event, and America's only unelected president, Gerald Ford, was in the White House. Even today, very occasionally, one of those quarters will turn up in the change I receive during a transaction, reminding me of that time in my youth.

ASA is about to enter a similar phase of great anticipation. October 6, 2004, marks the 99th birthday of our organization. A yearlong celebration of the 100th anniversary is being planned even as I write these words. What better way to begin the festivities than with the September issue of the *ASA NEWSLETTER*, with its focus on the Wood Library-Museum of Anesthesiology? Within the pages of this issue are articles that delineate the history of our specialty as influenced and created by ASA.

Our beginning was not auspicious. Nine physicians gathered in an auditorium in Brooklyn, New York, at the Long Island College of Medicine to "promote the art and science of anesthesia." A glance at the current constitution of ASA will show you those words, and they are seen consistently through our history. The Long Island Society of Anesthetists began with physicians teaching physicians and traveling a road of discovery about the administration of and science behind anesthetics. In many ways, this remains the current mission of ASA.

From time to time, I have heard that ASA is only a political organization concerned with one government function, increasing the financial remuneration for services rendered by members to patients. Nothing could be further from the truth. The Society is and always has been an educational organization first and a political one second. The problem is that political problems are more interesting than education and thus grab more attention. Think for a moment about the tremendous effort that goes into planning the ASA Annual Meeting. Registration for 15,000 to 19,000 people, for instance, can be mind-boggling. Add in the number of options, the need to properly schedule and coordinate hundreds of events, and so on, and the potential for problems is endless.

Over the next year, ASA members should take time to reflect upon the Society's roots, which are steeped in the trials, tribulations and triumphs of the 20th century. For a small specialty comprising only 5 percent of all physicians nationwide, we have overcome tremendous odds many



Douglas R. Bacon, M.D.,  
Editor

times during our almost century of existence. What are the odds that nine physicians gathered to study a clinical problem would create an organization that has almost 40,000 members a century later? Who would have believed that in 1938, when nurse anesthetists outnumbered physicians administering anesthesia almost 10 to one, the American Board of Anesthesiology would be created, defining the specialty on an equal footing with far more established medical practices such as internal medicine, surgery and ophthalmology? Are there lessons we can learn from our past that may help us to navigate through what seem to be the turbulent times in which we live?

Peter L. McDermott, M.D., the 1993 ASA President who retired from anesthesiology only to embark upon a second career as a university history professor, has an interesting theorem based upon George San-

---

***"Over the next year, ASA members should take time to reflect upon the Society's roots, which are steeped in the trials, tribulations and triumphs of the 20th century."***

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tayana's famous quote, written the same year as the founding of the Long Island Society: "Those who cannot remember the past are condemned to repeat it." Dr. McDermott believes that if we study the past and learn its lessons correctly, we are then faced with a future in which all the questions and problems have never been answered or solved. It is quite frightening, actually, to contemplate a future in which the past has been correctly understood, for there is then nothing to guide us. At least two lessons, both of which we still struggle with, emerge from the pages of this *NEWSLETTER*.

First, the Long Island Society of Anesthetists was created by a very small number of dedicated physicians interested in what we might now call "patient safety." They

*Continued on page 4*



## ASA Budgets: Alice-in-Wonderland Journey or Well-Planned Trip?

Roger A. Moore, M.D., Treasurer

**A**SA provides services to its membership at a cost of some \$22 million a year. For those of you who follow the ASA budget on a yearly basis, you know that the beginning of each year frequently begins with a list of expenses that are greater than the projected income. This has occurred in eight of the past 10 years. In only two of the past 10 years, however, has a deficit budget actually been found to exist at the end of the year. Therefore outside observers seeing this as a seeming disconnect between the proposed budget and the actual budget might logically ask why the budget process cannot be more accurate. I hope that this article will provide some insight into the entire budgetary process of ASA and why, even with the best of intentions, a completely accurate prediction of income and spending on a yearly basis cannot be provided.



Roger A. Moore, M.D.

### Breaking Down the Budgetary Process

The annual budgetary process begins in the prior year. In other words, in January 2004, planning began for the January 2005 budget. The primary cost centers for ASA are its various educational, administrative and research activities, which are broken down into divisions and sections under which groups of committees are governed. In addition other primary cost centers are for the support activities of our ASA Executive Office and Washington Office. Income, on the other hand, is primarily derived from dues, the Annual Meeting, workshops, publications, the Self-Education and Evaluation (SEE) Program and our investments. Letters go out at the beginning of each budget cycle to the chairs of each committee requesting that they provide information concerning the fiscal needs of their committee for the coming year. Committee expenses are incurred when a physical meeting is required as well as the cost of telephone conference calls, postage and secretarial help.

Increasingly ASA has been encouraging committee chairs to have their meetings during the Annual Meeting (at no cost to ASA) or to have virtual meetings through the Internet or conference calls. In spite of this, face-to-face meetings are occasionally necessary for some of the committees. In this case, an estimation concerning the number of members who might be attending the meeting, as well as the cost of their travel, has to be made. These are always estimates, and members who are expected to attend the meeting may sometimes not be able to make it, thus reduc-

ing the cost. In addition face-to-face meetings are increasingly being held at times and places that do not incur costs for ASA.

### Spring Cleaning

The next step in the budget process occurs in April when section heads are asked to review the budgetary requests of each of the committees that fall under their purview. They are challenged to find cost reductions of at least 10 percent that can be applied to help correct potential budgetary shortfalls. In addition the Section on Fiscal Affairs receives information from each of the foundations requesting funding from ASA: the Anesthesia Patient Safety Foundation, the Foundation for Anesthesia Education and Research and the Wood Library-Museum of Anesthesiology. These founda-

tion requests are analyzed at the March meeting of the Board of Directors, and recommendations are made concerning the level of financial support for each foundation. All of this information from division and section heads, committee chairs and the Section on Fiscal Affairs is funneled to a Budget Committee made up of the President, President-Elect, First Vice-President, Treasurer, Assistant Treasurer and administrative staff. The Budget Committee meets in May of each year at the ASA Legislative Conference. At this meeting, an in-depth discussion of the requirements and financial needs of each committee, the divisions, sections and foundations occurs as well as a review of the salaries and budgets of the administrative staff. It is from this meeting that a recommendation comes to the Administrative Council for consideration at its June retreat, where prioritizations of possible 10-percent reductions on the expense side are detailed.

### Predicting Income

Along with considerations of budgetary expenses is an evaluation of each income item. Income is estimated based upon the projected number of new ASA members as well as such variables as subscriptions to the SEE program, the number of exhibitors recruited to exhibit at the Annual Meeting, attendance at workshops and the year-end royalties from publications, which can vary as much as \$1 million. Once the Administrative Council has considered both the expense and income sides of the proposed budget, a recom-

*Continued on page <None>*





## Senate Passes Patient Safety Bill, Conference Expected in September

*Michael Scott, J.D., Director  
Governmental and Legal Affairs*

medical errors to federally certified public or private "patient safety organizations" (PSOs) whose task is to analyze such reports and issue advisories designed to lower the incidence of errors. Each bill contains provisions designed to ensure that the new regimen will not interfere with the traditional right of patients and their attorneys to gain discovery of information potentially relating to the existence of negligent care; it was the definition of this right that essentially held up Senate floor consideration of the legislation for several months.

Both bills contemplate that the Department of Health and Human Services (HHS) will issue regulations pursuant to which applications may be made for recognition as a PSO. The terms of both bills, however, suggest that qualifications will be relatively exacting, and maintenance of status as a PSO will not be without significant expense. A question arises, therefore, as to the extent to which HHS will receive applications from private organizations, not to speak of the ongoing question as to whether health care providers will in fact be prepared to file reports of errors.

The legislation has been strongly supported by organized medicine, including ASA, which is recognized as

### CMS Sets 2005 1.5-Percent Increase

In late July, the Centers for Medicare & Medicaid Services (CMS) issued its proposed physician payment rule for calendar year 2005. As required by the terms of the Medicare Modernization Act of 2003, the rule contemplates a 1.5-percent increase in physician reimbursement under the Medicare Fee Schedule for 2005. Absent provisions of the act, physicians would have experienced an estimated 3.7-percent cut in reimbursement next year. Operation of the Medicare update formula will produce ongoing cuts from 2006 until 2012 unless Congress acts again next year.

a leader in its patient safety initiatives. It appears, however, that there will be much work to do, as HHS develops implementing regulations, to assure that the new program will ultimately produce valuable patient safety data.

Just prior to leaving Washington for the conventions and the August recess, the Senate — eight months after the bill had been favorably reported by its Health, Education, Labor and Pensions Committee — finally got around to passing patient safety legislation similar to that which passed the House (H.R. 663) with only six dissenting votes in the early days of the 108th Congress. The Senate has already appointed conferees, and a conference is expected shortly after Congress returns on September 7.

Although the two bills differ in numerous details, the basic concept is the same: a mechanism is created by which physicians and other health care providers can confidentially report

## FTC, Department of Justice Publish Report on Competition

In late July, after two years of hearings, the Federal Trade Commission and the Department of Justice published "Improving Health Care: A Dose of Competition," a joint study of the current role of competition in

health care and how those two agencies can work to protect competition in the health care marketplace.

The comprehensive 371-page report covers all players in the marketplace, including physicians, hospitals,

insurers, drug makers and governmental entities. Of particular interest to ASA members, the report concludes — not surprisingly in light of the

*Continued on page 4*



authorship — that granting of collective bargaining rights to physicians would result in increased costs without a demonstrable improvement in quality. ASA, along with the American Medical Association and numerous state and specialty organizations, has supported legislation in the past two Congresses that would grant physicians, under limited circumstances, the right to bargain collectively; federal antitrust agencies consistently have opposed the legislation.

ASA was among those organizations invited to testify at the joint hearing organized in July 2003 to deal with

restrictions on allied health providers (AHP). The Society was represented by Jerome H. Modell, M.D., Professor Emeritus in Anesthesiology at the University of Florida College of Medicine, Gainesville, Florida. Dr. Modell's testimony reviewed ASA's aggressive posture in advocating on scope-of-practice issues before legislative and regulatory bodies under the so-called *Noerr-Pennington* doctrine. Of interest the FTC/Department of Justice final report does not attempt to denigrate this doctrine — under which petitioning of the government is deemed constitutionally protected — and mere-

ly refers to some cases in which the doctrine was not applied to protect nonadvocating speech.

The final report expressed concern that because state licensing boards consist of practitioners with a vested interest in restricting AHP access, consumer interests may be impaired by the limits on competition. The report recommends that membership on licensing boards should be increased to include representatives of the public and other individuals from outside the licensed occupation.

## From the Crow's Nest: Countdown to the Centennial

*Continued from page 1*

wanted to administer a better anesthetic and felt that the best way to do this was to learn about the field from each other and from those in related fields. It was common in the early years of the Society for physiologists to address the group, most notably Yandell Henderson, Ph.D., of Yale University. From nine to 40,000 in 100 years — such growth demonstrates the power that a dedicated group can have in moving something important forward. In the Society today, we see a dedicated group of people trying to improve the specialty for the benefit of all. Has the lesson of dedication come home to you?

The second lesson is that research into problems that affect anesthesiology is the backbone of clinical advancement of the specialty. As opposed to 1905, with none of the nine original physicians truly attached to academics and supported by the infrastructure of a university, the specialty enjoys a robust academic cohort that continues to study problems affecting anesthetics and their administration. Yet in the late 1990s, academic anesthesiology was on the ropes, and it is still recovering. Economics played a role, and time outside of the operating room became a precious commodity. The most junior people, the ones trying to establish them-

selves as investigators, were often the first pulled to cover the clinical load. Department chairs turned over with hospital and university administrations alike looking for replacement candidates who could keep the operating rooms running. Critical care and pain medicine were luxuries within the department — investigations seemed to be the last priority. As a specialty, we receive only .5 percent of the funding available from the National Institutes of Health, which compares unfavorably with the 5 percent of all physicians that anesthesiologists comprise. Without scientific investigation, the specialty will soon lose momentum, and innovation and the anticipated advances in patient care in operating rooms, critical care units and pain clinics may never materialize.

One hundred years is a long time, and we anesthesiologists have seen many interesting twists and turns on the road we have traveled. Come celebrate our triumphs and mourn our losses; but learn from these incidents so that, together, we can continue to build a specialty of which the nine physicians of Brooklyn, who met together so long ago, can be proud.

— D.R.B.



# Defining Moments for ASA

## and the **Ethics of Style**

Lydia A. Conlay, M.D., Ph.D., Trustee  
Wood Library-Museum of Anesthesiology

**T**his year's ASA Annual Meeting in Las Vegas, Nevada, will kick off a yearlong celebration of the 100th anniversary of the founding of what would ultimately become ASA. And as most of you know, the September issue of the *ASA NEWSLETTER* is traditionally compiled by representatives of the Wood Library-Museum of Anesthesiology.

This year's September edition follows the anniversary theme and is titled "Defining Moments of ASA." But how can we determine just what were the defining moments of ASA? No doubt there were very many. Nevertheless a few stand out as particularly important and of likely interest to our readers.

The earliest defining moment certainly occurred in a meeting 100 years ago at the Long Island College of Medicine. And who better to recount "In the Beginning: Three Stars?" than Douglas R. Bacon, M.D. (page 7)? Another defining moment that helped to shape the very essence of ASA was the formation of "The 4 Foundations: Jewels in the ASA Crown," reviewed by Alan D. Sessler, M.D. (page 9). A similarly defining issue for our specialty was the development of "Certification in Anesthesiology" (page 12) in which Myer "Mike" H. Rosenthal, M.D., and Francis P. Hughes, Ph.D., discuss the evolution of this process, including the ethical and moral tests previously given to applicants prior to allowing them to assume certification. But more about that later.

Another issue unique to us anesthesiologists is use of the "ASA Relative Value Guide (RVG): A Defining Moment in Fair Pricing of Medical Services" (page 15). Babatunde O. Ogunnaike, M.D., and Adolph H. Giesecke, M.D., discuss the RVG, which evolved from early efforts to estimate the work and complexity associated with the administration of anesthetics for surgical procedures. Or was it *United States v. the American Society of Anesthesiologists*, the antitrust case filed against ASA by the Department of Justice in 1975 concerning the Relative Value Guide? In the words of Michael Scott, Esq., "Some Justice Here, Some FTC There" (page 18).

A more recent defining moment occurred within the past decade when ASA engaged consultants from Abt Associates, Inc. to estimate the future need for anesthesiology providers. Alan W. Grogono, M.D., lends his opinion to "The Abt Report: What Was It, and What Happened?" (page 20). As we now know, Abt's predictions were based on a series of assumptions, not all of which turned out to be valid. Some scenarios, such as the need for anesthesia professionals for minimally invasive procedures, could not have been foreseen at all. Thus Abt predicted a surplus of anesthesia professionals by the turn of the last decade. Perhaps its legacy is reflected in the degree of caution now associated with projections of the anesthesiology workforce, which, given the Abt report's shortfalls, still persists today.



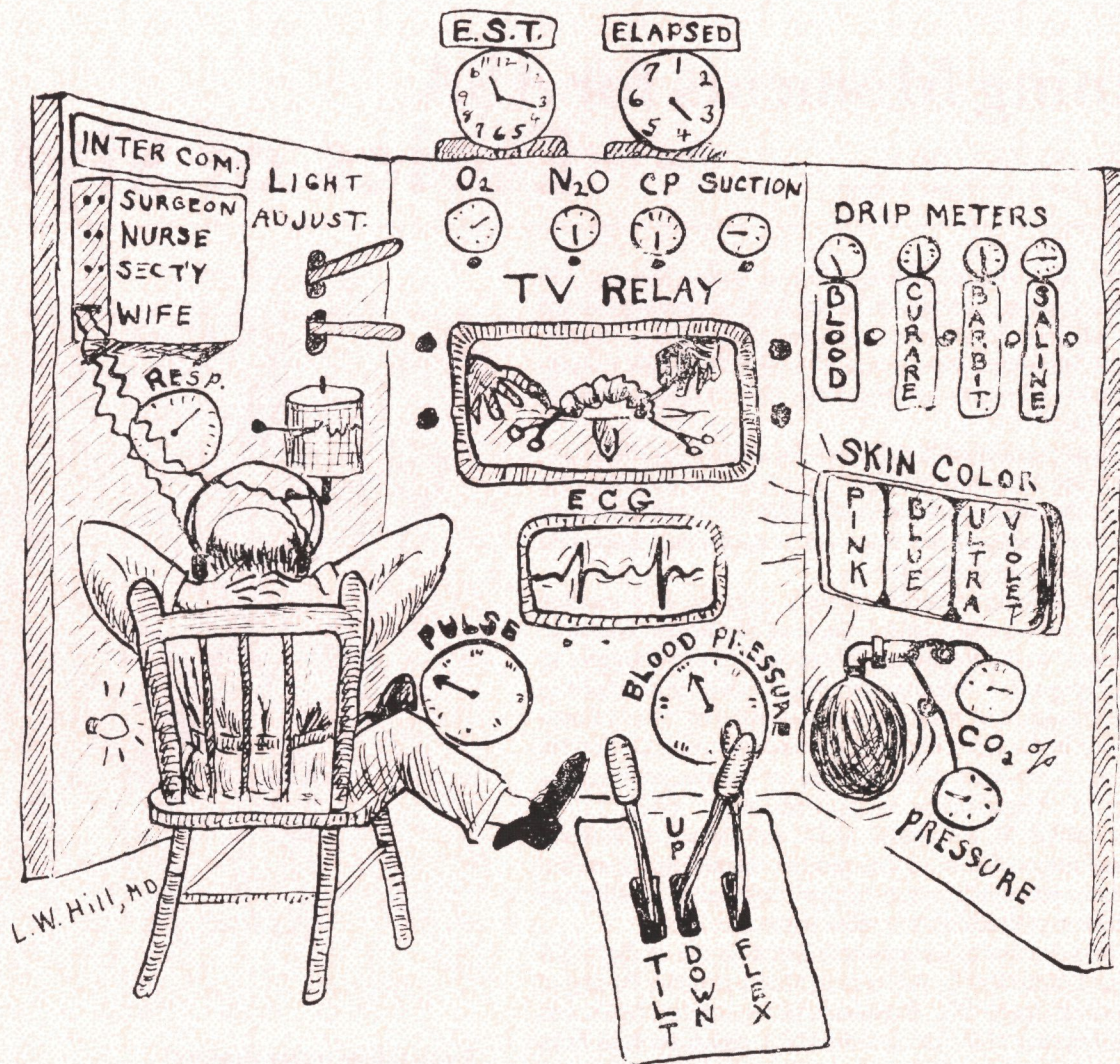
### Some things never change!

*Sittendrip, Demigod of Narcosis: Six-armed god of modern anesthesia. Illustration by Leonard W. Hill, M.D.*  
[Reprinted from *ASA NEWSLETTER*, 18(4), 1954]



Lydia A. Conlay, M.D., Ph.D., is Professor and Chair, Baylor College of Medicine, The Methodist Hospital, Houston, Texas. She is President of the Society for Ambulatory Anesthesia.





### Could radiation therapy and MRI have been foreseen half a century ago?

Anesthesia control booth: Futuristic view of anesthesiology, circa 1954. Illustration by Leonard W. Hill, M.D. [Reprinted from ASA NEWSLETTER, 18(11), 1954]

An issue of interest, and certainly one that helped shape our specialty, was the debate over physician compensation: fee-for-service versus salary, or something I call "The Ethics of Style." This controversy was surprising to me since, as an academic physician, I have been paid some form of salary for most of my professional life. Yet it was very much a "hot button" topic in the late 1940s and 1950s. In 1949 the American Medical Association House of Delegates issued the Hess Report, which delineated guidelines for relationships between hospitals and physicians.<sup>1</sup> For example the report specifically addressed hospital-based specialties and noted that they should have equal standing — with all rights

and privileges — as other active members of medical staffs and that their respective chiefs should be appointed in the same manner as other chiefs within the hospital. In addition:

*"The committee wishes to report again that so far as it can determine, on the basis of a study made by the Bureau of Legal Medicine and Legislation, as a matter of law the corporate practice of medicine is illegal in most states. In almost all instances, the classic example given by the courts of the type of corporate practice of a profession that is illegal is the instance in which a corporation hires a profession-*

*Continued on page 21*



# IN THE BEGINNING: Three Stars?

Douglas R. Bacon, M.D., Chair

Ad Hoc Committee on ASA's 100th Anniversary and WLM Secretary-Treasurer

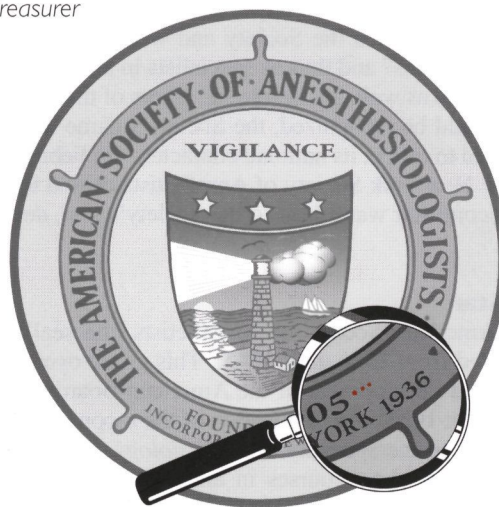
**T**he great ASA seal [Figure 1] contains three stars just after the phrase, "Founded in 1905." The seal is the everyday representation of the Society and is seen everywhere: It is on the masthead of ASA's journal *Anesthesiology*, the *ASA NEWSLETTER* and on official documents from the organization. Each one of those stars represents an organization that preceded the current ASA: the Long Island Society of Anesthetists, the New York Society of Anesthetists and the American Society of Anesthetists. Let us look at these organizations and their beginnings.<sup>1</sup>

## The Founding Nine

On October 6, 1905, nine physicians gathered at what is now the Long Island College of Medicine in Brooklyn, New York, and formed the Long Island Society of Anesthetists. This all-male group was brought together by Adolph F. Erdmann, M.D., with the expressed purpose of advancing the science and art of anesthesiology. Meetings were held quarterly and, after a brief business session, were devoted to clinical anesthesiology. Many of the papers stressed matching the anesthetic to the patient. Dues were \$1.<sup>2</sup> It was an exciting time to be interested in anesthesiology. Spinal anesthesia had been demonstrated in Germany and had then crossed to the United States. Procaine was introduced in 1905, replacing cocaine as the local anesthetic of choice.<sup>3</sup> There was only one other society in the world devoted to anesthesiology: The London Society of Anaesthetists!<sup>4</sup>

## First Star

On May 31, 1911, the first star was added to the yet-to-be-designed seal. The Long Island Society of Anesthetists changed its name and become the New York Society of Anesthetists. The reason for the name change was a direct outgrowth of the success of the Society; more people from the greater New York City area wished to participate in the Society. For the next 25 years, this group would slowly expand from the 20 members present at the inaugural meeting to a national society.<sup>2</sup> The meeting format was not different from the original Long Island Society — quarterly meetings demonstrated the best that science and clinical



**Figure 1:**

Seal of the American Society of Anesthesiologists.

studies could offer to the new specialty. Dues, however, were increased to \$3 per year.

The New York Society of Anesthetists made two major contributions to the specialty. In 1912 the Society put forth a resolution to the American Medical Association (AMA) asking for a section to be created within AMA so that issues germane to the specialty could be discussed. The AMA House of Delegates voted against the resolution; in response, the first national anesthesiology society, the Associated Anesthetists of America, was formed. James T. Gwathmey, M.D., the New York Society president, was elected the first president of the Associated Anesthetists of America.<sup>2</sup>



Douglas R. Bacon, M.D., is Professor of Anesthesiology and the History of Medicine, and Chair, Section on Anesthesia History, Mayo Clinic College of Medicine, Rochester, Minnesota.

\*The London Society became the Section on Anaesthetics in the British Medical Association about 1920.



## Second Star

The second major contribution of the New York Society of Anesthetists was the creation of a new class of members designated as "Fellows of the New York State Society" in 1934. Fellowship criteria matched AMA standards for specialty certification. This effort was rewarded as the membership ranks swelled with physicians from across the United States who joined the Society and wished to be recognized as "Fellows" and thus as specialists in anesthesiology. AMA noticed as well, but before the labors of the New York Society could be recognized, the Society's name needed to be changed to reflect its national character. On February 13, 1936, the New York Society of Anesthetists ceased to exist; thus a second star was added to the Society's seal, designed in 1932.<sup>2\*</sup>

## Third Star

The American Society of Anesthetists, the seal's third star, existed from 1936 until 1945. This group oversaw the creation and development of the American Board of Anesthesiology in 1938<sup>4</sup>; the publication of the second U.S. journal devoted to the specialty, *Anesthesiology*, in 1940<sup>5</sup>; and the creation of short courses in anesthesia for the armed services during World War II.<sup>6</sup> Thus in the short nine years of its life, the American Society of Anesthetists created most of the infrastructure that anesthesiology currently enjoys.

On April 12, 1945, the Society officially became the American Society of Anesthesiologists. In December the first PostGraduate Assembly, or PGA, was held in New York City, and the meeting functioned as an Annual Meeting for the Society.<sup>2</sup> Through the rest of the 1940s, the governance of the Society would change to its modern form with component societies and an Annual Meeting. ASA became the voice of American anesthesiology to the nation and the world.<sup>5</sup>

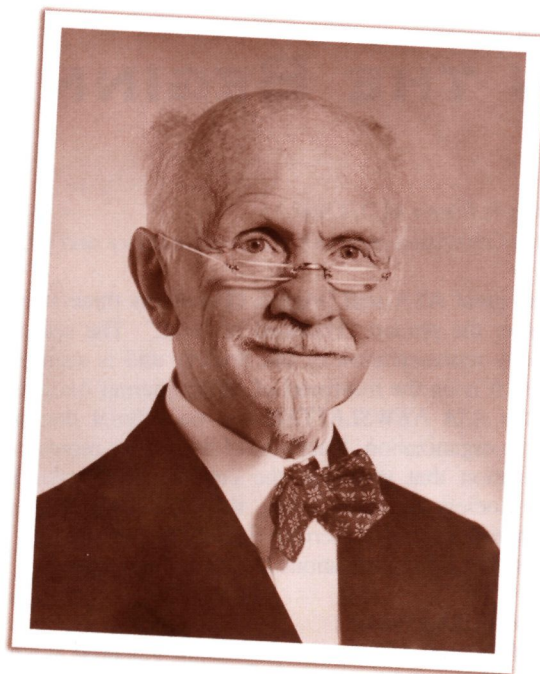
## 100 Years and Growing

As the days approach to the centennial of the founding of ASA, it is important to remember that nine physicians started our Society based on the desire to learn more about the administration of anesthetics. To fulfill this need, education

\* The ASA seal depicts the role of the anesthesiologist in patient care:

*"The patient is represented as (a ship) sailing in the troubled sea with the clouds of doubt and waves of terror being guided by the skillful pilot (anesthesiologist) with constant and eternal (stars) vigilance (motto) by the dependable (firmly based lighthouse) knowledge of the art and science of sleep (moon) to a safe (shield) and happy outcome of his voyage through the realms of the unknown. The perfect circle denotes the unity of a closed group (the Society)."*

As presented by its designer, Paul M. Wood, M.D. (April 13, 1932).



**Figure 2:**

Adolph F. Erdmann, M.D., circa 1956. (Photograph courtesy of the Wood Library-Museum of Anesthesiology)

focused not only on the clinical administration of the anesthetic but also the scientific reasons why events occurred during anesthesia in the manner that they did and continue to do. Early in its history, organized physician anesthetists recognized that there also was a political agenda that had to be met if the specialty was to survive. Almost 100 years later, we continue to learn these lessons.

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# The 4 Foundations: *Jewels* in the ASA Crown

Alan D. Sessler, M.D., Chair  
Committee on Academic Anesthesiology

*"By 2030 all surgical anesthesia will be administered and monitored by computers, with no need for professional medical supervision beyond the surgeon."*<sup>1</sup>

**A**mazing what one can find on the Internet! The author posted this prediction on a Web site <www.longbets.org> to stimulate discussion and as a wager to benefit a charitable organization. It is hard to tell if the author is particularly impressed by the possibilities of artificial intelligence or singularly unimpressed by the anesthesiologists he has met. Regardless, the prospect of clinical anesthesiology being the purview of automatons makes me increasingly thankful that ASA has placed such great importance on and trust in its four foundations. While specific recommendations are only beginning to emerge, what seems clear is that the challenges ahead require united, collaborative efforts and actions by ASA, the foundations and the entire anesthesiology community. The foundations provide vision in the face of speculation that we are again at a period in the specialty that calls for redirection.

The Anesthesia Memorial Foundation (AMF), the Anesthesia Patient Safety Foundation (APSF), the Foundation for Anesthesia Education and Research (FAER) and the Wood Library-Museum of Anesthesiology (WLM) are four separate yet complementary 501(c)(3) organizations through which ASA membership can support the specialty. To see that the foundations benefit from their affiliation with the Society, one needs to look no further than the fiscal bottom line. ASA contributes in many ways to each, and the foundations make major contributions to the Society in return. While each functions autonomously, they have been and will remain inextricably interdependent with the Society.

An examination of the names of the founding members, officers and board leaders confirms the proximate relationship to ASA. The foundations collectively possess the human resources and network linkages to provide the impetus to transform anesthesiology in the years ahead.

In October 2002, then-*NEWSLETTER* Editor Mark J. Lema, M.D., Ph.D., published an article highlighting WLM, APSF and FAER and urged the membership to increase its support of the foundations.<sup>2</sup> This appeared about a year following the beginning of an ASA "Planned Giving Program" initiated on behalf of the four foundations by past ASA President Ronald A. MacKenzie, D.O., and maintained through Executive Director Ronald A. Bruns and the ASA staff.<sup>3</sup> While persuading physicians to adopt a culture of philanthropy has been a slow process, there have been a number of committed individuals who have directed a portion of their

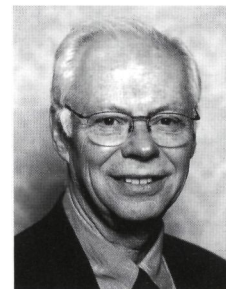
resources and estates to the foundations. Greater attention and effort to this in the future is important and essential to advance anesthesiology, pain medicine and perioperative medicine as scientifically based mainstream sectors in health care throughout the next century.

## Anesthesia Memorial Foundation

In 1956 the anesthesiology community lost a number of prominent leaders<sup>4</sup> with the deaths of R. Charles Adams, M.D., Arthur E. Guedel, M.D., Robert B. Hammond, M.D., Henry S. Ruth, M.D., Brian C. Sword, M.D., and J. Rolland Whitacre, M.D. In the fall of that year, the Anesthesia Memorial Foundation was incorporated "to loan or give money to deserving persons to assist them in becoming specialists in anesthesia or for research or study in anesthesia or related fields ... and to further the progress of anesthesia in every way possible."<sup>4</sup> At the time, the AMF Executive Committee included Scott Smith, M.D., A. William Friend, M.D., B.B. Sankey, M.D., and Mr. John Lansdale, Esq. The ASA Executive Committee of that time officially indicated their enthusiastic support of the foundation.



William D. Owens, M.D.  
President, Anesthesia  
Foundation



Alan D. Sessler, M.D., is President, Foundation for Anesthesia Education and Research, and Professor and Chair Emeritus, Mayo Clinic, Rochester, Minnesota.



Several years ago, AMF received a significant bequest to augment the loan fund. Today AMF <[www.AnesthesiaFoundation.org](http://www.AnesthesiaFoundation.org)> continues to manage a revolving loan fund for residents in need and periodically bestows a Book Award of \$10,000 for the best monograph in the specialty. The presentation is made at the Annual Meeting of the Academy of Anesthesiology where the author is invited to attend as a guest.

### Anesthesia Patient Safety Foundation

APSF <[www.apsf.org](http://www.apsf.org)> was incorporated in September 1985. The first *APSF Newsletter* was published in 1986 and contains a photo of the original seven-member Executive Committee. Remarkably five of the seven (Ellison C Pierce, Jr., M.D., E.S. Siker, M.D., Joachim S. Gravenstein, M.D., Jeffrey B. Cooper, Ph.D., and Burton A. Dole) stayed active in the foundation's leadership for 20 years, which speaks to their commitment to this important cause. John H. Eichhorn, M.D., was the original newsletter editor and remained in that post for many years. He subsequently edited a book titled *Anesthesia Patient Safety, A Modern History: Selections From the APSF Newsletter — The Formative Years, 1986-1993*, which details the activities conducted and issues addressed during those years.<sup>5</sup> More recently, in 2001, E.S. Siker, M.D., prepared a modern abbreviated history that appears on the APSF Web site.<sup>6</sup>

Among the many corporate contributors and donors to APSF, none has been more generous of his time and substance than Mr. Dole, longtime member of the APSF Corporate Advisory Council, who has been a continuous loyal supporter from APSF's inception to its present.

The foundation's work has resulted in significant changes in the practice of anesthesiology such as standards for monitoring, simulators for the training of personnel, the education of practitioners in risk management and a dramatic reduction in anesthesia-related deaths.

APSF has five current initiatives:

- Data Dictionary Task Force: To create a common lan-

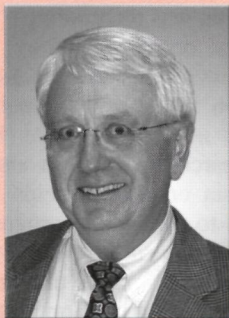
guage that will facilitate analysis of patient care experiences and be a benchmark for safety.

- Automated Information Systems: To yield pooled data, permitting comparisons among institutions.
- High Reliability Organizations: To achieve hospital safety in the perioperative area.
- Long-Term Outcomes: A panel to explore the role of inflammations in long-term postoperative outcomes.
- Audible Alarms: Workshop and task force made up of anesthesiology and corporate partners to study efficacy and limitations.

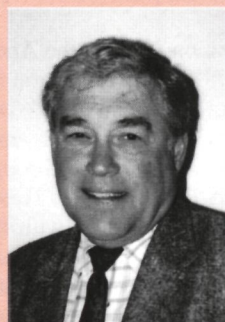
### Foundation for Anesthesia Education and Research

FAER <[www.f aer.org](http://www.f aer.org)> has quietly undertaken the task of trying to close the 10-fold research support gap that exists between anesthesiology and the highly research-oriented specialties. Anesthesiology, with almost 40,000 ASA members, ranks sixth in medical specialty size with 5 percent of practicing physicians but receives only 0.5 percent of National Institutes of Health dollars. It may be argued that this small research and development effort is one reason that anesthesiology is frequently viewed as a service department in academic health centers and a candidate for automation. These perceptions must change through our efforts and support, or the dire prophecy that medical anesthesiology will disappear as a specialty by 2030, as was predicted at the beginning of this article, may be fulfilled.

FAER research award amounts were increased in 2001. This year a Mentored Research Training Grant will be offered for the first time, and the Research in Education Grant has been increased.<sup>7</sup> In addition FAER has initiated an Academy of Mentors that will hold its first organizational meeting this fall on Friday, October 22, at the ASA Annual Meeting in Las Vegas, Nevada. With an increase in grant applications and fundable proposals as scored by Michael K. Cahalan, M.D., and the ASA Committee on Research, the FAER board increased the award program budget. Nonetheless FAER was unable to fund all the meritorious grants in 2003 and 2004. Future growth as a scientifically



Robert K. Stoelting, M.D.  
President, Anesthesia Patient  
Safety Foundation



Myer H. Rosenthal, M.D.  
President, Foundation for  
Anesthesia Education and  
Research



based medical discipline depends upon generating a higher level of annual funding for the grant programs.

FAER is addressing this need with ASA leadership, subspecialty societies and component societies, corporate sponsors, national foundations and individual donors. FAER will work to expand its base of support for 2005 through collaborative efforts with other ASA foundations and the Ad Hoc Committee on ASA's 100th Anniversary.

### Wood Library-Museum of Anesthesiology

While WLM <[www.ASAhq.org/wlm/](http://www.ASAhq.org/wlm/)> was formed in the 1930s, on July 21, 1950, the New York State Board of Regents granted a provisional charter. An absolute charter was granted on February 29, 1952.<sup>8</sup>

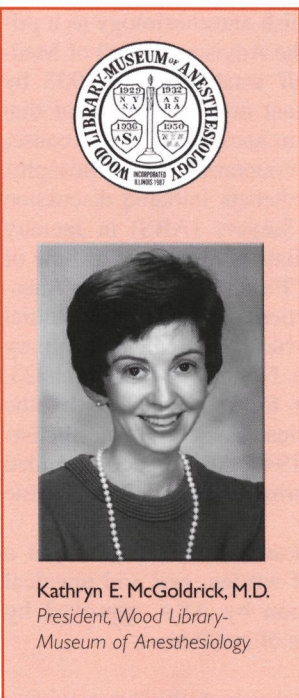
The collection of the WLM's printed materials and equipment was housed in various buildings throughout the years, under the guardianship of Paul M. Wood, M.D., with the various locations ranging from a drug company building to a boat house on Long Island. In February 1960, Leo V. Hand, M.D., then ASA President, "suggested the possibility of the Society offering space in the air-conditioned basement of the Park Ridge headquarters building."<sup>8</sup> The library's first major gift was from Oscar Schwidetsky, M.D., an instrument maker of Becton, Dickinson

support the Living History Collection. George S. Bause, M.D., has been a major donor to the museum, and Charles C. Tandy, M.D., and others have given to the rare books collection, which is largely unrivaled across the globe.

As they evolve, the ASA foundations remain our best prospects to serve as engines of change to effect the advances necessary for anesthesiology to transform and survive whatever challenges the future may hold.

We must accept the challenge and take the long-shot bet that proposes replacing medical anesthesiology with a robot by 2030. I am unwilling to believe you can write an algorithm to replace the judgment exercised by a vigilant, well-trained, experienced physician in the care of patients during anesthesia and the perioperative period.

To accomplish our goals, ASA and the foundations will require ongoing commitment and resources from the rank-and-file membership who currently support these activities through their dues and gifts. We believe leadership gifts and bequests can be increased over time and that a demonstrated record of responsible stewardship will speak for itself in earning the confidence of our colleagues to invest in this cause.



Kathryn E. McGoldrick, M.D.  
President, Wood Library-  
Museum of Anesthesiology

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son & Co., who bequeathed 10 percent of his estate as a leadership gift to WLM.<sup>9</sup>

WLM is a world-class resource that should make ASA members justifiably proud and is a prime example of the way in which bequests can help a foundation grow. In recent years, the WLM has expanded under the leadership of Librarian Patrick P. Sim, his staff and a long succession of dedicated presidents and trustees who have given generously of their time and substance to this renowned institution. For example John W. Pender, M.D., left a leadership gift to



## Certification in Anesthesiology: Where It's Been and Where It's Going

Myer H. Rosenthal, M.D., Past Director  
American Board of Anesthesiology

Francis P. Hughes, Ph.D., Executive Vice-President  
American Board of Anesthesiology

*This article has been edited for space considerations. A longer, more detailed version is available on the ASA Web site at <[www.ASAhq.org/Newsletters/2004/09\\_04/certif.html](http://www.ASAhq.org/Newsletters/2004/09_04/certif.html)>.*

**Concept to reality:** The beginnings of certification in American anesthesiology can be traced to the early 1930s with two efforts proceeding nearly simultaneously. The International College of Anesthetists (ICA), arising through the efforts of Francis H. McMechan, M.D., and the Committee on Fellowship, established in 1931 by the New York Society of Anesthetists (NYSA), issued the first anesthesia fellowship certificates to American anesthesiologists in 1935 and 1936, respectively. The two opposing certification processes arose out of the isolationist views of most medical societies in the United States, most notably the NYSA and the American Medical Association (AMA), and the internationalist approach favored by Dr. McMechan.

The first meeting of the Committee on Fellowship of the NYSA was held in July 1935 and was chaired by T. Drysdale Buchanan, M.D., later to become the first Chair of the Board of Directors of the American Board of Anesthesiology (ABA). In 1936 this committee issued its first certificates to 88 members of the NYSA certifying them as fellows "on record only." AMA initially opposed certification by this body based on the perception of local representation despite the NYSA membership, including anesthesiologists from 17 states. Therefore, in an effort to gain acceptance of its certifying process and thus recognition of anesthesiology as an independent specialty, the NYSA incorporated itself as the American Society of Anesthetists on December 10, 1936. In

its first bylaws, the American Society of Anesthetists stated that the purpose of certification was "to protect the public against irresponsible and unqualified practitioners who profess to be specialists in anesthesiology."

The initial attempts to establish anesthesiology as a primary board were opposed by the Advisory Board of Medical Specialties (ABMS), itself established in 1933 by AMA, as anesthesiologists were most often described at that time as "surgeons specializing in anesthesia." As a consequence of the unlikelihood of countering this philosophy, the American Society of Anesthetists initiated discussion with the American Board of Surgery (ABS) in January 1937, which resulted in an affiliation agreement in June of that same year to establish an "Examining Board in Anesthesiology" under the jurisdiction of ABS. This initial "Subsidiary Board" was approved by ABMS in February 1938 and was incorporated in New York on March 23, 1938. Persistence in lobbying for independence by the founding trustees and the American Society of Anesthetists finally paid off, and in March 1940, ABMS recommended to AMA that ABA become a primary board. This became reality on February 16, 1941.

In its first efforts at certification, ABA established a three-part process consisting of written, oral and practical examinations. Initial certification by ABA approved by ABS established four categories of candidates:

**Founders:** Professors and associate professors previously elected to fellowship by the Committee on Fellowships of the NYSA/American Society of Anesthetists to be certified without examination.



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Francis P. Hughes, Ph.D., Raleigh, North Carolina, has served as administrative head of ABA since 1982.



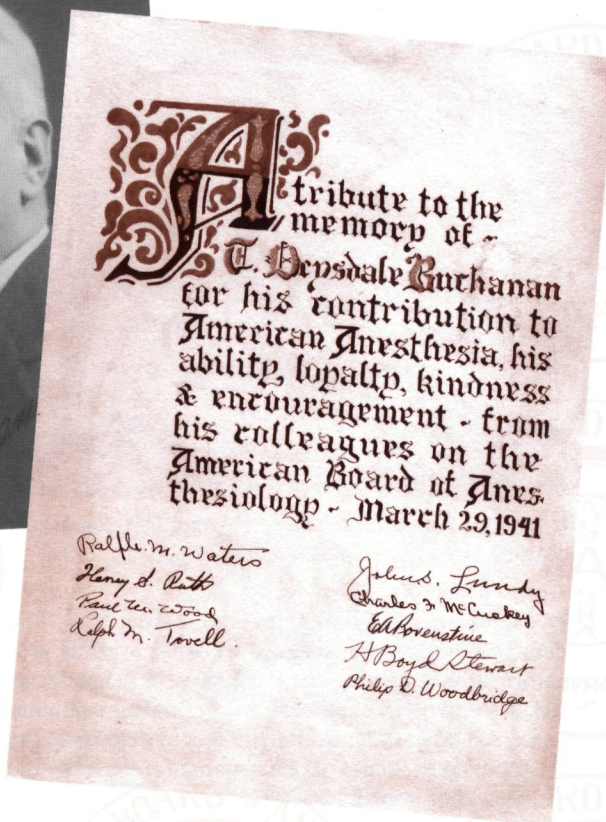
**Group A:** Those having practiced anesthesiology for 15 or more years appeared before the board but could be certified without examination.

**Group B:** Those practicing for seven and one-half years or more with 1,500 major procedures could be certified following an oral examination.

**Group C:** Those having graduated from an approved medical school, completed a year of internship and two years of anesthesia training with 18 months of practical education in anesthesia, have two years of practice devoted 100 percent to anesthesia and be a member in good standing of AMA or comparably approved national medical society could be certified after satisfying all three parts of the examination process and preparing 150 of their cases for evaluation.

The first ABA "Booklet of Information" in 1937 notified its constituency that three years of training in anesthesiology after completion of internship should be a requirement for certification and that such would be initiated for those entering their postinternship training after January 1, 1942. This proposal created great controversy, as it did when proposed again in 1958 to begin in 1963 and again in 1984 to commence in 1986. The efforts to initiate a four-year continuum were abandoned in 1944 and 1963. Such a requirement was, however, eventually adopted and applied to all candidates beginning their first year of anesthesiology training following internship on or after May 1, 1986.

**Written Examination:** Confusion exists in the records of the proceedings of ABA as to the occurrence of the first written examination. ABA records describe a seven and one-half-hour written examination in 1938 consisting of 25 essay-type questions with five questions from each of five sections: pharmacology, anatomy, physics and chemistry, pathology and physiology. The earliest documented evidence of a written examination administration, however, is in March 1939. It allowed candidates to choose three of the five proffered questions from each of the above sections. ABA continued to use essay-type questions for the written examination until January 1948, when they were replaced by 125 multiple-choice questions distributed equally among the same five content sections that composed the essay examination. The number of multiple-choice questions changed to 250 questions in 1949 and 300 in 1950. In 1957, ABA stopped identifying five sections of the written examination and set the number of questions at 200.

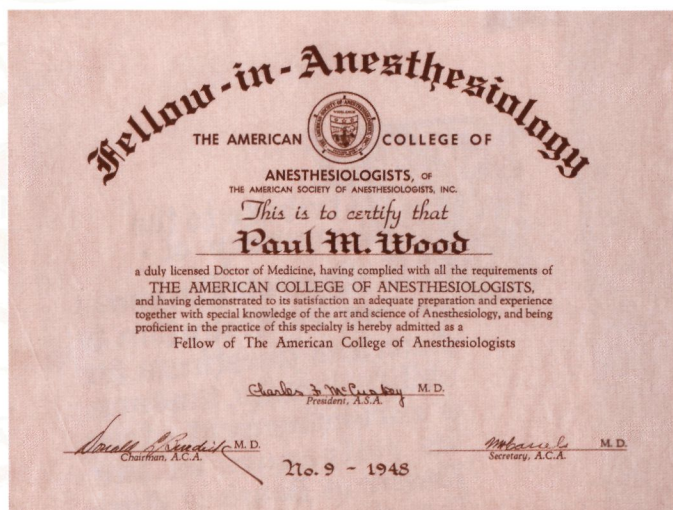


Thomas Drysdale Buchanan, M.D. (left), chair of the first ABA Board of Directors. The scroll above was signed by every ABA director in honor of Dr. Buchanan after his death. (Images courtesy of the Wood Library-Museum of Anesthesiology)

Representatives of ABA, the American Society of Anesthesiologists (ASA), the Association of University Anesthetists (later, Anesthesiologists) (AUA) and the Anesthesiology Section of the AMA met in 1966 to begin discussions about establishing an in-training examination for residents. ABA and ASA continued discussions following the first Liaison Committee meeting and eventually formed the Joint Council on In-Training Examinations with representatives appointed by both organizations. The Joint Council develops a 350-item in-training examination annually. It administered the examination to house staff for the first time in 1975. Since 1977, ABA selects 220-240 questions from the annual in-training examination as the written examination component of the ABA certification process.

**Oral Examination:** The oral examination has gone through numerous iterations since first administered in 1939, with each candidate examined in three rooms for 10 minutes in each room before two examiners. Examiners,





The original Fellowship certificate of Paul M. Wood, M.D. (Image courtesy of the Wood Library-Museum of Anesthesiology)

initially board members and invited guests from the “Founders” category, were assigned topics as well as provided information regarding the examinees deficiencies as identified in the written examination. Following examination of nine candidates, the examiners met to determine the results. Candidates could receive one of four possible results — pass, fail (repeat both written and oral or refused further attempts), conditional (repeat oral alone in six months or both written and oral) or questionable (repeat examination that same day in two rooms for 20 minutes each with two ABA directors). Changes to the logistics of the examination included one room for 10 minutes with three examiners in 1941, four rooms for 20 minutes with two examiners in 1943, three rooms for 20-30 minutes with two examiners in 1949, two rooms for 30 minutes each with two examiners in 1961 and two rooms for 35 minutes each with two examiners in 1997. As an aside, it is of interest to note that during World War II, oral examinations were conducted in theaters of operation in Europe and the Pacific for qualified candidates unable to return stateside for the oral examinations. A single board director (Ralph Tovell, M.D., in Europe and Charles McCuskey, M.D., in the Pacific) conducted an oral examination and reported the results back to ABA. In 1962, ABA investigated the validity of the number of rooms and examiners, and a publication by Carter concluded that the validity of the two-room examination was satisfactory. A similar study conducted by Kelley working with the National Board of Medical Examiners (NBME) also validated the two-room examination in 1969.

**Practical/Survey Examination:** Introduced as a proposed component of the original NYSA fellowship examination, ABA adopted the practical examination as an integral

part of the certification process in 1939. Subjective and inequitable in its approach, this component brought selected examiners to the site of a candidate’s practice, evaluating not only operating room practice but also cadaver demonstration of nerve blocks, clinical experimentation, evaluation of remuneration, involvement with nurse anesthesia and any other activities that reflected on the candidate’s practice or professional behavior. This component of certification became optional at the “Board’s discretion” in 1950 and was eliminated altogether in 1958. The survey also was used to gain insight into the candidate’s local practice and activity. In the year preceding the oral examination, one or more ABA Diplomates from the candidate’s locale conducted a local evaluation to determine whether the candidate was of “high ethical and professional standing.” This practice, first introduced in 1949, required a favorable report prior to admission into the oral examination. The survey became optional in 1958 and was eliminated altogether in 1977.

**CDQ to Voluntary Recertification to MOCA:** Recertification and the issuance of time-limited certification provided major challenges for ABA. Pressure from ABMS and the recognition of the public’s desire for assurance of continued expertise and competence for medical practice led ABA to consider the advisability of recertification in 1958. Lacking objective scientific-based evidence of the relationship of recertification to continued competence to practice medicine, ABA deliberated considerably over this matter. From the initial discussion in March 1958, little progress was made until 1971, when pressure from ABMS was directed to all of its member boards to consider recertification. Acceding to considerable outside pressure, ABA informed its constituency in 1979 of its intent to implement recertification in 1984. This was rescinded in 1982 to allow ABA further time to study the value of recertification.

In 1990, ABA, following discussion with ASA, established a program of voluntary recertification identified as Continued Demonstration of Qualifications (CDQ), and a written examination and credentialing process was implemented in 1993. This program was given formal approval for recertification by ABMS in 1996. Subsequently ABA took the final steps in the recertification process. In 1995 it informed its Diplomates that all certificates (including subspecialty) issued after January 1, 2000, would have a 10-year time limit to expiration. Voluntary recertification continues to be open only to Diplomates certified before 2000, and ABA will end the program in 2009. In 2004, ABA launched a program for maintenance of certification in anesthesiology (MOCA) that is open to all ABA Diplomates.

*Continued on page 32*



## ASA Relative Value Guide (RVG): A Defining Moment in Fair Pricing of Medical Services

*Babatunde O. Ogunnaike, M.D., Fellow  
Wood Library-Museum of Anesthesiology*

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

One of the defining moments in ASA's history was the development and adoption of the Relative Value Guide (RVG). The concept originated in the California Medical Association, and it was California's persistent advocacy that made the RVG a reality. The RVG was the Society's response to opposing and conflicting social pressures, which required careful thought and courageous action. The social pressure in one direction was the demand by employers, health insurers and a newly created federal bureaucracy to establish uniform fees for service in order to establish a budget. The social pressure in the opposite direction was the Department of Justice, which considered that any collaboration among doctors to establish fees was a violation of antitrust law. The resulting RVG became a prototype for all medical specialties, making ASA a leader in American medicine.

### Success and Failing

Passage of the Dependents Medicare Act (Public Law 569) by the 84th Congress in the early 1960s necessitated the development of some sort of fee schedule for anesthetic services in the Medicare program for military dependants, referred to as "CHAMPUS," the Civilian Health and Medical Program for the Uniformed Services. In the early 1960s, the ASA House of Delegates heard the details of the system adopted by the California Medical Association that would establish a Relative Value System (RVS), which would be the same throughout the state. Each surgical procedure was assigned a numeric unit value based on four evaluations: anesthesia risk, surgical problems related to anesthesia, skill required and time required. Different dollar amounts could be assigned to the units depending on the

cost of living in an area. For example a higher value was assigned to the unit in San Francisco compared to Modesto. Commercial insurance companies also looked closely at California's new relative value system. They wanted a yardstick, something concrete and uniform that could be readily converted into dollars and cents in order to plan a prospective budget and fix a premium for a health insurance policy.

The genius who devised and developed the concept of the RVS was an anesthesiologist from Los Angeles named Joseph H. Failing, M.D. Beginning in the early 1950s, he devoted seven years of his personal time, money and energy to perfect the concept and guide it through the California Society of Anesthesiologists and the California Medical Association. Having achieved those goals, he introduced the concept to ASA.

### Red HOD Debate About RVG

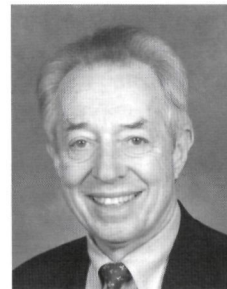
In the early 1960s, the debate over the RVG in the ASA House of Delegates was very intense. Those opposed to planning and implementing a national RVG claimed that this was a step toward socialized medicine. Those in favor felt that an RVG would help anesthesiologists establish and collect reasonable fees and that opponents were "dragging their feet." Proponents also favored assisting governmental agencies and insurance companies to do their jobs in an efficient manner. Even those who were unified in favor of an RVG were divided concerning the details. Some favored time-based units; others favored "usual, customary and reasonable," or UCR, fees.

Keeping in mind that a UCR survey for all physicians was being conducted on a national basis, ASA considered

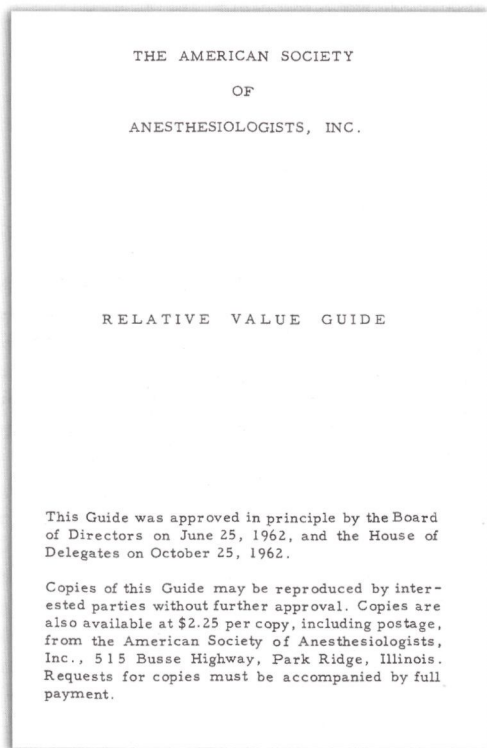
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*Adolph H. Giesecke, M.D., is Professor of Anesthesiology and Pain Management, former Jenkins Professor and Chair, University of Texas Southwestern Medical School, Dallas, Texas. He is a former Wood Library-Museum of Anesthesiology Trustee.*







*The first Relative Value Guide in 1962 was a book of stapled mimeographed sheets. The cover is pictured above. (Image courtesy of the Wood Library-Museum of Anesthesiology)*

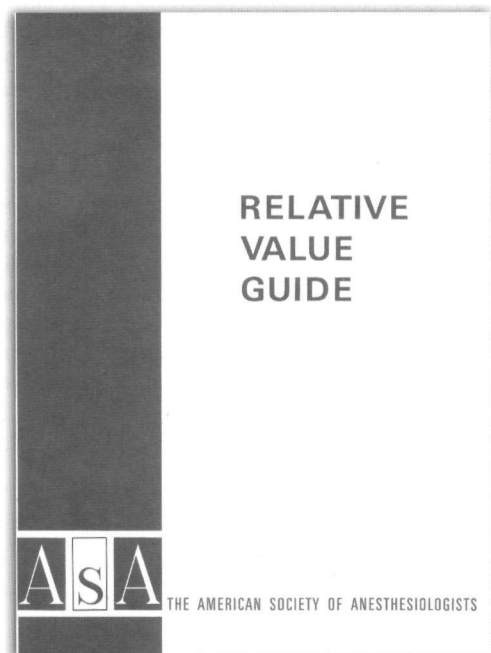
One of the defining moments in ASA's history was the development and adoption of the Relative Value Guide (RVG). The concept originated in the California Medical Association, and it was California's persistent advocacy that made the RVG a reality. The RVG was the Society's response to opposing and conflicting social pressures, which required careful thought and courageous action. The social pressure in one direction was the demand by employers, health insurers and a newly created federal bureaucracy to establish uniform fees for service in order to establish a budget. The social pressure in the opposite direction was the Department of Justice, which considered that any collaboration among doctors to establish fees was a violation of antitrust law. The resulting RVG became a prototype for all medical specialties, making ASA a leader in American medicine.

### Success and Failing

Passage of the Dependents Medicare Act (Public Law 569) by the 84th Congress in the early 1960s necessitated the development of some sort of fee schedule for anesthetic services in the Medicare program for military dependants,

referred to as "CHAMPUS," the Civilian Health and Medical Program for the Uniformed Services. In the early 1960s, the ASA House of Delegates heard the details of the system adopted by the California Medical Association that would establish a Relative Value System (RVS), which would be the same throughout the state. Each surgical procedure was assigned a numeric unit value based on four evaluations: anesthesia risk, surgical problems related to anesthesia, skill required and time required. Different dollar amounts could be assigned to the units depending on the cost of living in an area. For example a higher value was assigned to the unit in San Francisco compared to Modesto. Commercial insurance companies also looked closely at California's new relative value system. They wanted a yardstick, something concrete and uniform that could be readily converted into dollars and cents in order to plan a prospective budget and fix a premium for a health insurance policy.

The genius who devised and developed the concept of the RVS was an anesthesiologist from Los Angeles named Joseph H. Failing, M.D. Beginning in the early 1950s, he devoted seven years of his personal time, money and energy to perfect the concept and guide it through the California Society of Anesthesiologists and the California Medical Association. Having achieved those goals, he introduced the



*The second edition of the Relative Value Guide appeared in 1967 as a slick paper publication that sold thousands of copies. (Image courtesy of the Wood Library-Museum of Anesthesiology)*



society was urged to develop its own adaptation to the guide and to help to establish the value of the units. The Committee on Economics recommended that relative values for supervision of nurse anesthetists be developed at a local level with a suggestion by the President that the relative value for supervision of two simultaneous anesthetics be 50 percent of regular value.

### Legal Battles

Several medical societies followed this lead and published their own relative value guides. These included the American College of Obstetricians and Gynecologists, the American College of Radiology, the Illinois Podiatric Society and the American Dental Association. All of these organizations, including the California Medical Association and ASA, came under broad attack by the Federal Trade Commission, which alleged that they represented conspiracies to fix prices for medical services. In time all of the named associations, except ASA, agreed in consent orders to cease publication of their guides. ASA was left alone to face the Justice Department, which brought suit in 1975, alleging violations of the price-fixing prohibitions of the Sherman Antitrust Act.

Based on advice of its legal counsel, John Lansdale, Esq., ASA decided to fight the allegations. Jess B. Weiss, M.D., 1979 ASA President, testified on behalf of ASA at the trial, which lasted six days. New York District Court Judge Kevin T. Duffy issued his 40-page decision, which concluded that the RVG did not violate antitrust laws. ASA had faced the Department of Justice in court and had prevailed; the legality of the RVG had been dramatically established for anesthesiologists and all of medicine.

### The Gold Standard

In December 1989, President George H. Bush signed the Omnibus Budget Reconciliation Act establishing a physician payment schedule based on a Resource-Based Relative Value Scale. In 1992 the American Medical Association established an advisory committee named the RVS Update Committee, or RUC, to establish equity across specialties for the value of units. Dr. Failing's brainchild had now become the national standard for medical payments.

Dr. Failing was a contributor to many ASA programs in



Joseph H. Failing, M.D., (left) receives the Distinguished Service Award from President Nicholas G. DePiero, M.D., in 1969. Image reprinted with permission of the ASA NEWSLETTER. 1967; 31(11): 4.

addition to his monumental work in developing and promoting the RVG. In recognition of his career-long dedication to the goals of ASA, he was awarded the Distinguished Service Award in 1969.

The RVG stands as a tribute to the genius of Dr. Failing and to the foresight, maturity and leadership of ASA. Thankfully the leadership, which was so apparent then, is still evident today, and the future of ASA is bright.

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## 1979 Adventures in Antitrust: Some Justice Here, Some FTC There

Michael Scott, J.D., Director  
Governmental and Legal Affairs

In 1975 the Supreme Court struck down a minimum fee schedule promulgated by the Fairfax County Bar Association in northern Virginia, saying that it violated the federal antitrust prohibition against price-fixing (*Goldfarb v. Virginia State Bar*, 421 U.S. 773). For physicians, *Goldfarb* was to become a decision of enormous importance; in essence, it dispelled the prior uncertainty of the extent to which traditional antitrust principles were applicable to the provision of professional services.

Writing two years before *Goldfarb*, a former Chairman of the Federal Trade Commission (FTC) said with some prescience: "The fact that certain restrictive practices of learned professions have not been subjected to attack is the result of forbearance by the federal antitrust enforcement authorities and the interstate commerce requirement, not any recognized exemption to the antitrust laws" (Kintner, *Antitrust Primer* [1973] p. 33). With *Goldfarb* that whole house of cards came tumbling down, and the federal antitrust enforcers were off and running amok through the "house of medicine."

Among the early casualties were the relative value guides promulgated in 1956 by the California Medical Association (CMA) and a number of national medical specialty societies. These guides essentially compared the relative complexity and cost of various medical procedures each to the

other, just as the Medicare Resource-Based Relative Value System does for physician services introduced in 1992 and which are still in effect today. FTC alleged, however, that promulgation of relative value guides by medical associations amounted to price-fixing among its members — just as much as the fee schedule struck down by *Goldfarb*.

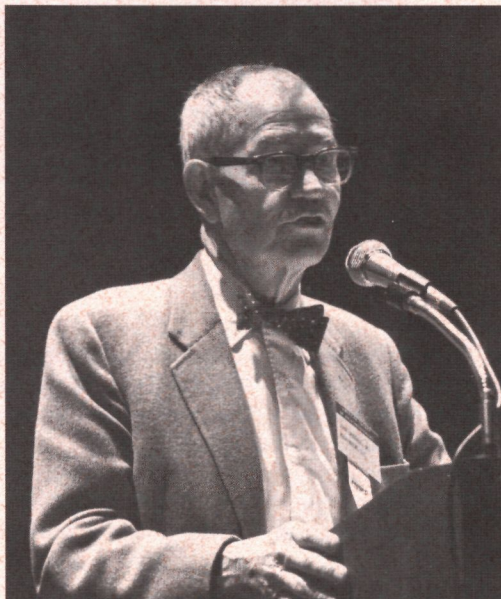
Principally concerned about the cost of litigating the issue with FTC, CMA and the specialty societies each agreed to a consent order by FTC, pursuant to which they were required to cease and desist promulgation of their guides and, indeed, to seek return of those guides previously distributed.

ASA also was one of those specialty societies that had developed a relative value guide. As ASA members know, anesthesiology came of age in the years immediately following World War II, and in the incipency of the specialty, there were numerous ways by which anesthesiologists charged for their

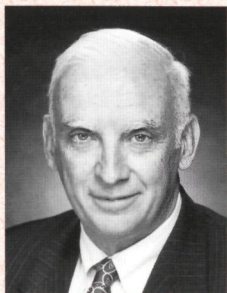
services, including a flat percentage of the surgeon's fee, elapsed anesthesia time, a charge based on the nature of the procedure or a combination of the last two. Increasingly several national third-party payers — led by Blue Cross/Blue Shield — became frustrated with this diversity in billing approaches. Out of the chaos, the first ASA Relative Value Guide (RVG) was born in 1962.

ASA members also know that the ASA RVG is derived, as it was in 1962, from a combination of base time units (complexity) and elapsed time units. The total of these units involved in a particular procedure is multiplied by a dollar amount "conversion factor" in order to arrive at the appropriate fee. ASA has never recommended what the conversion factor should be — that is a decision to be made by the individual physician or group providing the services or by the third-party payer "purchasing" those services on behalf of the patient.

For reasons never publicly explained, FTC chose not to attack the ASA RVG along with those of other medical associations. Not to be outdone, though, the Department of Jus-



Jack Lansdale, Esq., (1912-2003) in 1978.



Michael Scott, J.D., oversees the federal, state, regulatory, lobbying and legal activities in the ASA Washington Office.



tice filed suit in 1975, alleging that the RVG, in purpose and effect, violated the Sherman Antitrust Act's prohibition against price-fixing. ASA's long-time legal counsel, Jack Lansdale, Esq., recommended that ASA resist the suit, essentially on the grounds that the guide did not represent an agreement among competitors to fix prices. Instead, if it affected competition at all, it was pro-competitive in purpose and effect.

(While the RVG case was pending, FTC — not to be outdone by its fellow antitrust enforcer — issued a proposed complaint against ASA in 1977 alleging that a provision of its ethical guidelines, requiring that members practice on a fee-for-service basis and not as an employee of an entity such as a hospital, impaired competition and thus violated the antitrust laws. Mr. Lansdale advised the Society that the complaint was not worth fighting, and a consent decree was negotiated in early 1979 by which the Society agreed to abandon the fee-for-service ethical standard.)

After several months of discovery were completed, the RVG case went to trial in New York City in November 1978. The trial lasted six days. It was soon apparent that the government lawyers thought they had a “slam dunk” of a price-fixing case and were content to present little more than the existence of the RVG as their evidence. ASA responded with nine witnesses, including former ASA presidents, a nationally known expert on the economics of the health care marketplace, anesthesiology billing experts and a representative of the health insurance industry, all of whom painted a picture of the guide as a response to the industry's need to establish a method by which to evaluate anesthesia fees.

In January 1979, the trial court concluded that the government had failed to meet its burden of proof and that mere proof of the existence of the guide, “in the unique circumstances surrounding the anesthesiology profession and the adoption of relative value guides, was much too narrow an approach to the problem at hand (*United States v. American Society of Anesthesiologists* [S.D.N.Y. 1979] 473 F.Supp. 147). In short, ASA had beaten the government on the status of the RVG under the antitrust laws at the same time that other medical associations had decided not to resist. It was truly a seminal moment in the development of the specialty. The guide has been widely used ever since, even by the self-same government that brought suit in 1975.

It must be said in conclusion, however, that despite ASA's success in the RVG case and the resulting acceptance of the guide, the *Goldfarb* decision some three decades ago ushered in an era when counsel for ASA and every other medical association must be constantly attentive to the activities of their clients when viewed through the antitrust prism. Association members often express frustration with the antitrust advice of counsel, and quite understandably so. As long as one remembers, however, that a trade or professional association — because it is a fraternity of competitors or potential competitors — is almost by definition a walking potential antitrust violation, perhaps he or she will understand that when counsel says “no,” there may be a very good reason, post-*Goldfarb*.



## RELATIVE VALUE GUIDE 1975



THE AMERICAN SOCIETY  
OF ANESTHESIOLOGISTS

**“... the Department of Justice filed suit in 1975, alleging that the RVG, in purpose and effect, violated the Sherman Act's prohibition against price-fixing.”**



## The Abt Report: What Was It, and What Happened?

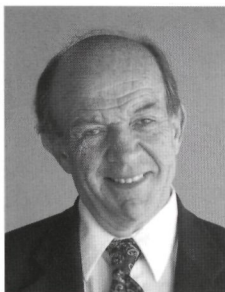
Alan W. Grogono, M.D.

Anesthesiologists in the United States have been accustomed to having to recruit residents; making our specialty attractive has been a tradition. In the late 1980s, concern about recruitment was exacerbated by the decision to lengthen the residency training program from two years to three. In fact what followed was our most successful period of recruitment ever: 1990 to 1993.

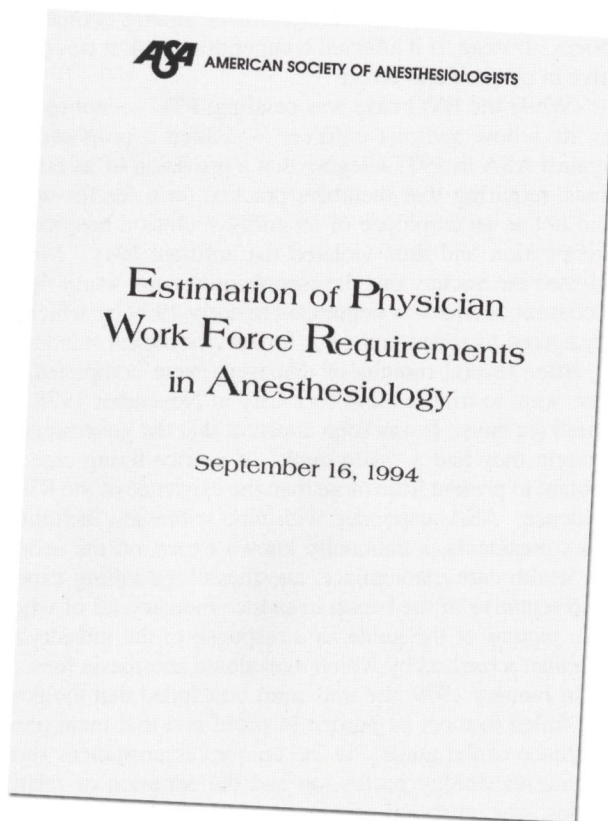
Nevertheless concern about recruitment resulted in regular presentations from anesthesiology chairs about recruitment via the National Resident Matching Program at the Annual Meetings, beginning in 1990. These presentations were followed by annual articles in the *ASA NEWSLETTER*, beginning in 1993. The tenor of the first article reflected our traditional concern of attracting both excellent medical students and excellent graduates. In the chairs' meetings, however, the potential impact of managed care and the possibility of changes in surgical practice were causing increasing concerns about the threat of an oversupply. In August 1993, ASA leaders exemplified their own concern by commissioning Abt Associates, Inc. to compile a report on "Estimation of Physician Work Force Requirements in Anesthesiology."

The final Abt report appeared in September 1994 and projected possible workforce requirements under several hypothetical scenarios. To meet these requirements, Abt also calculated the associated "Training Needs," assuming varying retirement ages, physician/nurse anesthetist mixes and hours worked per year. The startling conclusion was that, even using the most optimistic projections, Abt said we were training about 30 percent too many residents. The most pessimistic projections implied that we should train no anesthesiologist for the subsequent 16 years.

Influenced by this report and by the contemporaneous mood of the specialty, the 1994 Match article concluded, "The current decline in both applicants and positions may prove to be both necessary and desirable." This was a remarkably quick reversal from the year before!



Alan W. Grogono, M.D., now retired, is former Chair and Meryl and Sam Israel Professor, Department of Anesthesiology, Tulane University School of Medicine, New Orleans, Louisiana.



If, in 2004, we find it surprising that Abt reached the conclusions that it did, it is completely incomprehensible that the specialty took it so seriously — but we did! In operating rooms, meetings and publications, we openly expressed concern about declining employment opportunities. Practice groups and academic departments delayed recruitment, reasoning that "with so many applicants, let's wait until we need them and they are even cheaper." This made a significant contribution to an apparent shortage of employment opportunities.

Listening to the cacophony were three other groups. Our residents left the residency programs at unprecedented levels; the cohort that started its CA-1 year in 1994 lost more than 20 percent of its members by the start of the CA-3 year. Students were further back in the "pipeline" and were no doubt influenced by the third group, the deans. Their impact was delayed but, ultimately, far more influential. In 1992 we had 1,904 CA-1 residents, of whom 1,609 were graduates of American medical schools. In the years 1996-99, the



numbers of American CA-1 graduates fell to only 641, 493, 496 and 617, respectively.

Despite the subsequent decline in recruitment, we have, in the last 10 years, actually trained an average of 1,360 residents per year. Surprisingly this is higher than the maximum level Abt Associates contemplated in their scenarios. Despite that, we are still experiencing a significant shortage of anesthesiologists. Of concern now is that we only graduated 1,333 in 2003; still fewer are expected to graduate this year, and there is little prospect of a significant increase in the foreseeable future.

What would have happened without the Abt report? A significant decline in recruitment would have occurred any-

way. Even before its publication, concern about oversupply was growing and had already reduced the supply of U.S. graduates. The Abt report, however, amplified our concerns. The anxiety, the delayed recruitment and the associated apparent oversupply inhibited recruitment for years. Without the report, however, our traditional efforts to attract U.S. graduates might have been better maintained, which, in 2004, would appear to have been preferable.

*Dr. Grogono's articles appeared in the ASA NEWSLETTER in August 1993, May 1994, June 1995 and then in each May from 1996 to 2004.*



## Defining Moments for ASA and the Ethics of Style

*Continued from page 6*

*al man and then sells his services to the public on a fee basis for the profit of the corporation ..."*

and

*"If and when a physician is found to be unethical, and he is still retained on the staff of any hospital approved for resident or intern training by the Council on Medical Education and Hospitals, it shall be the duty of the Judicial Council to request the Council on Medical Education and Hospitals to show cause as to why that Council should not remove such hospital from the approved list under the assumption that the hospital is just as unfit for the training of young physicians for unethical reasons."*

Thus the Hess Report was interpreted to say that salaried employment by a nonphysician entity was probably illegal and that the physician who accepted such an arrangement was unethical. In a letter to a prominent surgeon in 1952, anesthesiologist Henry K. Beecher, M.D., stated: "A good many prominent anesthesiologists have decided that it is unwise for any man to accept a salary from a 'lay corporation,' i.e., a hospital or a university. They are busily imposing this curious point of view. Their chief weapon is a threat that the young man will never be certified by the Board if he takes a salaried position."<sup>2</sup> In at least one case, board certification was removed, and in some instances, anesthesiologists were expelled from or denied membership in their state societies because they were paid by salary.<sup>3,4</sup>

Some of these positions seem ludicrous to us today. But in those times, there were no doubt instances in which the development of anesthesiology as we know it

was delayed because of a hospital's desire to fill its purse at the expense of the anesthetist. Yet in other situations, particularly within universities, the arrangement worked very well. As is perhaps obvious, the issue was ultimately resolved, and anesthesiologists may practice, belong to state societies and receive certification irrespective of their economic circumstances today.

Of course this list of "defining moments" is not all-inclusive, and thoughtful readers might well prefer to select others or additional ones. But whatever one's preference, we can all agree that during the century of our organization's existence, there have been important issues and events — some for good, some perhaps less so. We hope you enjoy and celebrate our anniversary and, especially, that you enjoy this issue. We also look forward to the defining moments during the next century of ASA's growth and development.

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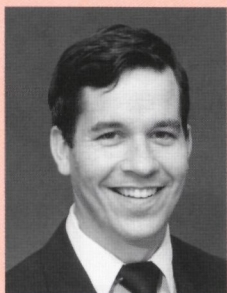
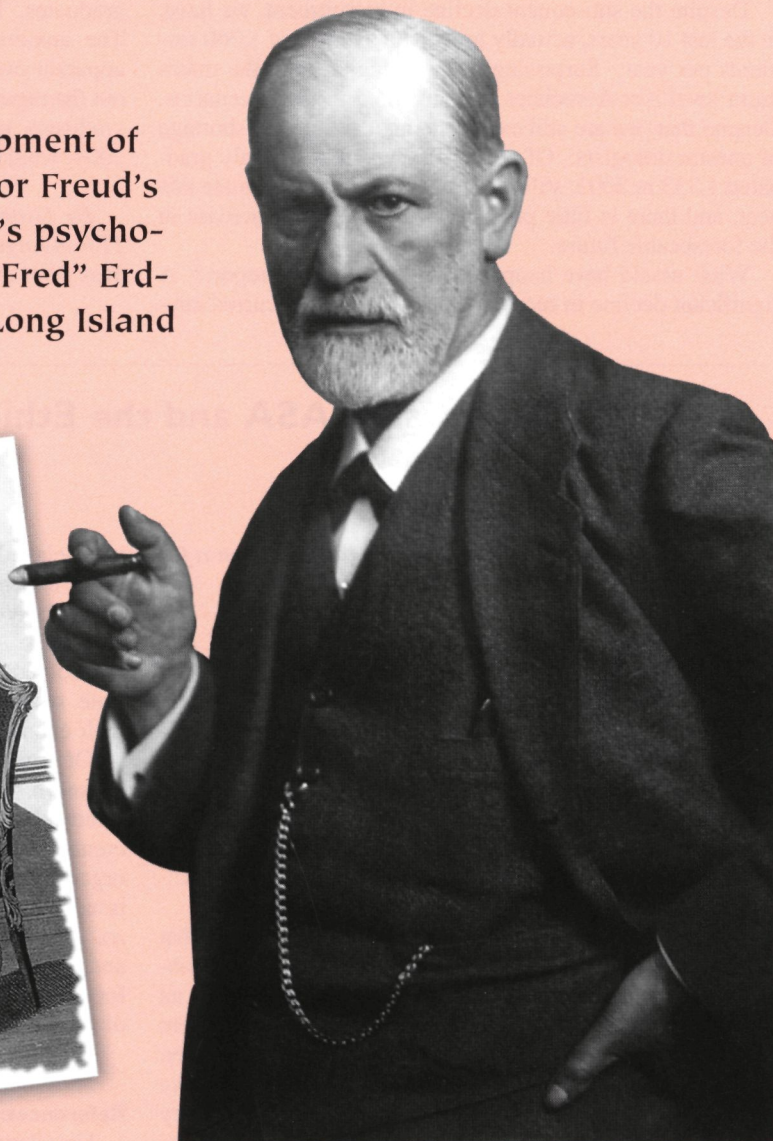




## ASA's Freudian Prelude: From Mesmerism to Cocaine

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

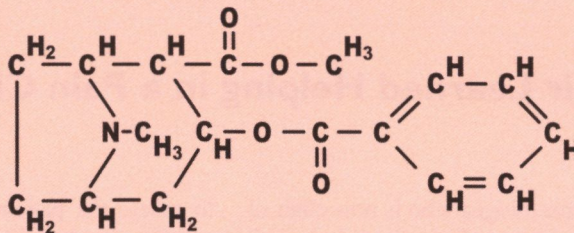
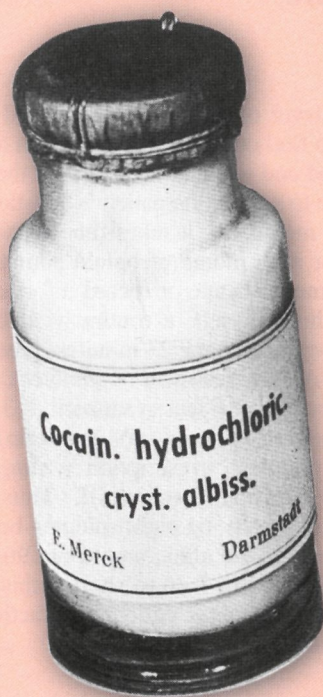
The year 1904 saw the development of Novocaine (as a replacement for Freud's cocaine); the penning of Freud's psychosexual theories; and the year "Fred" Erdmann began planning for the Long Island Society of Anesthetists.



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

Before promoting "free association" as talking therapy, Dr. Sigmund Freud (above) had tried mesmerizing patients with "animal magnetism." Perhaps recalling Freud and early hypnotists, today's anesthesiologist can make preoperative suggestions to allay patients' fears and even reduce their perioperative drug loads.





*Freud's letter to Koller*

Separatdruck aus Dr. Wittelshöfer's „Wiener Med. Wochenschrift.“  
(Nr. 5, 1885.)

### Beitrag zur Kenntniss der Cocawirkung.

Von Dr. SIGM. FREUD,

Sekundararzt im k. k. Allgemeinen Krankenhause in Wien.

Im Julihefte des von Dr. Heitler herausgegebenen Centralblattes für Therapie habe ich eine Studie über die Cocapflanze und deren Alkaloid Cocain veröffentlicht <sup>1)</sup>, welche auf Grund einer Prüfung der in der Literatur enthaltenen Berichte und eigener Erfahrungen dieses lang vernachlässigte Mittel der Aufmerksamkeit der Aerzte empfahl. Ich darf sagen, dass der Erfolg dieser Anregung ein unerwartet rascher und vollkommener war. Während Herr Dr. L. Königstein auf mein Ersuchen es unternahm, die schmerzstillende und sekretionseinschränkende Wirksamkeit des Cocains in krankhaften Zuständen des Auges zu prüfen, hat mein Kollege in diesem Krankenhause, Herr Dr. Karl Koller, unabhängig von meiner persönlichen Anregung, den glücklichen Gedanken gefasst, durch das Cocain, dessen abstumpfender Einfluss auf die Sensibilität der Schleimhäute seit Langem bekannt ist, <sup>2)</sup> eine vollständige Anästhesie und Analgesie der Cornea und Conjunctiva zu erzeugen, und hat fernerhin den hohen praktischen Werth dieser lokalen Anästhesie durch Thierversuche und Operationen am Menschen erwiesen. In Folge der darauf bezüglichen Mittheilung Koller's an den diesjährigen Kongress der Augenärzte zu Heidelberg ist das Cocain als lokales Anästhetikum zur allgemeinen Aufnahme gelangt.

In Fortsetzung meiner Studien über das Cocain habe ich nun versucht, die wunderbare Allgemeinwirkung dieses Alkaloids, welche in einer Hebung der Stimmung, der körperlichen und geistigen Leistungsfähigkeit und Ausdauer besteht,

<sup>1)</sup> „Ueber Coca“, Centralbl. f. d. ges. Therapie, II. Jahrgang, VII, Juli (nicht, wie vielfach fälschlich zitiert wurde: August) 1884.

<sup>2)</sup> Die siebente der von mir für den Gebrauch des Cocains aufgestellten Indikationen behandelt die örtliche Anwendung und schliesst mit den Worten: „Anwendungen, die auf der anästhesirenden Eigenschaft des Cocains beruhen, dürften sich wohl noch mehrere ergeben.“

86. Nr. 22.

Forsaking Freud's efforts to treat patients' depression and fatigue, co-worker Carl Koller (left) promoted cocaine instead as a local anesthetic for eye surgery. Freud saluted his colleague as "Coca Koller."



## 10 Things a Chair Learned Helping in a Pain Clinic

Raymond C. Roy, M.D., Ph.D.

I am a former cardiac anesthesiologist who is now chair of an academically strong department of anesthesiology with excellent physicians specializing in regional anesthesia, acute pain management and chronic pain medicine. Three years ago, I chased an experienced physician assistant (PA) away from our pain clinic by implying that she was not seeing enough patients. Rather than hire another PA, I took responsibility for one of the 10 pain clinic sessions per week. My goal was to acquire practical experience with chronic pain patients, pain clinic management and the economics of pain medicine in order to make better executive decisions regarding the clinic. Although I had no formal training in pain medicine, I naively reasoned that I knew more about it than a PA and that I could easily attend to more patients in one session than the PA could in two. The jury is still out on the former, but not on the latter.

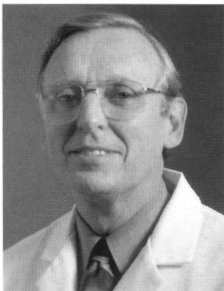
I have been doing this now for three eye-opening years. I see 12 to 16 patients per session, and my session tends to run late. I frequently schedule additional catch-up time in the clinic to keep the waiting list under control. All my patient visits are for evaluation and management (E&M) except for the occasional patient requiring triggerpoint injections. I refer patients who may benefit from invasive procedures to other physicians within the clinic. My learning curve is still very steep. When asked to write this article, my first step was to create a list of things I learned from my experience. I selected for discussion the 10 that were most significant from a management perspective.

**1. Four Patients Per Hour:** It is a challenge to see four patients per hour for routine evaluation of their pain medicine regimens or for follow up after interventional procedures. Part of the reason for this is that an assessment of a patient's activities of daily living (ADL) is as, or more, important than his/her physical examination. These assessments take time and are difficult to standardize. It takes time

to assess the patient's level of analgesia at rest and with activity. It takes time to find out whether he/she can afford to get prescriptions filled and whether he/she takes them as prescribed. It takes time to answer the patient's questions or those of his/her family members. It takes time to write a separate prescription for each month of opioid administration. Finally it takes time to dictate or record information. If I were to do everything myself, a routine visit by an uncomplicated patient would take me 23 minutes [greetings (1 minute), history and ADL assessment (4 minutes), analgesia assessment (2 minutes), physical examination (3 minutes), medication discussion (3 minutes), answering the patient's questions (2 minutes), prescription writing and review (5 minutes) and dictation (3 minutes)]. Thus after the first patient, I would already be eight minutes behind, and at the end of the session, the clinic would run 96 minutes late. Almost everything that I do to shorten this time either increases overhead, decreases patient satisfaction or jeopardizes quality of care.

**2. Ideal Care:** We are not providing the ideal care. For most patients with pain, providing analgesia should be part of a comprehensive approach that includes counseling, physical and occupational therapy, biofeedback, diet control, sleep assessment or psychiatric help. Managing all this takes time and training that the pain medicine physician frequently does not have and resources that neither the clinic can afford to add to its overhead, nor the insurance cover nor the patient pay for out of his/her pocket. In most cases, our current therapeutic goal is not to eliminate pain, as it should ideally be, but to control pain sufficiently to enable patients to cope, stay out of emergency rooms, satisfy their insurance carrier and to not call the clinic between visits.

**3. Work Hard, Lose Money:** Pain clinics are a low-margin business unless they are a boutique practice or only perform interventional procedures. Anesthesiologists who specialize in pain medicine frequently collect more than an operating room anesthesiologist, but operating room anesthesiologists do not have the burden of a clinic's overhead. For pain clinics to break even, continuous adjustments need to be made to the patient/payer mix, the ratio between E&M visits and procedures, the number of patients enrolled in studies and billing, coding, contracting, collecting and overhead costs. In most academic medical centers, these interrelationships are metastable. I am not as optimistic as I would like to be that pain clinics can survive in academic medical centers because the overhead is too high, the patient/payer mix too adverse, the dean's tax too onerous



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and the collection systems too unresponsive. We may find it necessary to outsource this care and training.

**4. Clinic Over, Work Not Done:** When most anesthesiologists complete the surgical schedule, they are satisfied that their work is done. When pain medicine physicians see their last clinic patient, they still have dictation demands, charts to review, telephone calls from patients and pharmacies to answer, consults to see, letters to write to referring physicians, disability forms to complete, insurance and medication inquiries to answer and a higher likelihood of medical-legal inquiries to address.

**5. Referring Physicians:** Referring surgeons, oncologists and primary care physicians frequently demonstrate an enormous reluctance to prescribed drugs for which you cannot circle refills, i.e., you must write out a separate prescription for each 30 days. Referring surgeons will go to great lengths to convince the patient and the pain medicine physician that it is the pain medicine physician who must prescribe opioids. Much of their reluctance is understandable. Unless pain clinic physicians make it very clear up front that the patient will return to the referring physician once a stable pain management regimen is established, however, there will be two undesirable consequences. First, the patient will begin to view the pain medicine physician as his/her primary care physician, a role for which the pain medicine physician is not adequately trained. Second, the delicate balance between E&M and interventional visits will be upset, and the clinic will lose money.

**6. Patient Satisfaction:** The percent of patients satisfied with their anesthesia is much higher than the patients who are satisfied with their analgesia. Chronic pain patients are more demanding, more manipulative and more dissatisfied with their lives than surgical patients. They challenge our professionalism more. When evaluating the clinical performance of faculty members, I cannot weigh complaints from chronic pain patients about their anesthetic experience the same way that I weigh complaints from surgical patients.

**7. Substance Abuse:** If you think the profile of a person who abuses opioids is someone between the ages of 16 and 40, poorly educated, poorly dressed with weird hair and poor personal hygiene, unemployed and with tattoos and body piercings, it would not take long in a typical university pain clinic before you recognized that abuse is not limited by age, gender, race, education, economic status or concern for personal appearance. If you think that pain clinic patients never sell or trade any of the opioids they are prescribed because they hurt so much, you also are in for a surprise. One of the reasons why pain clinic visits cannot be too abbreviated is because time must be spent with patients

evaluating their social situations and following up on suspicious behavior such as involvement in frequent accidents, losing prescriptions, requesting early prescription renewals, trying medications prescribed for their friends or family and escalation of their pain scores. There is a fine line between trusting your patients so that a reasonable analgesic regimen can be established, being suspicious that demands for more opioids may reflect abuse or dealing, and giving people the benefit of the doubt. Some patients need oxycodone 80 mg by mouth four times a day, while others requesting 20 mg twice a day should not get it. Some patients can be trusted with medication for breakthrough pain while others cannot.

**8. Physician Satisfaction:** I look forward to seeing most of my patients on return visits. They are basically good people who are just trying to lead reasonably normal lives. A bond is established when you demonstrate commitment to helping them do this. When you succeed, there is enormous positive feedback and reinforcement. Pain medicine physicians do improve the quality of life of most of their patients.

**9. Physician Frustration:** There is too much about pain that I do not understand. I have yet to get a handle on fibromyalgia, myofascial pain or headaches. I have deluded myself into thinking that I understand enough about acute pain and such chronic pain conditions as osteoarthritis, failed laminectomy syndromes and herpes zoster-associated pain to be comfortable treating these conditions. In between are the complex regional pain syndromes and diabetic neuropathy. When I go to the literature for help, the best I can hope for is consensus opinions. There are too few good clinic studies evaluating either interventional or medical chronic pain treatment regimens. Pain medicine has a long way to go before it becomes as evidenced-based as I think pain physicians would like it to be. I also think we rely too much on our traditional anesthesiology journals for help and not enough on contributions from genomics, neurology, neurosciences, neurosurgery, nursing, oncology, orthopedic surgery, pharmacology, physical medicine and rehabilitation, psychiatry, radiology and rheumatology. Pain medicine is multidisciplinary.

**10. Future:** I think it is more important than ever for anesthesiology to find ways to invest in pain medicine. Basic research on mechanisms, translational research on drugs and pain assessment and clinical research on interventions and treatment protocols are needed. We are relying too much on opioids, which I believe will be considered gross and inelegant medications in the next century. We must develop systems that will enable us to treat pain in a way that payers can afford, patients can accept and appreciate and in which pain medicine physicians can have job satisfaction and make a reasonable living. Our current system is barely holding itself together.



## USVA Committee Develops New Military Component Society

Paul D. Mongan, M.D., Chair  
Committee on Uniformed Services and Veterans Affairs

**T**he Committee on Uniformed Services and Veterans Affairs (USVA) is made up of ASA members with strong ties to the Veterans Affairs (VA) committee and the Department of Defense (DOD), which includes the Army, Navy and Air Force. The main goal of the USVA committee is to provide an avenue for communication for ASA and the anesthesiologists who work in VA and DOD facilities to enhance the practice of anesthesiology. The two major issues that this committee has focused on in the past five years have been the controversy of independent practice of

**“Since 1990, active-duty anesthesiologists have decreased from just over 600 to roughly 225.”**

nurse anesthetists and creating a component society for active-duty military anesthesiologists. Though these two issues may seem unrelated, the first stressed the dire need for the second.

The military has undergone dramatic changes in the past decade. One of the major changes has been the decrease in size of the active duty force, including a dramatic reduction in active-duty anesthesiologists. Since 1990, active-duty anesthesiologists have decreased from just over 600 to roughly 225. In the late 1990s, this reduction created a crisis as there were not enough anesthesiologists to staff all the military hospitals and support the care team model in every military hospital. In response the Navy implemented a universal policy of independent practice for nurse anesthetists for ASA Physical Status 1 and 2 patients, and the Army quickly followed. The response from individual anesthesiologists was exceptional, but it was uncoordinated and inef-

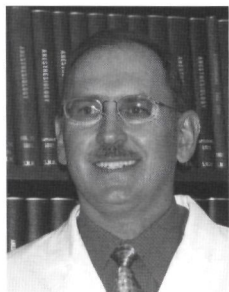
fective, and the nurse anesthetist policies were implemented. The lack of a coordinated response was reinforced when follow-up from anesthesiology specialty leaders in the Army and Navy at USVA meetings was instrumental in the Air Force not adopting a policy of independent practice. To capitalize on this opportunity for coordinated effort, from 2001 until 2003, Thomas H. Cromwell, M.D. (former ASA Secretary), Alvin R. Manalaysay, M.D., Ph.D., (former USVA committee chair), Lynn M. Broadman, M.D., (USVA committee member), Peter L. Hendricks, M.D., (ASA Secretary) and others paved the way for forming a component society for military anesthesiologists.

Military anesthesiologists have always been a geographically diverse group with few ties to the state component societies. Subsequently, few joined state societies, and less than 10 were active members of ASA in the past 20 years. In addition the military anesthesiology community is young with 80 percent less than five years out of residency and 95 percent less than 10 years out of residency. These factors, coupled with the increased practice of isolation, showed that the number who joined ASA as affiliate members had dwindled to less than 50 percent (2002 USVA committee survey). Members of the USVA committee and the military community worked diligently, and by early 2003, bylaws were drafted that were approved by ASA.

The Uniformed Services Society of Anesthesiologists (USSA) was officially chartered as a component society in October 2003. In anticipation of this event, members of the armed forces planned an inaugural meeting for USSA on October 10, 2003, at the San Francisco Hilton before the start of the 2003 ASA Annual Meeting. Despite deployments secondary to Afghanistan and Iraq and the need to provide clinical care at respective hospitals, the inaugural meeting was a huge success with 44 active-duty anesthesiologists attending. The professional interaction of that one event reinforced the need to work collaboratively and has helped to add 54 new active USSA/ASA members in only six months. In that time, USSA members have worked collaboratively on issues ranging from deployment concerns for recent graduates in the board-certification process to common equipment development issues and improving business practices to maintaining effective oversight of the medical practice of anesthesiology in all military hospitals.

Although reversing independent practice policies in the

*Continued on page 35*



Paul D. Mongan, M.D., is Associate Professor and Chair, Department of Anesthesiology, The Uniformed Services University, Bethesda, Maryland. He is a Lieutenant Colonel in the U.S. Marine Corps.



## Anesthesia Machine Obsolescence Guidelines Published

Jerry A. Dorsch, M.D.  
Committee on Equipment and Facilities

**T**he Committee on Equipment and Facilities has developed guidelines for determining if an anesthesia machine is obsolete and therefore not be used.

The following is an abbreviated version of the guidelines. The complete text is available on the ASA Web site at <[www.ASAhq.org/publicationsAndServices/machineobsolescence.pdf](http://www.ASAhq.org/publicationsAndServices/machineobsolescence.pdf)>. Please share these guidelines with your colleagues and government and credentialing organizations, especially those that regulate office surgery.

### Guidelines for Determining Anesthesia Machine Obsolescence

The following guidelines have been developed to assist anesthesia providers and other health care personnel, administrators and regulatory bodies in determining when an anesthesia machine is obsolete. Anesthesia equipment can become obsolete if essential components wear out and cannot be replaced. Equipment also may become obsolete as a result of changes in medical practices, changes in the training and experience of anesthesia providers and/or development of new safety features.

An anesthesia machine should not be considered obsolete solely because it has reached an arbitrary age. Furthermore a machine should not be expected to meet all of the performance and safety requirements specified in United States or international equipment standards published after the machine was manufactured. It is the responsibility of the anesthesia provider to determine if a machine's failure to meet newer standards represents a sufficient threat to patient safety to render the machine obsolete.

The ASA Standards for Basic Anesthetic Monitoring <[www.ASAhq.org/publicationsAndServices/standards/02.pdf#2](http://www.ASAhq.org/publicationsAndServices/standards/02.pdf#2)> apply to all anesthesia care. The equipment necessary to accomplish this monitoring may be integral to the anesthesia machine or separate from it. The criteria for defining obsolescence that are described in this document relate only to the gas and vapor delivery portion of the machine. Integral monitors (e.g., electrocardiograph, oxygen monitor, blood pressure monitor, pulse oximeter, carbon dioxide monitor) should be considered separately and are not addressed in these guidelines.

These guidelines apply only to existing machines and are not intended to unduly restrict the design of machines in the future. It is recognized that future machines may incorporate different safety mechanisms than those in use today to accomplish the same goals.

The guidelines are divided into absolute and relative criteria. Only the absolute criteria are presented here. If any of

***“An anesthesia machine should not be considered obsolete solely because it has reached an arbitrary age.”***

these criteria are present, the machine is by definition obsolete. The relative criteria are related to practice conditions. These relative criteria and the rationale for all the criteria can be found on the ASA Web site links mentioned above. These criteria should be shared with all component societies and other groups interested in anesthesia machine safety.

### Absolute Criteria

An anesthesia machine shall be considered to be obsolete if any of the following criteria apply:

#### I. Lack of essential safety features

- A. Minimum oxygen ratio device ( $O_2/N_2O$  proportioning system) on a machine that can deliver nitrous oxide;
- B. Oxygen failure safety (“fail-safe”) device;
- C. Oxygen supply pressure failure alarm;
- D. Vaporizer interlock device;

**Note:** This does not apply to an anesthesia machine that allows only one vaporizer to be mounted at a time.

**Note:** It may be possible to add a vaporizer interlock device to a machine.

- E. Pin Index Safety System;
- F. Noninterchangeable, gas-specific (e.g., Diameter Index Safety System [DISS]) connectors on the gas pipeline inlets.



Jerry A. Dorsch, M.D., is Associate Professor Emeritus, Mayo Clinic, Jacksonville, Florida.



## II. Presence of Unacceptable Features

A. Measured flow (flowmeter-controlled) vaporizers (e.g., Copper Kettle, Verni-trol);

B. More than one flow control knob for a single gas delivered to the common gas outlet of the machine;

**Note:** This does not include the flow control knob for an auxiliary oxygen flowmeter.

C. Vaporizer with rotary concentration dial such that the anesthetic vapor concentration increases when the dial is turned clockwise;

**Note:** It may be possible to replace an unacceptable vaporizer without replacing the entire machine.

D. Connection(s) in scavenging system of the same (i.e., 15-mm or 22-mm) diameter as a breathing system connection.

**Note:** It may be possible to replace an unacceptable scavenging connection without replacing the entire machine.

## III. Adequate Maintenance No Longer Possible

The manufacturer or certified service personnel will not or cannot service the machine with acceptable replacement parts so that it performs within the tolerances to which it was originally designed.

**Note:** Although a manufacturer may declare that its own subsidiaries will no longer service, support or

certify a particular machine, the essential core components of the machine may still be serviceable.

**Note:** Obtaining acceptable replacement parts can be a problem. In some cases, it may be possible to obtain the parts from the party who supplied them to the machine manufacturer. Alternatively such parts may be obtained from machines that have already been taken out of service.

**Note:** When a manufacturer declares that it will no longer provide support for a machine, responsibility is typically transferred to the user (health care facility) and/or the third party who services the machine.

When it has been determined that a machine is obsolete, it should not be placed somewhere in the facility where it might be used clinically (for example, as an oxygen delivery device). A machine that has been determined to be obsolete should either be destroyed or donated to a worthy party (e.g., zoo, laboratory or developing country). If the latter course is followed, it would be prudent to obtain legal advice about potential liability relating to the donation. Also it is prudent to ensure that the recipient possesses the infrastructure (e.g., electrical power, medical gases), access to drugs and supplies (e.g., volatile anesthetics, circuits, replacement parts), technical expertise and training to safely use the machine.

## Administrative Update: ASA Budgets

*Continued from page 2*

mendation is sent to the August meeting of the Board of Directors. Final approval, based on ASA Bylaws, is given by the House of Delegates at the Annual Meeting in October.

### Ironing Out the Kinks

One would think that after going through this long process, the budget tinkering would be completed. Further modifications of the budget, however, can occur during the budgeted year by the approval of new expenses from recommendations sent to the March and August Board of Directors meetings. In the past five years, there have been significant emergency allocations required for patient safety initiatives and public awareness programs that were not anticipated at the time of the original budget formulation. The conservative approach of the Budget

Committee in the estimates of income and realistic estimates of expenses, though, usually provides enough of a buffer so that, by the end of the year, ASA remains in the black.

I hope this description has provided the ASA membership with a sense of the extremely detailed way in which ASA deals with its budgetary projections to provide fiscal oversight and solvency for our great Society. In regard to whether the process could be considered a fanciful journey or a well-thought-out trip, I think the answer is, it is a little of both! Attempts have been made in the past few years to strengthen the scientific basis upon which decisions are made in the fiscal affairs of ASA. Even with the best of intentions, though, the budget is a fluid document that cannot be maintained by rigid and exact constraints.



*Following up on their development of a spreadsheet program for calculating operating room (O.R.) utilization, which was the subject of this column in June 2004 and is available on the ASA Web site, Joseph Laden, Michael J. Monea, W. David Ackley, Care H. Costantini, M.D., and Robert Ison (programming), of the Kentucky/Ohio Anesthesia Managers Association (KOAMA) defined a method to determine the cost of inefficient O.R. utilization. They describe the method and its associated spreadsheet program, also downloadable, below.*

*Users should note that neither ASA nor KOAMA makes any representation regarding the benefits or accuracy of the spreadsheet and that we are not able to provide any user support.*

**P**rior to presenting the new spreadsheet, we would like to make several observations.

### **Reasonable Utilization Rates**

An anesthesiology group must be realistic in its expectations regarding utilization rates. A 100-percent efficiency level is not achievable. Experts consider a range of 75 percent to 85 percent to be the maximum attainable utilization rate. This number is arrived at for a number of reasons, including the fact that unforeseen events may affect the efficiency of the schedule. The reasons can include the following:

1. The case finishes early, and the next case cannot be moved up;
2. The patient has an unanticipated medical problem; and
3. There are planned gaps between cases by different surgeons to allow for over-runs and to avoid delaying the start of the next case.

Conversely unacceptably low levels of utilization can be created by:

1. Hospital demands for extensive and open block time, much of which may remain unused, to attract surgeons;
2. Late arrival of personnel, patient and/or surgeon;
3. Equipment, medication and supply delays;
4. Missing labs and reports;
5. Uneven scheduling, i.e., heavy in the morning and very late afternoon; and
6. O.R nurse shortage.

## **The Cost of Inefficient O.R. Utilization**

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

### **Calculating the Cost of Inefficiency**

How do you quantify the cost of inefficiency so as to determine the levels that are acceptable to you and your institution? We have reviewed a number of methods, including:

1. Calculate the hourly cost of staffing by taking the total yearly expenses of the group (anesthesiologist and nurse anesthetist salaries and benefits, billing and administrative expenses, etc.) and dividing this amount by the total number of billed hours for that year. In our opinion, a problem with this sys-

tem is the fact that it would artificially inflate total expenses due to an inefficient schedule. Specifically, if the hospital was allowing the O.R. suite to run more efficiently, it might not be necessary for the group to employ as many clinicians.

2. Calculate total income and divide that figure by the number of billed hours. This amount is then multiplied by the number of available hours not utilized in the O.R. and represents theoretical income that could be used to cover real expenses. It is, in essence, the unacceptable cost (from our perspective) of doing business. This is the method we utilize and that the spreadsheet will calculate.

### **Total Income — What Is Included?**

There are many groups that receive subsidies and stipends from hospitals to provide services. These subsidies can include, but are not necessarily limited to: compensation for call coverage, stipends for medical director activities, compensation for differences between the cost of locum tenens and the group's own providers, or subsidies due to poor payer mix. In calculating total income, we recommend that the anesthesiology group include only the income received that is related to providing surgical and/or obstetrical anesthesia services. For example a stipend to cover expenses because of a poor payer mix would probably be included. Income received for activities associated with medical director responsibilities might be excluded.

### **Determining the Optimal Utilization Rate**

Recognizing that 100-percent efficiency is impossible and impractical, what is a reasonable utilization rate for your practice? Our answer is to calculate the O.R. utilization rate of a sample of the busiest O.R. schedules of the past year. For example if your utilization rate on these busy days was 70 percent, you could assume that this rate is achievable on a consistent basis. If you have determined that the average utilization rate for the previous year was 61.5 percent, then



Table 1. O.R. Utilization Rate

O.R. UTILIZATION FOR ANESTHESIA											
A	B	C	D	E	F	G	H	I	J	K	L
I N P U T									Enter OR Hour-Blocks		
Hospital Or Variation	Start Date	Stop Date	Holidays Within Time Frame	% After-Hour Week-End	Room Turnover Time	Total Cases For Period	Total Minutes For Period	Total Overtime Hours	8 Hr Rms	Hr Rms	Hr Rms
Hosp/Var #1	1/1/2003	12/31/2003	6	0.24	20	9,389	1,304,305	0	14		
Hosp/Var #2											
Hosp/Var #3											
Hosp/Var #4											
Hosp/Var #5											
Hosp/Var #6											

Basic data on the use of O.R. time yields a 62-percent utilization rate, as described fully in the "Practice Management" column on page 17 of the June 2004 ASA NEWSLETTER.

A	B	C	D	E	F
R E S U L T S					
Hospital Or Variation	Total O.R. WeekDays	Total Available OR Hours	Utilization Percentage	Rooms Not Used	Daily Additional Cases
Hosp/Var #1	255	28,560	62.01%	5.32	17.14
Hosp/Var #2	0	0	0.00%	0.00	0.00
Hosp/Var #3	0	0	0.00%	0.00	0.00
Hosp/Var #4	0	0	0.00%	0.00	0.00
Hosp/Var #5	0	0	0.00%	0.00	0.00
Hosp/Var #6	0	0	0.00%	0.00	0.00
<b>TOTAL:</b>	255	28560		5.32	17.14

you might assume that the facility is running at an 8.5-percent inefficiency level.

The utilization rate of the busiest days can be unacceptably low, however, by local and industry standards. If your research indicates that an 80-percent efficiency rate is the more reasonable level, then, using the example above, the inefficiency level is actually 18.5 percent.

### Using the O.R. Utilization Cost Spreadsheet

We will illustrate the O.R. Utilization Cost Spreadsheet through the O.R. utilization percentage rate spreadsheet that accompanied the June 2004 NEWSLETTER article [Table 1].

Table 1. O.R. Utilization Rate

Adding some information from the group's billing data, we produce a dollar figure for the potential additional revenue that could be realized, as shown in the last column in the new spreadsheet appearing in Table 2A and Table 2B. (Note: For those of you who enjoy reviewing such things, we have included in the downloadable file a worksheet [ORUE tab] that defines the new spreadsheet's formulae.)

### Table 2A and Table 2B. The Cost of a Low Utilization Rate

- **Column EI:** During the time period selected, 24 percent of all services were performed after hours. After-hours O.R. use is excluded from the core hours utilization rate.
- **Column II:** The income of \$6.6 million is the total received for services performed; 24 percent of the \$6.6

million is deducted in the calculations in the Results Table [Table 2B]. The O.R. management stipend paid to the group by the hospital is not included.

- **Column NI:** Based upon discussions with the hospital and a review of the literature, the group felt that a utilization rate of 75 percent for this facility was reasonable.

### Results Table [Table 2B]

- **Column DR:** The utilization rate for the facility was 62.01 percent on average during the eight-hour time frame examined. What does this mean for the hospital and the anesthesiology practice?
- **Column FR:** Specifically, at a utilization rate of 62.01 percent, there are, in theory, 2.43 O.R.s not being used at any one time during the eight-hour day. (To see that this is correct, reduce the number of eight-hour rooms in Table 2A, Column KI from "14" to "12." The utilization rate moves very close to the ideal of 75 percent.)
- **Columns GR, HR and IR:** Based upon this group's average time per case [Column HR] (calculated by dividing total billed minutes for the period by total cases), the hospital could theoretically schedule 5.86 additional cases per day in these rooms. For the group's historical mix of long cases requiring long turnover times (e.g., cardiac surgery) and short cases requiring



**Table 2A : The Cost of a Low Utilization Rate**

Adding revenue data plus an ideal utilization rate produces the potential revenue not earned.

INPUT TABLE													
AI	BI	CI	DI	EI	FI	GI	HI	II	JI	KI	LI	MI	NI
Hospital OR Variation	Start Date	Stop Date	Holidays Within Time Frame	% After-Hour Week-End	Room Turnover Time	Total Cases For Period	Total Minutes For Period	Period O.R. Revenue	Total Overtime Hours	Enter OR Hour-Blocks			Ideal Room Utilization
										8 Hr Rms	10 Hr Rms	Hr Rms	
Hosp/Var #1	1/1/2003	12/31/2003	6	0.24	20	9,389	1,304,305	\$6,600,000	0	14			75%
Hosp/Var #2													
Hosp/Var #3													
Hosp/Var #4													
Hosp/Var #5													
Hosp/Var #6													

**Table 2B: The Cost of a Low Utilization Rate — Results Table**

RESULTS TABLE									
AR	BR	CR	DR	ER	FR	GR	HR	IR	JR
Hospital OR Variation	Total OR WeekDays	Total Available OR Hours	Utilization Percentage	OR's Unused 100% Utilization	OR's Unused At Ideal	Daily Extra Cases At Ideal	Potential Billable OR Hours	Hourly Revenue Rate	Potential Billable Revenue
Hosp/Var #1	255	28,560	62.01%	5.32	2.43	5.86	3461	\$303.61	\$1,050,871
Hosp/Var #2	0	0	0.00%	0.00	0.00	0.00	0	\$0.00	\$0
Hosp/Var #3	0	0	0.00%	0.00	0.00	0.00	0	\$0.00	\$0
Hosp/Var #4	0	0	0.00%	0.00	0.00	0.00	0	\$0.00	\$0
Hosp/Var #5	0	0	0.00%	0.00	0.00	0.00	0	\$0.00	\$0
Hosp/Var #6	0	0	0.00%	0.00	0.00	0.00	0	\$0.00	\$0
TOTAL:	255	28560		5.32	2.43	5.86	3461	\$303.61	\$1,050,871

frequent but shorter turnover times (e.g., tonsillectomies), 5.86 additional cases per day would generate 3,461 additional billable hours.

**Note:** Potential Billable O.R. Hours [Column IR] reflect the following:

- The 2.43 O.R.s unused even at the greatest efficiency level (Column FR) are still idle 25 percent of the time; and
- Turnover of 20 minutes per case.

This unused capacity represents the time during which the anesthesiology group (and for that matter, the hospital, too) is incurring expense without generating income.

- Columns JR and KR:** At a calculated rate of \$303.61 per hour (which factors in turnover), the group could potentially generate more than \$1 million in additional income if the hospital had sufficient cases to bring utilization up to 75 percent.

### Negotiating With the Hospital

The group is now in a position, using the spreadsheet and establishing that a 75-percent utilization rate would be acceptable while a 62-percent rate is not, to ask the hospital either to provide financial support to compensate for the

inefficiency or to change the number of O.R.s that the group is expected to staff.

A hypothetical outcome of the negotiations might be as follows:

- The hospital reduces the total number of O.R.s that must be staffed by anesthesia personnel from 14 to 12. Two sites, however, become 10-hour rooms.
- The hospital commits to decreasing turnover time from 20 minutes to 15 minutes.

The impact of these changes is shown on the row headed "Hosp/Var #2 in Table 3 on page 32.

- Unused O.R.s, even at the ideal room utilization level, drop from 2.43 to 1 (Column FR). This means that at any given time during the day, at least one O.R. is available for a surgeon to add on a case at the last minute.
- Potential billable revenue (Column KR) for the anesthesiology groups decreases by more than \$500,000, but actual income, of course, remains the same.
- The reduction in the number of rooms that must be staffed allows the practice to release two locum tenens providers at a potential savings of \$400,000 or more per year.

*Continued on page 32*



**Table 3. A Negotiated Increase in Efficiency**

INPUT TABLE												
AI	BI	CI	DI	EI	FI	GI	HI	II	JI	Enter OR Hour-Blocks		
Hospital OR Variation	Start Date	Stop Date	Holidays Within Time Frame	% After-Hour Week-End	Room Turnover Time	Total Cases For Period	Total Minutes For Period	Period O.R. Revenue	Total Overtime Hours	8 Hr	10 Hr	Ideal Room Utilization
Hosp/Var #1	1/1/2003	12/31/2003	6	0.24	20	9,389	1,304,305	\$6,600,000	0	14		75%
Hosp/Var #2	1/1/2003	12/31/2003	6	0.24	15	9,389	1,304,305	\$6,600,000	0	10	2	75%
Hosp/Var #3												
Hosp/Var #4												
Hosp/Var #5												
Hosp/Var #6												

If the hospital reduces turnover time and the number of rooms, the increased efficiency can create significant savings.

RESULTS TABLE									
AR	BR	CR	DR	ER	FR	GR	HR	IR	JR
Hospital OR Variation	Total OR WeekDays	Total Available OR Hours	Utilization Percentage	OR's Unused 100% Utilization	OR's Unused At Ideal	Daily Extra Cases At Ideal	Potential Billable OR Hours	Hourly Revenue Rate	Potential Billable Revenue
Hosp/Var #1	255	28,560	62.01%	5.32	2.43	5.86	3461	\$303.61	\$1,050,871
Hosp/Var #2	255	25,500	68.78%	3.75	0.99	2.53	1493	\$303.61	\$463,237
Hosp/Var #3	0	0	0.00%	0.00	0.00	0.00	0	\$0.00	\$0
Hosp/Var #4	0	0	0.00%	0.00	0.00	0.00	0	\$0.00	\$0
Hosp/Var #5	0	0	0.00%	0.00	0.00	0.00	0	\$0.00	\$0
Hosp/Var #6	0	0	0.00%	0.00	0.00	0.00	0	\$0.00	\$0
TOTAL:	510	54060		9.06	3.42	8.39	4954	\$607.22	\$1,504,108

This outcome is a classic win-win situation for both the hospital and anesthesiology group. At the very least, the hospital lowers its overhead by no longer having to keep two O.R.s running while maintaining its capacity to provide service at the same level as before with continued room to grow. The anesthesiology group saves on the cost of clinical personnel.

The ability of this new spreadsheet to create, review and check various options has been, for us, significant. We hope that our friends in the specialty will find it equally helpful.

## Certification in Anesthesiology

*Continued from page 14*

**Subspecialty Certification:** Subspecialty certification was and continues to be a controversial area for anesthesiologists and has provided for considerable deliberation by ABA. The two subspecialty areas that have thus far been granted certification status by ABA with approval by the ABMS to include training, credentialing and written examination components have been critical care medicine in 1986 and pain management in 1993. These two areas were felt by ABA to justify a certification process based on the multidisciplinary nature of the subspecialty and the need to maintain an equitable presence for its Diplomates as other primary boards moved to gain similar subcertification for their diplomates.

As with other specialties of medicine, the certification processes for anesthesiology have undergone considerable revision since their beginnings in 1931. As a young specialty now preparing to celebrate the 100th anniversary of its national organization, anesthesiology has made marked progress and gained considerable respect from other member boards for the thoughtfulness and thoroughness that ABA has put into continuously improving its certification processes to ensure that it fulfills its responsibilities to its candidates, Diplomates, the specialty of anesthesiology, the medical profession and the public.





## Scope-of-Practice Issues Heard in the Courts

S. Diane Turpin, J.D.

Associate Director of Governmental Affairs

**N**urse anesthetists continue to file legal challenges to office-based surgery regulations throughout the country. **Florida** has seen more than its share of such litigation.

In a recent decision by the 4th District Court of Appeal, the court held that the Board of Medicine's regulation requiring that an anesthesiologist supervise the administration of anesthesia in Level III cases in the office setting exceeded the board's authority. Level III cases are those defined as using general anesthesia or major conduction anesthesia and preoperative sedation. In a prior case in the 1st District Court of Appeal, the court upheld this same provision. The conflict over this provision has continued although the board will review a surgeon's petition for a waiver or variance from the rule. The regulation states, "If the anesthesia provider is not an anesthesiologist, there must be a licensed M.D. or D.O. anesthesiologist, other than the surgeon, to provide direct supervision of the administration and maintenance of anesthesia." The board published guidelines in 2002 to be used to evaluate a surgeon's ability to supervise the administration of anesthesia. These guidelines and the complete text of the office-based surgery regulation may be found at <[www.ASAhq.org/Washington/oba-fl.pdf](http://www.ASAhq.org/Washington/oba-fl.pdf)>.

Litigation brought by nurse anesthetists over physician supervision requirements continues in **Illinois**, **New Jersey** and **North Carolina**.

Litigation brought by an anesthesiologist assistant (AA) against the State Medical Board of **Ohio** challenging the scope of practice for AAs has been resolved, at least initially, in favor of the AA. In 2000 the Ohio legislature passed legislation to license AAs and establish a scope of practice. The scope of practice as set forth in Ohio Revised Code Section 4760.09 reads as follows:

If the practice and supervision requirements of section 4760.08 of the Revised Code are being met, an anesthesiologist assistant may assist the supervising anesthesiologist in developing and implementing an anesthesia care plan for a patient. In providing assistance to the supervising anesthesiologist, an anesthesiologist assistant may do any of the following:

- Obtain a comprehensive patient history and present the history to the supervising anesthesiologist;
- Pretest and calibrate anesthesia delivery systems and monitor and obtain and interpret information from the systems and monitors;
- *Assist* the supervising anesthesiologist with the implementation of medically accepted monitoring techniques; [emphasis added]

- Establish basic and advanced airway interventions, including intubation of the trachea and performing ventilatory support;
- Administer intermittent vasoactive drugs and start and adjust vasoactive infusions;
- Administer anesthetic drugs, adjuvant drugs and accessory drugs;
- *Assist* the supervising anesthesiologist with the performance of epidural anesthetic procedures and spinal anesthetic procedures; [emphasis added]
- Administer blood, blood products and supportive fluids.

The medical board incorporated these provisions as written above in its regulations. The medical board regulations also contained the following provision (Section 4731-24-04[B]) at the heart of the litigation:

Nothing in this chapter of the Administration Code of Chapter 4760 of the Revised Code shall permit an anesthesiologist assistant *to perform* any anesthetic procedure not specifically authorized by Chapter 4760 of the Revised Code, including epidural and spinal anesthetic procedures and invasive medically accepted monitoring techniques. For purposes of this chapter of the Administrative Code, "invasive medically accepted monitoring techniques" means pulmonary artery catheterization, central venous catheterization and all forms of arterial catheterization with the exception of brachial, radial, and dorsalis pedis cannulation. [emphasis added]

The AA argued essentially that the language in the regulation prohibiting AAs from "performing" epidural and spinal anesthetic procedures and invasive, medically accepted monitoring techniques was in conflict with the statutory language that permits AAs to "assist" with epidural and spinal anesthetic procedures and invasive, medically accepted monitoring techniques.

Ignoring the question of why the legislature chose to use the term "assist" with respect to two of the eight items specified as being within the AA's scope of practice, the court focused on the legislature's failure to specifically prohibit AAs from performing these procedures. The court also latched on to the training requirements as set forth in the statute that referred to the training requirements of the AA program necessary for an AA to be certified. These programs included clinical experience in the areas of

*Continued on page 39*



## Stress Management: Peeking Out of the Koala's Pouch

Jessie A. Leak, M.D.  
Committee on Communications

**Marsupial:** a mammal having no placenta and bearing immature young that are developed in a pouch on the mother's abdomen.

— *Encarta Dictionary*

*There is no failure except no longer trying. There is no defeat except from within, no really insurmountable barrier save our own inherent weakness of purpose.*

— Ken Hubbard

**H**ow many of us walk out to our nice vehicles at the end of a long work day and can honestly say in the moment, "This has been a *great* day"? The reality is that we generally walk or drift through the day on autopilot, doing our jobs (to the best of our ability), often daydreaming during a long case or a meeting about our next day off. The days run together, and in the totality, we know that time seems to be going faster; we feel recurrent panic because the years seem to be getting shorter and shorter. We know that we need to explore why we periodically feel a deep hole in our lives. Nothing seems particularly wrong. If we are religious or spiritual, we may step back, count our blessings and expeditiously relegate the emptiness out of our minds. Nonetheless we sometimes wonder to ourselves: "Is this all there is?"

But every now and then, we have a glimpse that we could be more active participants in our lives and that every day could be great. This concern may contribute to our long-term, low-level stress. The problem is that we have not let ourselves peek out of our "pouch," our comfort zone. Yet we know that we can be more, feel more, at work, at home, with our families and, most importantly, deep in our core.

In previous articles (April 1998, August 1999, October 2000, November 2000, November 2001, November 2002, December 2003), I have emphasized that stress does not

occur in a vacuum. Work stress melds in with stressors concerning our personal lives — toxic persons and anger issues, physical environment clutter or chaos, financial disarray and, most importantly, the stress of losing ourselves to health concerns, lack of time set aside to explore our religious or spiritual lives and a loss of self. I also have written of the importance of thinking about your life purpose. Yet even with attention to these areas, we may often still feel that hole, an incompleteness in our lives. How many of us have done anything about these issues or sought to find our life purpose? Perhaps this could be the impetus we might need to "take a peek." Even if we have done the work to find our life purpose, have we done anything about pursuing our dreams?

### What Really Makes the Difference Between an Average Life and a Life With a Feeling of Wholeness?

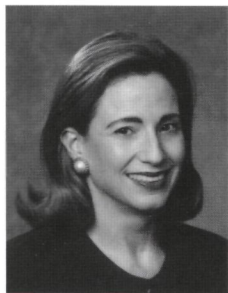
John Maxwell, a well-known expert on leadership, states that the qualities that most of us attribute to successful individuals (or at least those who experience the sensation of success) are *not* their family background or socioeconomic beginning, opportunities thrown or not thrown their way, their morals or even hardships that they may or may not have suffered. Rather he explains: "The difference between average people and achieving people is their perception of and response to failure."<sup>1</sup>

*To achieve your dreams, you must embrace adversity and make failure a regular part of your life. If you're not failing, you're probably not really moving forward.*

— John Maxwell

Most of us physicians have led a reasonably linear professional career: college, medical school, residency, (graduate school, fellowships) and practice. What we do in our professional lives after this linear progression can take many forms. With some focused vision and honest self-assessment, we can be or do anything that we wish.

It is never too late to pursue your dreams. As some of the most successful people in the world will attest, they have, in many cases, spent years doing one thing. After much thought and while living their proscribed lives, they finally "take a peek out of the pouch." They deliberately take a risk to reach for their dreams, the aspirations that will make them feel alive, the road that will allow them to have that "great day."



Jessie A. Leak, M.D., is Clinical Professor, University of Texas Health Science Center at San Antonio, San Antonio, Texas.



### **If I Have Finally Decided That I Have a Specific "Life Purpose," What Happens if I Feel That I Am Failing in My Efforts to Get There?**

Probably the greatest champions in this world also have experienced more failures than most of us encounter in a lifetime. Their perspective on failure is the lightning rod for their success.

*Many of life's failures are people who did not realize how close they were to success when they gave up.*

— Thomas Edison

Maxwell believes that failures are the emotional outlay that we pay for progress and achievement. They are simply acts that providentially keep us from straying from our path. He believes that adversity enhances our chances of success; it builds resilience and maturity, expands the envelope of

creativity, innovation and motivation or may create more or unexpected opportunities or benefits.<sup>1</sup>

Failure in this paradigm is simply the impetus for alternate plans and growth rather than a sign to quit. With clear focus on our dreams, these detours only make us feel more alive. *Living* each day versus drifting through life is what gives us memories and wholeness.

Because we are physicians accustomed to our linear lives, these concepts are an anathema. Yet your life is waiting to get started; do not waste any more time thinking. Just do it!

#### **Reference:**

1. Maxwell JC. *Failing Forward*. Nashville: Thomas Nelson Publishers; 2004:115-119.

## **USVA Committee Develops New Military Component Society**

*Continued from page 26*

Army and Navy is not likely, through increased interaction and opening of communications, this extended professional network is working to ensure that patient safety is protected through a unified voice for policy development. Recent success has been achieved for oversight of clinical practice to reduce practice variability between military hospitals by pursuing consistency in core credentialing parameters. The pursuit of these policies helps to ensure that the credentialing procedures of anesthesiologists and nurse anesthetists are based on training and demonstrated competency. These issues have become increasingly important as nurse anesthetists in the past year have sought to increase the scope of their practice to include the delivery of care in pain medicine clinics and the performance of advanced regional anesthesia procedures. Another positive action was effectively providing input for the approval of the use for anesthesiologist assistants for Tricare payment and for hiring at military facilities.

While the achievements of USSA and closer cooperation in the military is a step in the right direction, its expansion to VA anesthesiologists and civilian anesthesiologists working at military facilities may be warranted. In the Army alone, there are more than 50 civilian anesthesiologists who work full time in military hospitals. Most do not belong to state societies, and their concerns

are similar to the active-duty anesthesiologists with whom they work. In addition there is increased congressional pressure for collaboration between the VA committee and DOD. Past VA-DOD collaboration has resulted in positive benefits in the development of practice guidelines for postoperative pain <[www.oqp.med.va.gov/cpg/pain/pain\\_cpg/frameset.htm](http://www.oqp.med.va.gov/cpg/pain/pain_cpg/frameset.htm)> and opioid use for chronic pain <[www.oqp.med.va.gov/cpg/cot/cot\\_cpg/frameset.htm](http://www.oqp.med.va.gov/cpg/cot/cot_cpg/frameset.htm)>. Other areas of common interest for the VA-DOD anesthesiology community continue to be independent practice issues, the integration of intraoperative record keepers into enterprise-wide computerized patient records, and joint residency and anesthetist training initiatives. Some of the civilian anesthesiologists employed by the military and VA have expressed interest in expanding USSA membership criteria and joining USSA since their major concerns are not addressed by state societies.

Achieving a critical mass of interested and active participants is necessary for any organization to be fully successful. Perhaps the benefits of improved professional collaboration and representation would be best served by allowing free choice for civilian DOD and veteran anesthesiologists in choosing a component society when they feel disenfranchised by their current options.



## Robert Wood Johnson Foundation to Foster Anesthesiology Residents

Jill M. Mhyre, M.D., Co-Editor  
Residents' Review

**M**aking the transition from an anesthesiology residency to an academic faculty position is challenging. Although the first step has traditionally been a clinical subspecialty fellowship, there are other options available. This article highlights one alternative or additional opportunity, the Robert Wood Johnson Clinical Scholars Program (RWJ CSP).

The RWJ CSP is a funded two-year fellowship in research methodology and health care policy that is ideal for physicians interested in health services research. Through coursework and practical research experiences, scholars learn how to ask answerable questions about health care delivery and how to design, execute and fund research that addresses those questions.

A number of anesthesiology departments offer excellent health service research fellowships. The RWJ CSP may be unique in the amount of protected time for education and research, in the interdisciplinary structure and in the expanded emphasis on health care leadership and policy development. For inexperienced but highly motivated and independent researchers, the RWJ CSP is one way to start pursuing a novel and interdisciplinary line of inquiry with instruction, mentorship and support.

The program offers a common curriculum in the fundamentals of evidence-based medicine, epidemiology, biostatistics, health economics, health care policy and clinical research design. Although two years is not enough time to acquire expertise in the full range of possibly relevant qual-

itative and quantitative methods, scholars do gain a basic understanding of the structure, function, strengths and limitations of alternative research approaches. Scholars finish the program prepared to evaluate and choose the most appropriate methodology for a given question and to collaborate across disciplines to conduct creative, relevant and rigorous investigations.

Scholar projects are comprehensive. Independent project work includes: developing relevant clinical expertise around a specific clinical concern; identifying appropriate research mentors; defining the specific research question; evaluating and choosing between alternative methods for addressing the question; writing the project proposal; designing and defending a research budget; navigating the research regulatory process; hiring, training and leading a

research team; monitoring data quality, data management, programming and statistical analysis; and data presentation and manuscript preparation. A word to the wise: there is no such thing as just a little research project!

Finally the program offers very practical advice about the work-life balance and the academic-teaching-clinical balance, both of which are particularly acute for anyone in this stage of his/her career. The key seems to rest in identifying personal strengths, maintaining focus, maximizing effort on those activities that bring enjoyment and delegating out those activities that compound stress. Like anything else, this balance takes practice.

The CSP seems to work. Over the past 30 years, the program has trained almost 1,000 physicians representing a variety of disciplines, including internal medicine, pediatrics, surgery and anesthesiology. Approximately half of the former scholars have joined the ranks of academic medicine, some 162 alumni are full professors and 25 are chairs of medical school departments. Eighteen former scholars have been elected to the Institute of Medicine of the National Academy of Sciences. Others have found positions with the government, the National Institutes of Health and in major policy organizations such as the Robert Wood Johnson Foundation, the RAND Corporation and the Agency for Healthcare Research and Quality. Several anesthesiologists

**“Expanding our training opportunities to external programs such as the Robert Wood Johnson CSP will facilitate collaboration across disciplines and will help to disseminate innovations both within and beyond our profession.”**



Jill M. Mhyre, M.D., is a CA-3 anesthesiology resident at the University of Michigan, Ann Arbor, Michigan.



have participated in the program. Donna A. Kalauokalani, M.D., is a pain medicine physician at the University of California-Davis, Sacramento, California. Andrew L. Rosenberg, M.D., is an intensivist at the University of Michigan, Ann Arbor, pursuing research in critical care outcomes and quality measures.

If this program sounds interesting, the application process begins 18 months before candidates seek entrance into the program. So potential scholars for July 2006 will need to apply by February 15, 2005. Participating universities for the cohort entering in 2006 will include: the University of California-Los Angeles, the University of Michigan, the University of Pennsylvania and Yale University. Beginning in 2005, all scholars will earn a master's degree in health and health services research and will have the opportunity to apply for a third year of funding. More information can be found at <<http://rwjcsp.stanford.edu>>.

The Robert Wood Johnson Foundation, based in Princeton, New Jersey, is the nation's largest philanthropic organization devoted exclusively to health and health care. It concentrates on four goal areas: 1) to assure that all Americans have access to quality health care at reasonable cost; 2) to improve the quality of care and support for people with chronic health conditions; 3) to promote healthy communi-

ties and lifestyles; and 4) to reduce the personal, social and economic harm caused by substance abuse in the form of tobacco, alcohol and illicit drugs.

Anesthesiologists have led developments in patient safety, health care economics, perioperative care, pain medicine, palliative medicine and substance abuse, among other areas. Expanding our training opportunities to external programs such as the Robert Wood Johnson CSP will facilitate collaboration across disciplines and will help to disseminate innovations both within and beyond our profession.

*"Health services research examines how people get access to health care, how much care costs and what happens to patients as a result of this care. The main goals of health services research are to identify the most effective ways to organize, manage, finance and deliver high-quality care, reduce medical errors and improve patient safety."*

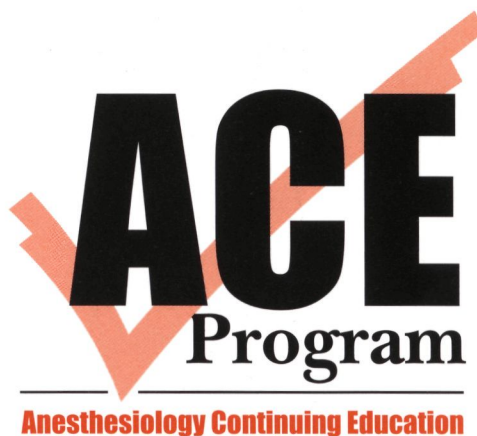
— Agency for Healthcare Research and Quality, 2002

*Please send any topic ideas, sample articles or questions to the editors of "Residents' Review" at <[residents.review@ASAhq.org](mailto:residents.review@ASAhq.org)>.*

## ACE Program Available Soon: Subscribe Today!

**A**CE, or Anesthesiology Continuing Education, is a new ASA continuing medical education (CME) product designed to facilitate lifelong learning and prepare anesthesiologists for Maintenance of Certification in Anesthesiology (MOCA). ACE is a CME opportunity that does not require travel. With ACE, practitioners can assess the status of their knowledge, identify areas for improvement and prepare for written anesthesiology recertification examinations.

Scheduled for an October 2004 release, the ACE program initially will be available in booklet form only, although an electronic version is expected in the future. ASA is accepting subscriptions for the initial 2004 single issue, the 2005 standard double issue, or both. Please contact the Publications Department at the ASA Executive Office at (847) 825-5586 or by fax at (847) 825-1692 to request additional information and a subscription form. Subscription forms also can be downloaded from



the ASA Web site at <[www.ASAhq.org](http://www.ASAhq.org)> under "Continuing Education Resources."



## SPA: A Melting Pot of Diverse Interests

Anne M. Lynn, M.D., President  
Society for Pediatric Anesthesia

**“Over the past 15 years (which parallels the growth of SPA), pediatric anesthesiology has grown as a subspecialty with input in various areas.”**

**A**SA NEWSLETTER Editor Douglas R. Bacon, M.D., kindly invited me, as the current President of the Society for Pediatric Anesthesia (SPA), to submit an article for the NEWSLETTER. As I pondered which pediatric anesthesiology topics would be of most interest to the ASA membership, I realized that Lynne Maxwell, M.D., 2003 Winter Meeting Program Chair, and the Committee on Education had put together a group of talks on the Sunday morning of our 2003 Winter Meeting last February in Ft. Myers, Florida, which covered areas of great variety and were a good example of the breadth of interests of SPA members. So I will report a short synopsis of my impressions from these talks.

### Winter Meeting

Sunday morning began with four speakers discussing different approaches to participating in international pediatric anesthesiology in developing countries. The traditional voluntary medical mission — where anesthesiologists join a complete group to accomplish surgeries — with its immediate personal satisfaction was outlined, including important aspects of planning to maximize good outcomes for those giving and receiving these services. Harvard Medical International (HMI) is a very different model. HMI works with international partners to develop a sustaining medical care delivery and education system, emphasizing global changes in diseases such as the re-emergence of infectious diseases like tuberculosis and HIV. This can be a significantly difficult undertaking if the local infrastructure is not firmly established or funded.

The World Federation of Societies of Anaesthesiologists (WSFA) has established two (soon to be three) pediatric anesthesiology fellowship programs. Anesthesiologists selected by their country's local society train at these programs for six to 12 months both in general pediatric anesthesiology and in pediatric cardiac anesthesiology. They return to their home country to share their expertise with colleagues.

The fourth presentation was of the long-standing institutional partnership between Indiana University and Moi University in Kenya, an affiliation that has existed since 1989 and which has generated publications and grants that benefit partners and their faculties. The wide spectrum of ways to partic-



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ipate in improving pediatric anesthesiology care in developing countries was impressive.

The next session consisted of two speakers who discussed a recent controversy in the science of pediatric anesthesiology. Studies in newborn rat pups have reported neurodegeneration and long-term maze learning deficits in animals exposed to several hours of isoflurane, nitrous oxide and midazolam. After presenting these studies and reviewing the process of apoptosis in the normal development of the maturing central nervous system, the speakers discussed unresolved issues of species specificity, accompanying hypotension, hypoxia and poor nutrition in the postexposure period in the animal studies, which would not pertain to human neonates and the time equivalence in human neonates of a six-hour exposure in rat pups. The known morbidity of stress from neonatal surgery or pain was reviewed as well.

The second speaker reviewed literature and studies supporting a neuroprotective role for inhalational anesthetics when ischemia occurs (focal or global). Having inhalational anesthetics seems most protective (equivalent to 2 degrees of hypothermia) when they are present for the period immediately preceding the ischemic injury. Both speakers agreed that balancing the stresses of inadequate anesthesia for neonatal surgery with the possibility of anesthetic effects on the neonatal central nervous system during this rapid period of development will require further study, and major changes in neonatal anesthesia would be premature.

The morning finished with presentations by two pediatric anesthesiologists on the development of the subspecialty in California. Over the past 15 years (which parallels the growth of SPA), pediatric anesthesiology has grown as a

subspecialty with input in various areas. The formalization of curricula for pediatric anesthesiology fellowship training achieved recognition by the Accreditation Council for Graduate Medical Education (ACGME) in 1997. Currently there are 43 fellowship programs with ACGME certification. The

ASA Committee on Pediatric Anesthesia and the American Academy of Pediatrics (AAP) Section on Anesthesiology and Pain Medicine have both published material on the pediatric perioperative environment, outlining space, equipment, ancillary services necessary as well as a process for anesthesiology departments to determine the pediatric procedures that may

be undertaken at each institution. The latter outlines the training needed for anesthesiology practitioners to safely accomplish these pediatric procedures, including prior training and ongoing continuous clinical competence. In California this resulted in a model policy for pediatric anesthesia being written by the California Society of Anesthesiologists, which was presented at the 2003 ASA House of Delegates. In the community hospital where one of the pediatric anesthesiologists practices, a subgroup of seven to eight practitioners has evolved with ongoing clinical competence to cover complex pediatric and neonatal cases 24/7.

I am struck again as I write on the diversity of interests (science, clinical care and subspecialty development) that SPA members show. More complete information on these talks is available at the SPA Web site at <[www.pedsanesthesia.org](http://www.pedsanesthesia.org)> in the form of 2004 Winter Meeting author syllabus submissions and in the Spring *SPA Newsletter* meeting summary written by SPA members of the newsletter editorial staff.



## State Beat: Scope-of-Practice Issues Heard in the Courts

*Continued from page 33*

indwelling vascular catheter placement, including intravenous and arterial catheters, administration and maintenance of volatile anesthetics, narcotics, hypnotics, anesthetic agents and muscle relaxants, patient monitoring and regional anesthetic techniques. These factors, combined with some language in the regulations whereby the court interpreted "assist" to mean "carry out," led the

court to hold that the medical board had exceeded its delegated authority with respect to the limitations on the practice of AAs. As a result, Section 4731-24-04(B) is invalid, and AAs are permitted to perform epidural anesthetic procedures and spinal anesthetic procedures and implement medically accepted monitoring techniques. An appeal is likely.



## 12 Candidates Announce for Elected Office

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

### President-Elect

Orin F. Guidry, M.D.

### First Vice-President

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

### Vice-President for Professional Affairs

Alexander A. Hannenberg, M.D.

### Vice-President for Scientific Affairs

Arnold J. Berry, M.D.

Robert L. Hines, M.D.

Charles W. Otto, M.D.

### Secretary

Peter L. Hendricks, M.D.

### Treasurer

Roger A. Moore, M.D.

### Assistant Secretary

Gregory K. Unruh, M.D.

### Assistant Treasurer

John M. Zerwas, M.D.

### Speaker, House of Delegates

Candace E. Keller, M.D.

### Vice-Speaker, House of Delegates

John P. Abenstein, M.D.

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

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

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

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

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

As approved by the Board of Directors in August 2000, a Candidates' Forum is now available on the ASA Web site. ASA members can view candidates' curricula vitae at <[www.ASAhq.org/candidates](http://www.ASAhq.org/candidates)>.

## Opportunities Abound at Technical Exhibits During Annual Meeting

**T**he 2004 Technical Exhibit Program represents another exciting aspect of the educational experience at the 2004 Annual Meeting. The exhibits offer the opportunity for attendees to see demonstrations of many new products and obtain information about existing products and services. Exhibits are limited to those that apply directly to the practice of anesthesiology.

The exhibits will be located in Halls C3-C4 at the Las Vegas Convention Center. Hours are Sunday, October 24, 12:30 p.m. to 6 p.m.; Monday, October 25, 9 a.m. to 4 p.m.; and Tuesday, October 26, 9 a.m. to 4 p.m. Approximately 275 companies will exhibit.

An exhibit reception will be held again this year in the exhibit hall from 4:30 p.m. to 6 p.m. on Sunday. Registrants will receive one complimentary drink ticket.

Exhibitors contribute vital support to the ASA Annual Meeting and the medical specialty of anesthesiology, and attendees are encouraged to visit the exhibit hall.

## ASA and AANA Leadership Have 5th Meeting

**T**he ASA and American Association of Nurse Anesthetists (AANA) leadership met for the fifth time on July 18, 2004. The group discussed the procedural agreement, Medicare anesthesia payment issues and how to introduce the joint meeting process to our respective members at the state and local level.

A draft procedural agreement was completed and will now be presented to the ASA and AANA leadership, respectively. The procedural agreement is a living, working document that will assist us in developing and maintaining a respectful professional relationship and act as a guide in addressing common issues in the future.

Two Medicare anesthesia payment system issues also were discussed, including the need to support the Medicare anesthesia fee

schedule and the need to address the medical direction rules that negatively impact anesthesiology practice.

The need to integrate more state and local members into the process was expressed by all present. We will continue to work on a plan that will engage state and local ASA and AANA leaders in the process. Two new leaders were introduced to the mediation process at this meeting, Brian Thorson, CRNA, and Mark J. Lema, M.D., Ph.D. In August the AANA Board of Directors and the ASA Administrative Council will meet face-to-face for the first time as part of this process.

Tom McKibban, CRNA, announced that this would be his last meeting as AANA President and thanked all of the participants for their openness and dedication to the process.



## James E. Cottrell, M.D., Named Fellow by Royal College of Anaesthetists

**A**SA Immediate Past President James E. Cottrell, M.D., Brooklyn, New York, has been unanimously selected as a "Fellow by Election" by the Royal College of Anaesthetists.

Fellows by Election are distinguished medical practitioners who are elected by the College Council and "have shown themselves worthy of having made, or having played a significant role in the making of, an outstanding contribution to anaesthesia, critical care, pain management, or any other related field of medicine or science of relevance to the College, whether in the area of practice, education or research, and such contribution shall preferably, in the opinion of the Council, be regarded as of national or international significance; provided that, where such contribution has been wholly or largely made in a country or

countries other than the United Kingdom, the candidate ... shall be recognized as being of high standing in any country where the contribution has been made."

Fellows by Election are entitled to use the post nominals F.R.C.A., vote at all College Council elections and stand for College Council.

Of the 9,000 Royal College of Anaesthetists, only 130 are Fellows by Election. With his election next year, Dr. Cottrell becomes only the 29th Fellow by Election in the United States. His admission ceremony will take place on January 19, 2005.

The Royal College of Anaesthetists is the professional body responsible for the specialty of anesthesiology throughout the United Kingdom.

## Component Society News: ASA Member Appointed to Virginia Board of Medicine

**A**SA Alternate Director for Virginia Patrick W. Clougherty,

M.D., was selected last July by Governor Mark R. Warner to serve on the Virginia Board of Medicine. Dr. Clougherty's term begins in July 2004 and ends in 2008.

Dr. Clougherty was President of the Virginia Society of Anesthesiologists in 2003. As a member of the Virginia Board of Medicine, Dr. Clougherty will help to develop rules and regulations for the provision of office-based anesthesia in the state.

Because of his knowledge of issues concerning nurse anesthetists, Dr. Clougherty also has been asked to serve on Virginia's Committee of Joint Boards of Nursing and Medicine. This committee regulates nurse practitioners, who derive their authority to perform medical acts from the Board of Medicine.

Dr. Clougherty is Chair of the Department of Anesthesiology at Inova Fairfax Hospital, Falls Church, Virginia.

## ABA Announces ...

### ABA Recertification Examination Dates

**T**he transition from a voluntary recertification examination program to maintenance of certification began in January 2004. Only ABA diplomates certified before 2000 are eligible for the recertification program. Participation will not jeopardize their diplomate status. Diplomates who might have a future need to recertify should consider participating in the program before it closes. The last year in which ABA will administer its recertification examination is 2009.

Eligible diplomates may take the

examination by computer at more than 350 test centers during a two-week period, July 9-23, 2005. Recertification candidates will receive test site information by May 15, 2005. Diplomates may apply electronically at the ABA Web site <[www.TheABA.org](http://www.TheABA.org)>, download an application from the Web site or request the form by writing ABA at 4101 Lake Boone Trail, Suite 510, Raleigh, NC 27607-7506. Applicants may file their application directly from the Web site or via mail.

Applications will be available October 15, 2004. The standard deadline for the ABA to receive a completed recertification application is **December 15, 2004**. ABA will consider applications received by January 15, 2005, with payment of an additional fee for late filing. **The Board will not consider applications received after January 15, 2005.**



# Anesthesiology in the News

## PONV in the Press

**C**hristian C. Apfel, M.D., and Allan Gottschalk, M.D., Ph.D., published research in the *New England Journal of Medicine* that led to features by the Associated Press and Health-Day News. Their research, which was issued in June, examined prevention treatment for postoperative nausea and vomiting. The study also was mentioned in a *Boston Globe* article in July. This piece featured quotes by Beverly K. Philip, M.D., Carl Rosow, M.D., and Dr. Apfel.

## Stimulating Simulator in Iowa

**P**articipants in a patient simulator exercise were able to speak about their experience in the *Telegraph Herald* of Dubuque, Iowa. Cynthia S. Yuan, M.D., and Adam I. Levine, M.D., were quoted in the July article.

## Found in Translation

**B**rian Stanton, M.D., had a full feature article on his medical form translation Web site in the Oklahoma City newspaper *Daily Oklahoman* in July. One purpose of Dr. Stanton's site is to help the medical community break through language barriers.

## Historical Milestones

**I**n July, *Science News Magazine* chronicled the historical milestones and scientific advances in anesthesia. The research-based report featured work and comments by James M. Sonner, M.D., Roderic G. Eckenhoff, M.D., Nicholas P. Franks, M.D., and Alex S. Evers, M.D.

## Sedation for Infants

**D**artmouth anesthesiologists Stephen O. Heard, M.D., George T. Blike, M.D., and Joseph P. Cravero, M.D., were featured in an article about sedation for infants undergoing a hearing examination. The article was published in the *Telegram & Gazette* of Worcester, Massachusetts, in August.

## Out of Hiding

**T**he specialty of anesthesiology was prominently featured in the *U.S. News & World Report* "America's Best Hospitals" issue in July. The comprehensive article "Hidden Spe-

cialties" followed a day in the life of anesthesiologists Magdalena Anitescu, M.D., Jeffrey L. Apfelbaum, M.D., Thomas W. Cutter, M.D., Jerome M. Klapf, M.D., Annette Y. Schure, M.D., and Kenneth L. Rodino, M.D., all from the University of Chicago. Resident Allain Coppel, M.D., was featured on the cover of the issue.

## Monkey Business

**M**ajor media outlets from New York to California covered the tooth extraction and physical examination of Koko the gorilla on August 8. Koko became famous because of her ability to use American Sign Language. In order to complete the procedures, the 300-pound primate was treated by a team of doctors, including Stanford University anesthesiologists Ethan C. Jackson, M.D., Parag N. Mathur, M.D., and Fred G. Mihm, M.D.

## DXM Campaign Continues

**L**etters to the editor addressing the growing problem of dextromethorphan (DXM) abuse were printed in a June issue of the *Chicago Sun-Times* by ASA President Roger W. Litwiller, M.D., and a July issue of the *Denver Rocky Mountain News* by Jan Gillespie, M.D. Drs. Litwiller and Gillespie addressed what ASA is doing to raise awareness about the issue.

## Four Places at Once

**I**n August the "CBS Evening News" and "CBS The Early Show" featured Paul J. St. Jacques, M.D., of Vanderbilt University using a new device that allows him to manage four operating rooms at one time. By attaching miniature goggles to his glasses, Dr. Jacques can monitor vital signs using live-stream video.

*The ASA Communications Department is interested in hearing from members who have been quoted in the media. To let us know that you have been interviewed, or for assistance with media relations, contact Roseanne Durril in the ASA Communications Department at (847) 825-5586 or e-mail <r.durril@ASAhq.org>.*



## FAER Board Meeting Creates Historic New Opportunities

Thomas M. Bruckman, Executive Director  
Foundation for Anesthesia Education and Research

**A**fter significant preparation, deliberation and motivation, the Foundation for Anesthesia Education and Research (FAER) Board of Directors voted recently to approve several landmark programs to better serve the needs of anesthesiology researchers, practitioners, mentors, educators and patients.

The FAER Board members are:

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Nathan D. Grunewald, Manager of Information Technology

The precedent-setting decisions made by the board include adding a mentorship award as part of the Research

Training Grant, facilitating the creation of the Academy of Anesthesia Mentors, approving the start of a Medical Student Fellowship Program in 2005, launching new Fund Development Programs focusing on specific research areas and approving the funding of nine new research and education projects with a budget of \$940,000.

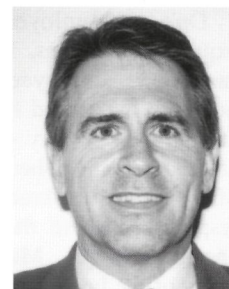
**Adding a Mentorship Award as Part of the Research Training Grant:** The board voted to add a \$40,000-per-year Mentorship Award for individuals serving as mentors to the FAER/ASA Research Training Grant awardees. This will bring the total for the RTG awards starting in January 2005 to \$255,000 over two years, \$175,000 to the researcher and \$80,000 to the mentor.

For more details on this program and other FAER research programs, visit <[www.faer.org](http://www.faer.org)>.

**Creation of the Academy of Anesthesia Mentors:** A FAER subcommittee, chaired by John P. Kampine, M.D., Ph.D, has led to the establishment of an Academy of Anesthesia Mentors. This group will meet for the first time as an independent entity at the October 2004 ASA Annual Meeting on Friday in Las Vegas, Nevada. The group was formed to recognize and foster the efforts of scientific and educational mentors who have and will continue to enrich their trainees and the profession of anesthesiology.

**Medical Student Fellowship Program:** Beginning in 2005, FAER will recruit and sponsor up to 10 medical students for approximately 10 weeks to gain exposure to and basic experience in the field of anesthesiology. It is expected that these students will be recruited for summertime activities and housed in medical academic centers for their training.

*Continued on page <None>*



Thomas M. Bruckman became FAER Executive Director in 2003. Previously he was Executive Director and CEO of the American Foundation for Urologic Disease.



**Fund Development Initiatives:** The FAER board voted to create four new initiatives focusing on developing new relationships and increasing fund development efforts in geriatrics, pain medicine, pediatrics, and trauma and critical care medicine. Each board member will actively participate on at least one of these new programs and will use his/her skills and influence to increase funding and attention to the research and education needs of their respective areas. FAER will continue to solicit, score and fund research programs in all areas of anesthesiology, but funding for these specific areas will be supplemented by these development initiatives. Details on how other ASA members and groups can help with these efforts will be forthcoming.

**New Awards Granted:** The FAER board was pleased to receive the report from the ASA Committee on Research that had reviewed and scored 30 applications for FAER sup-

port. The FAER board approved the funding of nine new projects with a total budget expenditure of \$940,000. There were several additional proposals deemed worthy of funding, but resources were not available. FAER is currently committed to spending at least \$1.5 million on research and education grants for 2004 and will review another series of applications in October from the August submissions. Look in future issues of the *ASA NEWSLETTER* for the announcement of these new award recipients.

FAER continues to be grateful for the support offered by ASA as well as individual members and support organizations. Additionally FAER extends its appreciation to the family of John D. "Jack" Michenfelder, M.D., a tribute to whom appeared in the July 2004 *ASA NEWSLETTER* (page 46). Donors to the Michenfelder Memorial will be recognized in a separate section of our 2004 annual report.

## First FAER Golf Fundraiser Tees Up Annual Event

**O**n July 12, 2004, FAER organized and operated the first ever FAER Lunch, Golf, Reception fundraiser in Rochester, Minnesota. This initial effort attracted 45 participants and raised a modest amount of money. Plans are under way to shape this event into an annual celebration of progress in anesthesiology research. For information on how you can help support FAER on this initiative, please call the FAER office at (507) 266-6866.

### FAER 2003 Annual Report Soon to Be Available for Distribution

FAER will soon be sending out its 2003 annual report to various constituencies. Included in the report are details of new activities, supporters' names, financial condition and future plans. Those scheduled to receive a copy include individual FAER donors, corporate supporters, FAER and ASA board members, component societies, corporate and foundation prospects, current and past grant recipients and members of all FAER and ASA committees. If you would like additional copies, please call the FAER office.

### New Staff

Due to employee turnover and expanding services, FAER has hired two new employees. Mary M. Schrandt has joined FAER as Associate Director. Mary comes to FAER after a distinguished career at the Mayo Clinic with broad administrative responsibilities in the department of anesthesiology. Mary will absorb many of the tasks previously assigned



Mary M. Schrandt

to Kerry Todd, who has moved on. Additionally Mary will play a key role in FAER's marketing efforts.

Nathan D. Grunewald joins FAER in the new position of Manager of Information Technology. Nathan's responsibilities include all FAER Web sites, Internet activities and maintenance of the FAER database. Nathan joins FAER from the nonprofit organization Wisconsin Energy Conservation Corporation where he was Coordinator of Operations. Coincidentally Nathan's wife, Courtney, will begin school at Mayo in the nurse anesthesia program.

Mary and Nathan have critical roles in supporting and implementing FAER's much expanded fund development efforts.



Nathan D. Grunewald

## Erratum: Duke Tarheels?

**T**he *NEWSLETTER* staff wishes to inform the readership that Duke University has *not* moved to Chapel Hill, as readers were led to believe in the August 2004 *NEWSLETTER*. In the FAER awards article on page 40, Frederick W. Lombard, M.B., Ch.B., was correctly listed at Duke University, but Duke was incorrectly listed as residing in Chapel Hill. Duke is, of course, in Durham. Our sincerest apologies to Dr. Lombard and Blue Devils and Tarheels everywhere.



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Photos courtesy of the Las Vegas News Bureau

## *ASA 2004 Annual Meeting*

**Registration opens at 3 p.m. Friday, October 22,  
at the Las Vegas Convention Center**