

ASA 100

A Century of Advancing
PATIENT SAFETY

This special edition in honor of ASA's Centennial reflects on our beginnings as well as how far we have come as a Society.

For more information about ASA's history, special Centennial events and keepsakes, see the back cover of this publication.



ISTS

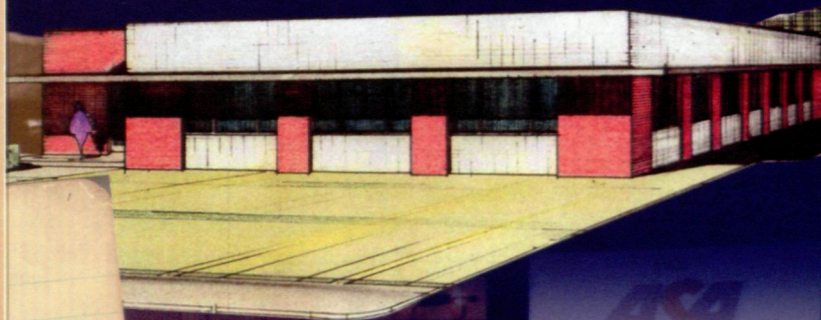
BETTER

Memorative Issue



ASA 100

Century of Advancing
PATIENT SAFETY



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AMERICAN SOCIETY
OF ANESTHESIOLOGISTS



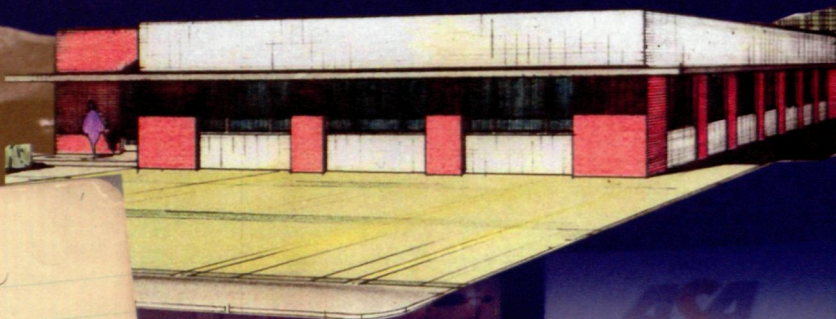
NEWSLETTER

Special Commemorative Issue



ASA
100

A Century of Advancing
PATIENT SAFETY



*Constitution and By-laws
of the
Long Island Society of Anesthetists.*

Article 1.

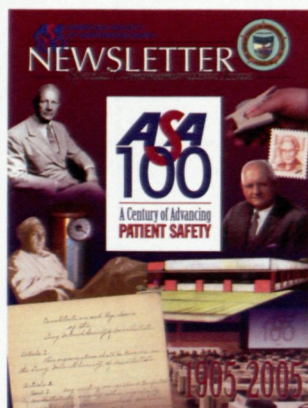
*This organization shall be known as
the Long Island Society of Anesthetists.*

Article 2.

*Sect. 1. Any visiting or resident hospital
anesthetists or any other regularly
employed physician whose particular
duties may become*



1905-2005



On the cover: Clockwise from bottom left, the original constitution and bylaws from 1905; Ralph M. Waters, M.D.; 1952 Copper Kettle; James T. Gwathmey, M.D.; a modern pulse oximeter; Virginia Apgar, M.D., stamp of 1994; Paul M. Wood, M.D.; sketch of ASA headquarters circa 1960; House of Delegates during the 2004 Annual Meeting, which broke an attendance record with 18,459 attendees.

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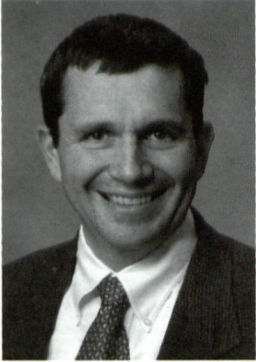
Denise M. Jones

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.

A Centurion Arrives — Why Our Past May Help to Mold Our Future

I have had the pleasure of knowing one person well who reached the age of 100. My maternal grandmother was born in 1890 and died in 1994, two months short of 104 years of age. She was the grandmother portrayed in stories, always there for my sister and me, never condescending and always loving. She had a perspective on life that I came to admire, giving advice to me in my youth that I still use today. Her life was a fascinating study of the growth of the United States in the early 20th century. Growing up in Buffalo, New York, the stories of her childhood remember a time passed that will no longer be. Perhaps my favorite is the time her uncle came to pick her up in his horse and buggy to take her to a family party. She asked him how the horse knew the way to go, and her uncle replied, "I've whispered it in his ear." As a young girl (and quite a tomboy, if the family legends are to be believed), she would hitch a ride on the back of a sled and slide down the snow-



Douglas R. Bacon, M.D.,
Editor

covered streets, not unlike catching the back bumper of a car and sliding behind it, only a bit slower and perhaps a lot safer.

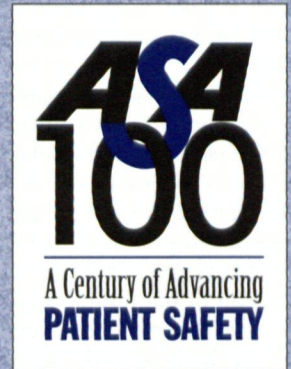
Growing Pains

ASA, in its youth, was a bit like my grandmother, a little naive perhaps but growing and changing as the 20th century demanded. Our Society's history reflects a time that cannot be recreated yet may hint at solutions to future challenges. Formed at the Long Island College of Medicine (now part of the State University of New York Downstate Medical Center) by eight physicians and a medical student, the Society was dedicated to enhancing the art and science of medicine. The early meetings were small, almost private affairs — for the giving of anesthetics was neither as glorious nor as rewarded as the operation itself. The Long Island Society of Anesthetists, as it was called, was a group of men trying to learn about the mysteries of anesthesia to better care for their patients. Meeting three or four times a year, sharing a meal and listening to a lecture or two and a practical demonstration harkens back to a similar and perhaps more naive time in the history of our specialty. Yet the dual focuses of the Society, patient care and education, are the roots of our organization, and we have never, ever abandoned them.

In 1901, Buffalo, the burgeoning industrial city on the shores of Lake Erie, hosted the world at the Pan-American Exposition. As an elementary student, grandma went to the exposition on a streetcar with her class. William McKinley, then President of the United States, came and was assassinated at the fair. Grandma remembered the newsboys on the street corner yelling, "Extra! Extra! McKinley shot in the stomach."

When my grandmother was 13, my great-grandfather died early in the school year. As an eighth-grader, grandma finished the year and won the gold medal for the highest grade point average of all the children in her grade in the city of Buffalo. So, too, did the Long Island Society go through some growing pains. The group had grown, and many members came from across the river.

The Society moved uptown and became the New York Society of Anesthetists. The organization petitioned the American Medical Association (AMA) for a sec-



"Our Society's history reflects a time that cannot be recreated yet may hint at solutions to future challenges."

tion on anesthesia, ostensibly for the study of problems within the field, especially with nonphysicians who provided anesthetic services. The request was reasonable as the ophthalmologists had made a similar one that was granted. Unfortunately this 1912 petition was denied, but that denial spurred the leadership of the New York Society to create the first national anesthetic society, the Associated Anesthetists of America. Like my grandmother's marriage to my grandfather a scant three years later, the creation of a national society demonstrated a new phase in the Society's growth, a maturation.

In 1920 my grandmother voted for Warren G. Harding for president, the first time in her life that she ever voted, and she never missed an election thereafter. Why wait until the age of 30 to vote? A constitutional amendment had been ratified in time for her to vote — for women in the United States did not have that right and honor until 1920. It is that simple act of voting, of participating in the determination of the future, which my grandmother instilled in me. The roaring 1920s were a time of growth and maturation for the New York Society as well; the group started to represent all of the state, not just the city, and began to expand into the surrounding states. New York Society President (1920-21) J.J. Buettner, M.D., of Syracuse, played an active role, although he was hours by train from the center of the action. Dedication to the Society's principles and the need to further the specialty were critical to Dr. Buettner, the New York Society and anesthesiology.

Hard Times and a New Beginning

The Great Depression challenged my grandmother and her family. Money was hard to come by, and meals often consisted of lima bean casseroles. These were dark days

indeed for my family and for the nation as a whole. Yet out of the Depression came the desire to certify physicians as specialists in anesthesia, confirming that the specialty was the equal of surgery or internal medicine. The 1930s saw the creation of the American Society of Anesthetists, taking the New York Society national over this issue. The Associated Anesthetists had become a North American organization, the Associated Anesthetists of the United States and Canada, and its Secretary-General, Francis H. McMechan, M.D., refused to join any certification process that had AMA involvement. The American Society felt differently, and in creating the American Board of Anesthesiology, was transformed from a greater New York City and New York State Society into one that looked out for the interests of the entire country. In 1939 Dr. McMechan died, and the American Society became, by default, the national organization when the Associated Anesthetists folded into the International Anesthesia Research Society.



Francis H. McMechan, M.D.

The War Years

World War II was difficult for my grandmother. Many of her friends lost sons in the conflict. Her husband served on the draft board, being too old for active service. His work was often criticized, and this took a toll on her. ASA was no different as it helped to organize an effort to teach anesthesia to physicians in the Armed Forces in 90-day courses held throughout the United States. At the outset, when looking for sites to establish these educational areas, every known ASA member was rated on his/her clinical ability, and special qualifications in administration and teaching were noted. A curriculum was established and modified through feedback from graduate officers now practicing at the front. While it was difficult for Society members to get together on a national basis due to gasoline rationing and travel restrictions, the sacrifice of the members who established and taught in the 90-day courses was repaid in the immediate post-war period as requests for residency training and establishment of departments of anesthesiology skyrocketed. As the war ended, the Society changed its name to the American Society of Anesthesiologists to better serve its members, who were felt to study the anesthetic state, striving to make anesthesia safer for the patient.

After the War

The post-war years were kind to my grandmother. She found time to be active as a volunteer, and her husband's business thrived. In the mid-1950s, there was yet another life change for her as her grandchildren appeared. I can still taste her chocolate chip cookies, and despite using her recipe, I cannot replicate them myself. The 1950s and '60s were similar for ASA. In the late 1950s, it became clear that ASA was the voice of American anesthesiology. By joining the World Federation of Societies of Anaesthesiologists, ASA assumed an active role in international organized medicine and in advancing the specialty across the globe, looking to help establish physicians in the practice of anesthesiology and supporting growth and development of societies of anesthesiologists everywhere in the world. Domestically ASA in general and the California Society of Anesthesiologists in particular were critical in the establishment of a new method of payment for services. The Relative Value Guide (RVG) helped anesthesiologists across the United States to create a universal system of billing that was adaptable to regional differences in payment. Several other specialties adopted the system. The federal government, however, in the form of the Federal Trade Commission, felt that the system was monopolistic and put pressure on all groups to stop using the RVG. ASA eventually stood alone in a lawsuit

brought by the government in 1975. ASA's eventual victory clearly demonstrated the maturation the Society had reached.

In her last days, my grandmother awaited the birth of my sister's third child. A great-granddaughter was born and shared her middle name. Grandma felt her time was done, and she slowly faded, dying two months short of her 104th birthday.

Do I think that ASA will die four years hence, worn out, mourned by friends and generations of anesthesiologists? No! Just as grandmother's life lessons were instilled in her progeny, ASA moves on with each generation. As a Society, we must continue to grow, encourage participation at all levels of the organization, consider new options and opportunities and not rest on our laurels. For each generation, there are highlights and the feeling that these are the best of times. If there is one universal lesson that ASA's history teaches us, it is that each one of us must continue to strive to make anesthesiology the best that we can, for the anesthesiologists 100 years hence must be willing to look back on a glorious 200-year history with confidence that the best the specialty has to offer lies in the future, as those of us looking forward to the second 100 years certainly do.

— D.R.B.

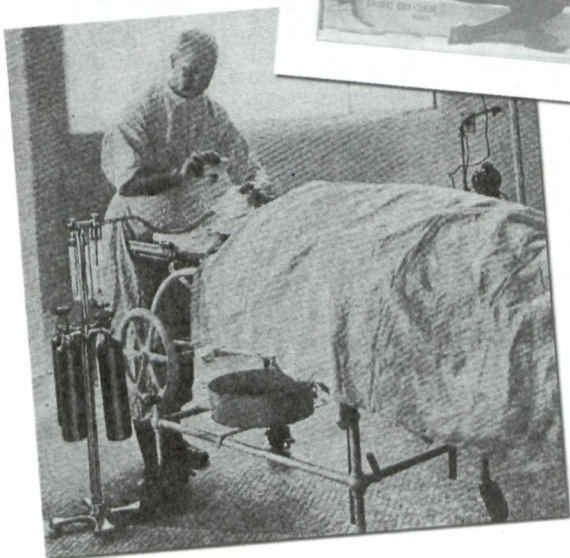
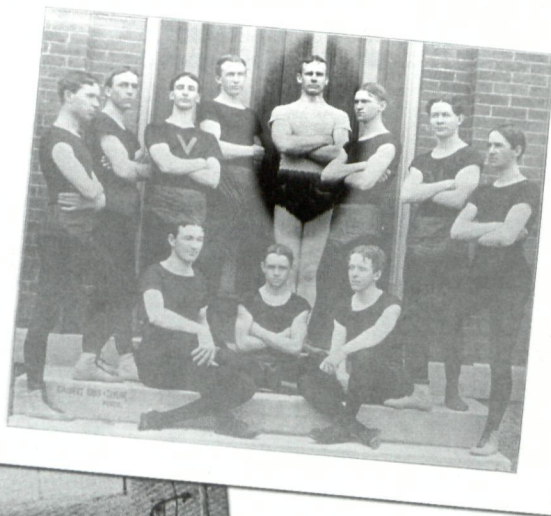


World War II found the U.S. medical corps critically understaffed for surgical anesthesia. Emergency training in this field led many physicians to specialize in anesthesiology after the war. This picture was taken in Percy, France, and shows a mobile surgical unit caring for the wounded during an Allied bombing run in August, 1944. Photo courtesy of the Norman Kornfield Collection, Wood Library-Museum of Anesthesiology.

A Day in the Life: 1905

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

James T. Gwathmey, M.D., was an avid gymnast before embarking on a career in anesthesiology. He was Director of the Gymnasium and Instructor in Physical Exercise at Vanderbilt University, Nashville, Tennessee, where he also was awarded an M.D. in 1899. Image courtesy of Bradley E. Smith, M.D.



Open ether anesthesia in the early 20th century.

At the turn of the last century, transforming technologies reshaped the world and altered how people lived, worked and played. A clear example can be found in electricity, which had been understood since Thomas A. Edison developed the filament light in 1879. But it was not until giant dynamos illuminated the streets of Paris with hundreds of thousands of electric lights at the 1900 World's Fair that the death knell sounded for gas lighting.

So, too, the discovery of anesthesia — beginning with the painless removal of a neck tumor by Crawford W. Long, M.D., in Georgia on March 30, 1842, and later the public demonstration of ether anesthesia by W.T.G. Morton, on October 16, 1846 — heralded a major transforming technology. Yet the world of medicine was not revolutionized until decades later when anesthesia became the standard of care for surgery, allowing a host of procedures, once complex beyond imagination, to become commonplace.

In 1905 a Dr. Thomas Bennett of New York City was described by James Tayloe Gwathmey, M.D., as the first American “practicing anesthetics” exclusively. At that time, the administration of anesthetics as a specialty was recognized in only a few of the larger cities. Dr. Gwathmey was one of the earliest private-practice anesthesiologists. He followed various surgeons from hospital to hospital to care for their patients, submitting his



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own bill and demanding to be treated as any other physician specialist.

These were the last days of “red-blooded, full-throated, get out of my way or I will run you down” capitalism, and medicine, like business in general, was ripe for entrepreneurship. Dr. Gwathmey, an intern at the New York Skin and Cancer Center, had decided that anesthesiology offered better practice opportunities than dermatology. In 1902 he described his portable “anaesthetic outfit,” which consisted of an “18-inch dress suit case” containing the whole of all he would carry to each hospital to perform anesthesia (see box at right).

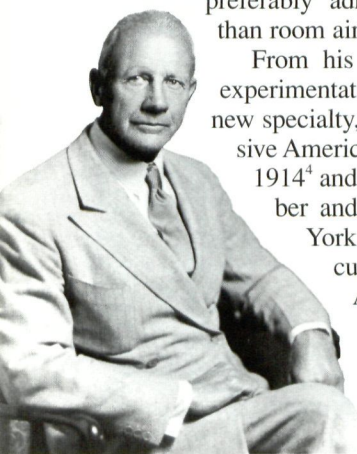
In 1903 he published his own anesthetic chart with a graphic display of pulse to be taken every five minutes, rate of the mixture he used, often administering “A.C.E.” (one part alcohol, two parts chloroform and three parts ether) using an inhaler he modified. He reported its use “in over 50 very difficult cases, most of them over three hours and two of them over four hours in duration. Several of these cases were athletic alcoholics, such as give most trouble to the anaesthetist, but it has never failed to give satisfaction.”² In 1904 he anesthetized cats² in a series of experiments, concluding that the four general anesthetics then in common use should be listed in the following order of safety:

- Nitrous oxide gas and oxygen;
- Nitrous oxide gas and air;
- Ethyl chloride and oxygen;
- Ethyl chloride and air;
- Ether and oxygen;
- Chloroform and oxygen;
- Ether and air;
- Chloroform and ether and air (two parts chloroform, three of ether);
- Chloroform and air.³

In 1905 his preference was to sequence agents gas (N_2O) followed by ether and then chloroform, all warmed and preferably administered with oxygen rather than room air.

From his extensive private practice and experimentation, he went on to explore this new specialty, publishing the first comprehensive American textbook of anesthesiology in 1914⁴ and becoming a key founding member and the first president of the New York Society of Anesthetists, a precursor of the American Society of Anesthesiologists.

Dr. Gwathmey's early advice to Richard von Foregger, M.D.,



James Tayloe Gwathmey, M.D.

Dr. Gwathmey's Portable Anesthesia Outfit

- 1 Bennett's inhaler, complete
- 1 Esmarch's chloroform inhaler, complete with dropper
- 1 steel tank for 100 gallons nitrous oxide gas, complete
- 1 Kelly's infusion apparatus.
- 1 tongue holding forceps, C/12489
- 1 mouth gag
- 1 hypodermic syringe with metal piston
- 4 sponge forceps, Foerster's
- 1 3ii minim glass for hypodermic injections and for measuring the ether
- 1 pus basin
- 1 operating gown

Drugs

- 1 tin absolute æther, 250 gram
- 1 two-ounce bottle of chloroform
- 1 two-ounce bottle of brandy
- 1 bottle for nitrate amyl pearls
- 1 vial strychnine tablets, 1/30 grain
- 1 vial nitroglycerine tablets, 1/100 grain
- 1 vial morphine tablets, 1/4 grain

was to “seize opportunities as they arise,” and this he did with vigor — the face of medicine, and in particular anesthesiology and surgery, was changed forever.

References:

1. Gwathmey JT. Remarks on gas-æther anaesthesia. *Med Rev Reviews*, October 25, 1902;976-979. [Collected in Pittinger CB. James Tayloe Gwathmey, M.D. American Pioneer Anesthesiologist. Vanderbilt University School of Medicine Department of Anesthesiology, 1989].
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4. Gwathmey JT. *Anesthesia*. New York: D. Appleton and Co; 1914:945.



A Day in the Life: 1955

C. Ronald Stephen, M.D., Former Trustee
Wood Library-Museum of Anesthesiology

“In 1955 little did we realize the tremendous changes that would occur in 1956 and future years by the introduction of halogenated anesthetics.”

In 1955 I was a Professor of Anesthesia and Head of the Division of Anesthesia at Duke University Hospital. In the division were several staff anesthesiologists, including Drs. Martin, Fabian, Hall and North, and a similar number of residents in training.

All patients having elective surgery were admitted to the hospital at least one day prior to the operation. Each patient was seen the day before surgery by a staff anesthesiologist and a resident and plans made for the anesthesia the next day.

The anesthetic drugs used in 1955 included thiopental, divinyl ether, nitrous oxide, cyclopropane, ether, succinylcholine and d-tubocurarine. Two potential difficulties were associated with these drugs:

- The surgeries were limited in the use of the cautery because both cyclopropane and ether were explosive.
- Nausea and vomiting postoperatively occurred in 20 to 25 percent of patients. An investigation was conducted in the use of Marezine™ to reduce the incidence of vomiting. In this study, Marezine appeared to reduce the incidence by about 25 percent. Chlorpromazine also was evaluated in a study but was not found to be of value for this purpose.

Clinical space for laboratory studies had been sorely needed for conducting research in anesthesia. Three years prior to 1955, in 1952, trichlorethylene had been evaluated as an analgesic to relieve the pain of labor. It had been found to be very useful, and a trilene inhaler was made so that patients could administer this drug to themselves as required for pain. A total of 50,000 of these inhalers were sold in the



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country, and they had been found to be useful. A sum of \$2 in the sale of each inhaler was allocated to increase laboratory space in the division of anesthesia.

Clinical lectures were held three times a week for the residents on a variety of anesthesia-related topics and to help to establish where further studies might be appropriate. The actual teaching of the residents, however, occurred at the head of the table in the operating room while the resident was administering anesthesia under the care and supervision of a staff anesthesiologist. It was found to be important for the resident anesthesiologist to maintain a close watch not only on how the patient fared but on how the surgical operation progressed.

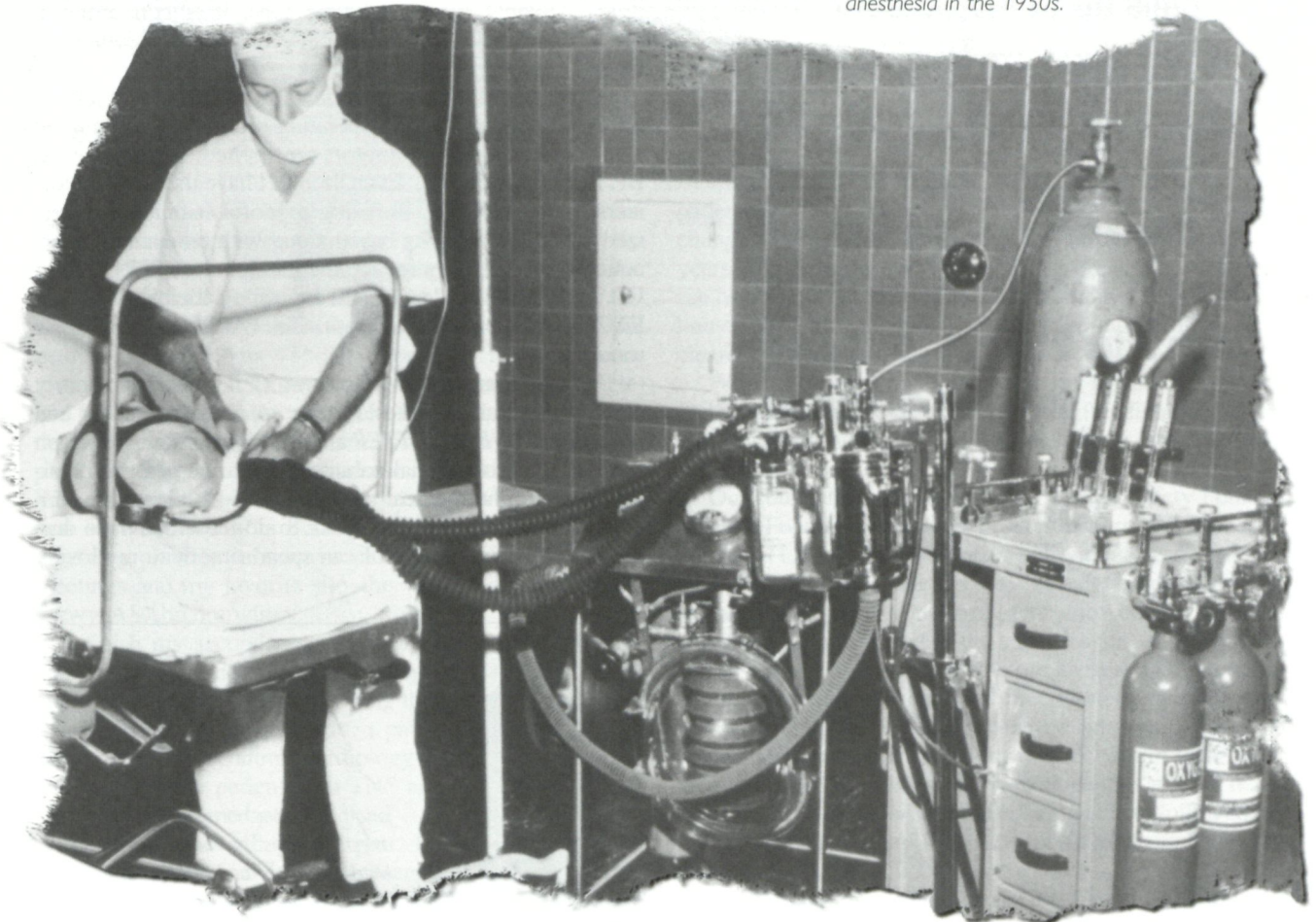
In the mid 1950s, a new suite of operating rooms was opened, and directly adjacent to it was a 10-bed recovery room for which the Division of Anesthesia was responsible. Staffed by excellent nurses, this recovery area proved to be

a great boon in the safe care of patients in the immediate postoperative period.

One of the studies conducted in our expanded laboratory space concerned research in animals of a long-lasting depotype of local anesthesia, which was called efocaine. The local anesthesia in this compound was procaine, and the solvents were propylene glycol and polyethylene glycol. Such a compound provided excellent long-lasting local anesthesia, but it was found that the solvents themselves provided such anesthesia and, in some instances, damaged the tissue around which the compound had been placed. Further study of this compound was not undertaken.

In 1955 little did we realize the tremendous changes that would occur in 1956 and future years by the introduction of halogenated anesthetics. 

John Michael Duffy, Jr., M.D., administering anesthesia in the 1950s.



A Day in the Life: 2005

Jonathan C. Berman, M.D., Trustee
Wood Library-Museum of Anesthesiology

“The intensive care unit (ICU) calls up to the OB suite (how they know I am here is beyond me); they have a patient with a tube leak and want the endotracheal tube changed. Nervously I head down to the ICU; even after 28 years, that procedure still scares me.”

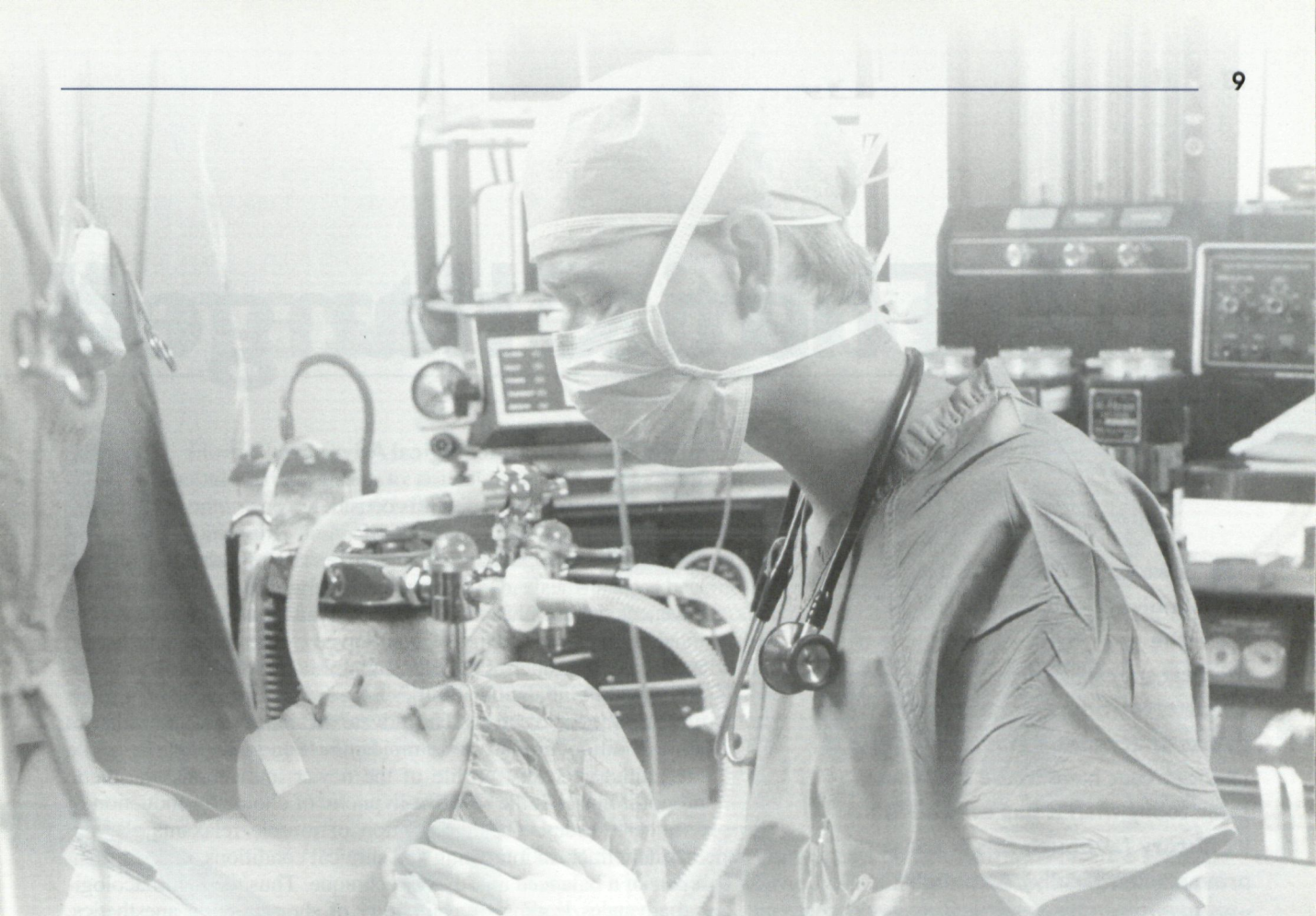
It is 2005, a Saturday morning, a call day, one of the seven I take a month. It is 5 a.m., and I am arising for a morning of cases. Since when are gallbladders emergency cases? Arriving early I check the patient's name on our computerized system and begin to fill out my anesthesia record. I cannot wait until the hospital approves our request for new machines with automated record keeping, transferring the data from Medetech onto my record. I call obstetrics (O.B.) to see how busy they are. I then restock my room, getting supplies from a computerized dispensing system (Pyxis®). I complete the FDA machine check and then sign all my drugs, fentanyl, succinylcholine (yes, it is still around), propofol, mivacurium and Zofran®, from another computerized dispensing system (AcuDose).

The patient arrives. Interview, examination and signed informed consent. To the operating room, again relying on amazing technology. Monitors are applied: BIS®, pulse ox, BP, ECG temperature. Even though I have the latest vaporizers, I choose TIVA. Infusing propofol with a computerized pump (on a mg/kg basis) along with relaxant and narcotic, to theoretically reduce the incidence of PONV. OTI UDV x1 BSBE (at least I still examine patients). Positive ETCO₂. Emergence smooth. To PACU (not recovery room).

Between cases (a two-hour wait), I go to the poorly appointed, small anesthesia office to organize papers and read the ASA NEWSLETTER and *Anesthesiology*. I work on some of my professional volunteer committee jobs as president-elect of the medical staff and Wood Library-Museum of Anesthesiology Trustee. I like to do these activities during down time at work so I can spend time with my lovely



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wife and marvelous 13-year-old twins. There are some things as important as our careers.

An O.B. doctor interrupts me, asking about a patient who had a spinal for cerclage. The patient has severe pain radiating down her legs. I think the history sounds like transient neurologic symptoms (TNS). "Come to the emergency room for evaluation," I say. I get on the Internet (Google) and find the latest review article on TNS and run the copy to the emergency room. I curse the computer to dispense supplies and drugs, praise it to dispense information. The ASA Web site <www.ASAhq.org> is great, providing information on what is new in Society news, clinical information regarding practice parameters and guidelines, a calendar of meetings and my favorite site, the Wood Library-Museum <www.ASAhq.org/wlm>.

I finish my second case and head upstairs to complete pain rounds, checking on our postop lumbar and thoracic epidural patients. It is great seeing the improvements anesthesiology has brought about in pain medicine. The last case is canceled pending "cardiology clearance." I examine and reassure the patient with TNS and dictate a note. At least I will be home by 5 p.m.

The pager goes off. It is 11 p.m. I head back to the hospital for an abdominal delivery (cesarean). Mother and child are well. The intensive care unit (ICU) calls up to the O.B. suite (how they know I am here is beyond me); they have a

patient with a tube leak and want the endotracheal tube changed. Nervously I head down to the ICU; even after 28 years, that procedure still scares me. After evaluation I figure out the cuff is above the cords, I readjust and plan to go home when the supervisor tells me the cardiologists have cleared the last case, and it is on for 8:30 a.m.

With the news of an 8:30 case on my mind, I drive home and reflect on my choice of profession (medicine) and specialty (anesthesiology). The profession is stronger than ever.

Our foundations, the Anesthesia Patient Safety Foundation, the Foundation for Anesthesia Education and Research, the Wood Library-Museum of Anesthesiology and the Anesthesia Foundation, lead the way in safety, education and research and professionalism. Our subspecialty societies and journals have added to the expertise and improvements for all anesthesiologists. Academic anesthesiology continues to train future leaders and practitioners. In fact I am thankful: thankful for my colleagues who work on ASA committees; for the friends I have made within the profession, not only physicians but the fine people at ASA headquarters; for a good living and for being able to follow in my father's footsteps (may I practice for 40 years and have the same impact).

It is a great job (profession)! Gee, I wish I did not have that 8:30 case.



10 THINGS

That Changed

Girish P. Joshi, M.D.

As we celebrate ASA's 100th anniversary, it is time to reflect upon the great strides made in the medical specialty of anesthesiology. Since its introduction, anesthesiology has undergone significant changes that have made anesthesia safer today than it has ever been in its history (although this is not yet proven scientifically). Although the numerous and impressive advances in anesthesiology are too great to cover in such a small article, I will attempt to identify 10 broad categories that may have contributed to improved patient safety and perioperative outcome.



Girish P. Joshi, M.D., is Professor of Anesthesiology and Pain Management and Director of Perioperative Medicine and Ambulatory Anesthesia, University of Texas Southwestern Medical Center, Dallas, Texas.

1

Pharmacological Advances

The introduction of anesthesia revolutionized surgical care and thus is considered one of the most important achievements of modern times. Much has changed, though, since the days of induction of anesthesia with open-drop ether. One of the major advances in anesthesia was the introduction of nonflammable inhaled anesthetics, which was followed by the newer shorter-acting inhaled anesthetics (i.e., desflurane and sevoflurane) that probably allowed inhalation anesthesia to remain the mainstay of modern anesthesia practice. The advent of intravenous anesthetics allowed smoother and more rapid induction of anesthesia, while the unique recovery profile of the newer intravenous anesthetic propofol makes it the sedative-hypnotic of choice for induction of anesthesia today. The introduction of muscle relaxants allowed excellent tracheal intubating and surgical conditions, making them a part of a balanced anesthesia technique. Thus the pharmacological advances leading to availability of shorter-acting anesthetics, analgesics and muscle relaxants offered the potential for rapid and smooth induction of anesthesia, rapid recovery from the anesthesia and expansion of ambulatory anesthesia and surgery. The availability of local anesthetics also led to introduction of conduction anesthesia. Spinal and epidural anesthesia have now become excellent alternatives to general anesthesia. In addition regional analgesic techniques, particularly epidural analgesia and now continuous peripheral nerve blocks, are the cornerstones of a multimodal analgesia technique.



Nondepolarizing muscle relaxants became a part of the anesthesiologist's armamentarium in the 1940s. Image courtesy of the Wood Library-Museum of Anesthesiology.

Anesthesiology

2

Fluid Therapy

Another major advance that has received relatively little attention is the introduction of balanced salt solutions (i.e., crystalloids) and then colloids during surgery. It has been generally assumed in the past that fluid administration had little impact on outcomes. It appears, though, that we have become too casual with the amount and type of fluid administered in the perioperative period, and more recent research indicates that management of fluid therapy intraoperatively has vast potential for influencing intraoperative and postoperative morbidity and mortality. Of course fluid therapy remains one of the most controversial topics in perioperative management, particularly concerning the choice of colloid versus crystalloid solutions.



Commonly used crystalloids and colloids.

3

Airway Management

One of the fundamental components of safe anesthesia practice is maintenance of a patent airway. The availability of the tracheal tube and the tools for its placement (e.g., laryngoscopes) revolutionized anesthesia practice as it allowed isolation of the trachea and safe delivery of anesthetics as well as adequate ventilation. Soon after the introduction of tracheal tubes and muscle relaxants, tracheal intubation and anesthesia were considered almost synonymous. Another major advance in airway management was the introduction of the laryngeal mask airway (LMA), which has helped to save innumerable patients threatened by difficult airways. The LMA has since been incorporated into the ASA Practice Guidelines for Management of the Difficult Airway (see the ASA "Difficult Airway Algorithm"). In fact the LMA has gained popularity as a general-purpose airway device and is currently used for routine elective surgical procedures as frequently as the tracheal tube.



Laryngeal mask airway. Image courtesy of the Wood Library-Museum of Anesthesiology.

4

Ventilators & Pumps

Advances in drug delivery systems, both anesthesia gas delivery equipment (i.e., anesthesia machines) and infusion devices, have significantly improved administration of anesthesia. The availability of ventilators in the operating room (O.R.) has allowed uninterrupted control of ventilation. Prior to introduction of ventilators in the O.R., ventilation had to be performed manually, which may sometimes be inadequate due to fatigue or need to perform other responsibilities. Since their introduction, infusion pumps have evolved into sophisticated therapy-specific devices (e.g., general purpose intravenous pump, epidural analgesia and peripheral nerve blocks) that provide more effective patient care and improve patient safety.



Penlon Nuffield Ventilator. Image courtesy of the Wood Library-Museum of Anesthesiology.

5

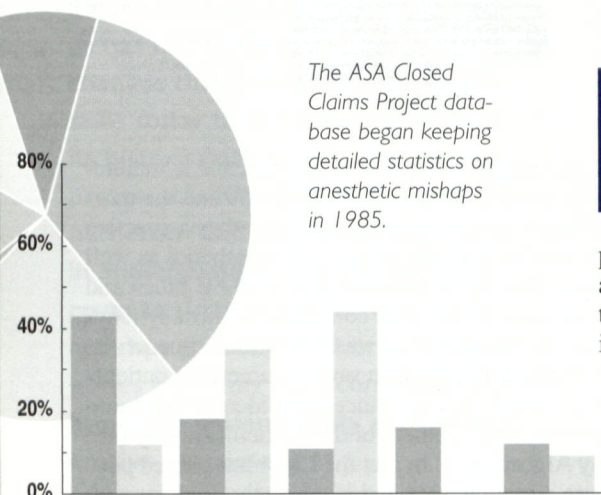
Monitoring Devices

Technological advances leading to development of sophisticated monitors such as noninvasive blood pressure monitoring, pulse oximetry and capnography have improved and continue to improve anesthesia care. More recently transesophageal

echocardiography and ultrasound-based hemodynamic monitoring provide excellent alternatives to the pulmonary artery catheter and can be used to optimize intraoperative hemodynamics and fluid administration. Another advance, which is the focus of recent debate, is electroencephalography-based monitoring for depth of hypnosis.



American Optical Pulse Oximeter, 1960s. Image courtesy of the Wood Library-Museum of Anesthesiology.



The ASA Closed Claims Project database began keeping detailed statistics on anesthetic mishaps in 1985.

6

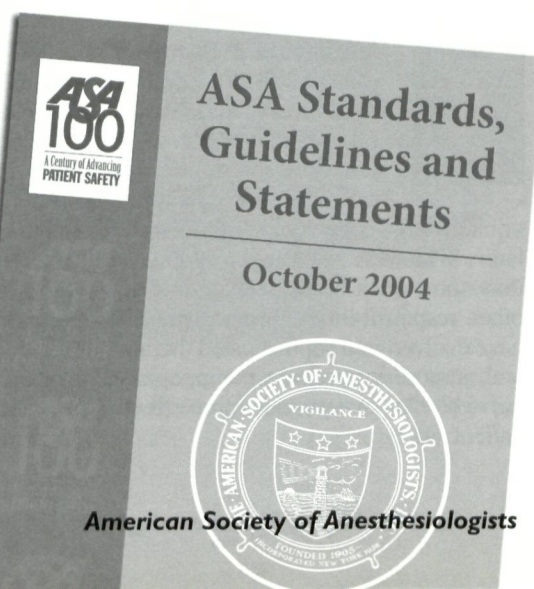
Closed Claims Project

An important and far-reaching undertaking of ASA was the development of the Closed Claims Project in 1985. The Closed Claims Project database has allowed correlation between anesthetic care and the occurrence of adverse events. Identification of the source of injury provides anesthesiologists and others with information of specific areas of emphasis. In the late 1980s, for instance, information from the database revealed respiratory-related events to be the single most important source of liability and also that many of these events could have been prevented. This data prompted ASA to develop guidelines relating to pulse oximetry, capnography and management of the difficult airway, which were mentioned previously in this article and which led to number 7 in my list of important achievements in anesthesiology history.

7

Standards & Guidelines

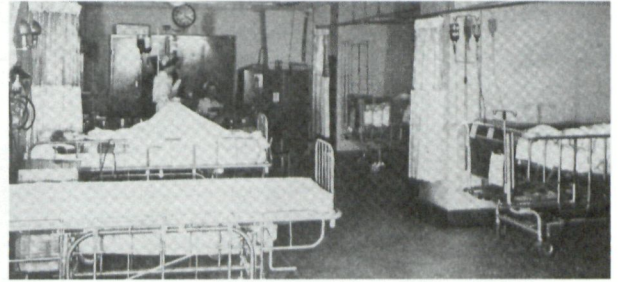
The development of standards and guidelines represent a major milestone in the specialty and are directly related to the activities of ASA. The "Standards for Basic Anesthetic Monitoring" and several updates since their introduction represent just some of the many ASA efforts that have significantly improved anesthesia care and patient safety. The success of the standards led to the development of evidence-based guidelines and practice parameters for specific clinical situations or procedures, such as the aforementioned Practice Guidelines for Management of the Difficult Airway.



8

Perioperative Care

Anesthesiologists functioning as perioperative physicians spearheaded the introduction of preoperative clinics that allow preoperative optimization of patients and improved postoperative management, including development of organized acute pain services and multidisciplinary approaches to chronic pain management. Establishment of intensive care units (ICU) has been a major advancement in medical care, and anesthesiologists have been at the forefront of involvement and development in ICU management. Noted anesthesiologist Peter Safar, M.D., developer of cardiopulmonary resuscitation and creator of the nation's first paramedic ambulance service, formed the country's first ICU in 1958. Within a decade, almost all U.S. hospitals had at least one ICU.



*An intensive care unit at the University of Illinois Research and Educational Hospitals in Chicago circa 1955. Photo taken from *The Recovery Room — Immediate Postoperative Management*, W.B. Saunders Company; 1956.*

9

Board Certification

The administration of the certification examination by the American Board of Anesthesiologists marked another important milestone in anesthesiology in the United States. The examination became possible soon after ASA's formation and recognition of



anesthesiology as a separate medical specialty. The certification and maintenance of certification of anesthesiologists and subspecialists in pain medicine and critical care medicine assesses competence and thus may be associated with improved quality of care and patient safety.

10


Anesthesiology Research

Obviously none of the advances discussed above would have been possible without research. When Crawford W. Long, M.D., administered the first ether anesthetic for surgery in 1842, he helped to initiate a shift in the way physicians viewed surgical treatment and trauma. Anesthesiologist researchers soon came to lead research endeavors in an attempt to create a controlled and predictable state of anesthesia care. Research anesthesiologists

recognized the importance of vital sign monitoring, helped to determine the importance of pulse and respiratory rate during surgical procedures and developed ventilation and heart monitor machines. Anesthesiologist-led research into neural transmission is changing the way pain is treated, and anesthesiologists are active in genetic research that, though it seems like science fiction now, will some day revolutionize anesthesia care.

Many of the important achievements in anesthesiology have a tendency to be taken for granted, and our history of progress and development in such a relatively short span of time can often go unnoticed. Our specialty has gone through (and continues to go through) an amazing evolution. The development of new drugs and technological innovation continue to change our practices, which have been refined over the years and have increased in complexity and sophistication. Recent years have seen an unprecedented rate of progress, and I am sure that anesthesiology will continue to change with further improvements in patient safety and perioperative outcome. Such improvements will happen through a better understanding of drug effects, particularly with advances in genetic technology, use of sophisticated

delivery systems, including anesthesia machines with superior ventilators and alarms systems, and improved smart-infusion pumps that utilize closed-loop technology. In the future, robotics will surely play a key role in patient care, and perhaps anesthesia will be delivered remotely. Improved training using simulators and advanced communications through the Internet as well as outcomes analyses should further reduce perioperative mortality as well as morbidity.

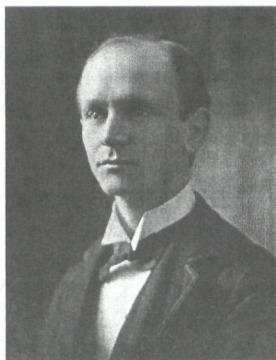
ASA and anesthesiology have accomplished much in the last 100 years, but, as has always been the case in anesthesiology's storied yet short history, the best is yet to come. Here's looking to another 100 years and the hundreds of new things that will change anesthesiology for the better! 

The Long Island Society of Anesthetists

Joseph P. Giffin, M.D. (1942-2004)

Kathleen E. Powderly, Ph.D.

“... there are a few physicians practicing anesthesia in the area, these men ought to get together and form a society.”

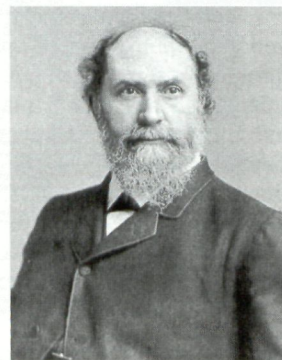


A. Frederick Erdmann, M.D.

ASA has its roots in the Long Island Society of Anesthetists, founded in 1905 in Brooklyn, New York. A. Frederick Erdmann, M.D., a hospital anesthetist and instructor in anesthesia at Long Island College Hospital, convened the first meeting on October 6 of that year to coincide with Ether Day. Dr. Erdmann invited a group of physician-anesthetists to meet because, as he put it, “there are a few physicians

practicing anesthesia in the area, these men ought to get together and form a society.”¹ These events coincided with an increase in specialization in medicine and a concurrent establishment of specialty societies. When the Long Island Society of Anesthetists was established, there was only one specialty society in anesthesiology in existence: the London Society of Anesthetists, founded in 1893.

It is not surprising that these events took place in Brooklyn and at the Long Island College Hospital (LICH). LICH had been established in 1860 as a combination of a hospital and a medical school. It also was the first institution to combine clinical and classroom teaching for medical students. Brooklyn had only recently become part of New York City and was the third largest city in the country at the time it merged. It was an important industrial area which contributed to the success of a busy hospital with busy operating rooms. The Medical Society of the County of Kings had been founded in 1822, and there were other specialty societies such as the Brooklyn Gynecological Society, the fifth oldest specialty society in obstetrics and gynecology in the



Alexander J.C. Skene, M.D.



Joseph P. Giffin, M.D., served as Chair of Anesthesiology, Long Island College Hospital and Executive Vice-Chair of Anesthesiology, State University of New York Downstate Medical Center, Brooklyn, New York.



Kathleen E. Powderly, Ph.D., is Acting Director, Division of Humanities in Medicine, State University of New York Downstate Medical Center, Brooklyn, New York.

United States. One of the most prominent graduates of LICH in the 19th century was Alexander J.C. Skene, M.D., an 1863 graduate and Scottish immigrant for whom the glands in the female genitalia are named. Dr. Skene served on the faculty at LICH for his entire career, except for service in the Civil War.² He was a mentor to Dr. Erdmann and was President of LICH when the Polhemus Building (classrooms and a dispensary) was dedicated not long before his death in 1900. It was in the Polhemus Building, which still houses the offices of the departments of anesthesia and surgery at LICH, that the Long Island Society of Anesthetists held its first meeting. The original founders group of the Society included Dr. Erdmann and eight of his medical colleagues.

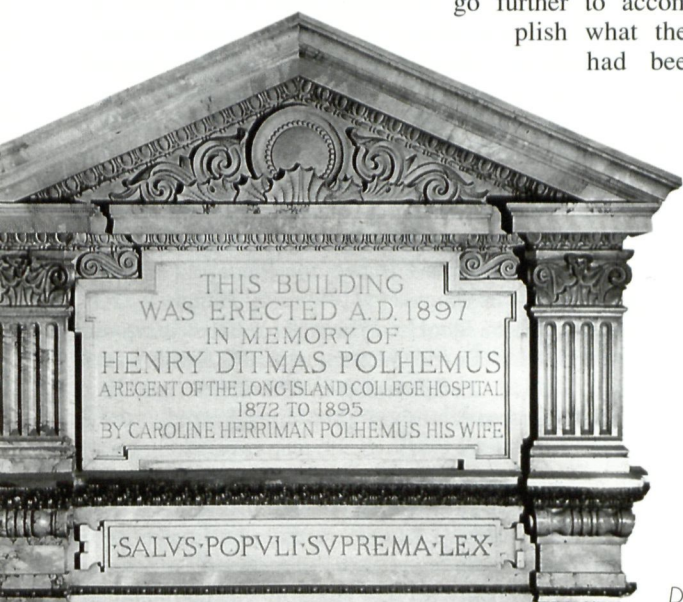
The Society existed as a local group until May 31, 1911, when the last meeting was held. The meeting was called to order by the President Erdmann. As a last act of the Society, he gave a brief history from the inception until it "was swallowed up by the group of men in New York City." He feared that the Society would lose its identity with its broadened scope and change of name. He admitted, though, that they had gone so far that they must go further to accomplish what they had been



The Long Island College Hospital, 1899.

intending to do. "I am overwhelmed," he concluded, "by the recognition of the changes which will take place, and by the fact of the necessity for making those changes."¹ Thereafter the name of the Society was officially changed to the New York Society of Anesthetists.

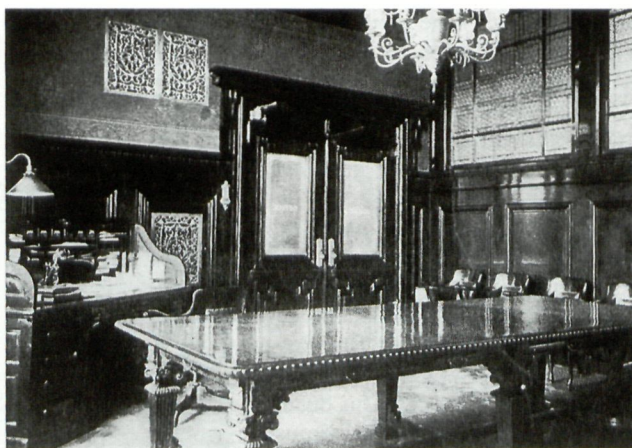
Dr. Erdmann not only founded the Long Island Society, but he would remain active in the New York Society. He served at various times as secretary, librarian, historian and politician. He was a meticulous recorder as secretary and always a man of influence in the Society. He collected the papers and minutes of the Long Island and New York societies as well as the successor organization, the American Society of Anesthetists, from 1905-36. Erdmann also served as Librarian, an elected office established in 1912, and attempts were made to establish a library. His "contribution of a full show case of anesthesia equipment and two shelves of books and reprints were a substantial factor in the development of the present Library-Museum of Anesthesiology."³ As historian he stated, as the Society evolved into the American Society of Anesthetists, "A few men are still living who gave anesthetics in the late years of the 19th century. To bring both the living, our Silver Greys, and the dead who were the pioneers into the ken of the ever-increasing host which the American Society of Anesthetists has become my task ... and will any one who knows about the



Dedication fresco, which appears on the Polhemus Memorial Clinic.



Dispensary entrance to Polhemus Memorial Clinic.



Secretary's Office in the Polhemus Memorial Clinic.



Polhemus Memorial Clinic Library.

days of the '90s or earlier cooperate in writing this history for the boys who will follow us?" The Historian's Report in 1936 also pointed out the pressing need for an official organ of the Society — support for what was to become *Anesthesiology*.

Dr. Erdmann also was involved in the "politics" of anesthesia during his years with the various societies. The final objective of the founders group was to have the medical anesthetists equal the internist, surgeon and obstetrician. In 1915 the New York Society of Anesthetists worked toward amending the Public Health Law of the State of New York "to define the administration of a general anesthetic as the practice of medicine." In 1924 the Society applied to recognize medical anesthetists in the listing of medical fees, and in 1934, another bill was introduced in the New York State

Legislature to limit the administration of anesthesia to physician anesthetists.¹

Dr. Erdmann published as well. His publications include "How Music Heals the Sick" in the *Popular Science Monthly* in October 1937; "It Has Charms: Therapeutic Music Drives Away and Prevents Dental Pain" in *Literary Digest* in May 1937; and "Music Aids the Anesthetist" in *The Scientific American* in August 1933. He also received several honors, including the Distinguished Service Award in 1948 and served as Long Island Society President in 1911.

On February 13, 1936, a meeting was held "to make this Society, in name, as well as in fact, a national society in anesthesia." Nothing would be changed in the Society except to replace the word "American" for "New York" throughout the Constitution. In 1945 the Society would finally become the American Society of Anesthesiologists, Inc., as we know it today.

This article is dedicated to the memory of Joseph P. Giffin, M.D., friend, colleague and mentor. We will miss his wisdom and insight.

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1. Betcher AM, Ciliberti BJ, Wood PM, Wright LH. The jubilee year of organized anesthesia. *Anesthesiology*. 1956; 17:226-263.
2. Powderly K. Unpublished dissertation, 1998.
3. *Bull NY State Soc Anesth*. 1953; 5(7):3.



A History of

The Distinguished Service Award

“There is no finer tribute than to be so honored by your fellow anesthesiologists.”

Paul J. Schaner, M.D.

The Distinguished Service Award (DSA) is the highest recognition ASA has traditionally bestowed upon outstanding members. The DSA was established in 1945 on the recommendation of the Committee on Awards and Honors for outstanding work in and service to anesthesiology. Following Paul M. Wood, M.D., as the first recipient, the 1946 Committee on Distinguished Service Award submitted the names of Ralph M. Waters, M.D., Ralph M. Tovell, M.D., and Stuart C. Cullen, M.D., to the Board of Directors (BOD). Dr. Waters was the winner. The BOD then requested the committee, thereafter, to submit three names to the BOD and provide an outline of the accomplishments of the three candidates.

Then, as now, the selection of the DSA is not an easy task. In September 1947, the committee submitted the names of Adolph F. Erdmann, M.D., John S. Lundy, M.D., and Dr. Cullen for consideration for the DSA. Emery A. Rovenstine, M.D., was to present plans for presentation of the award to Dr. Waters. Originally the award was decided by vote of the BOD. Urban H. Eversole, M.D., made an attempt in 1948 for the award to be by vote of the House of Delegates (HOD); John Adriani, M.D., supported this. The HOD became the body that selected the DSA recipient in 1948. The 1948 Committee on Awards and Honors also recommended that the award not be an annual one or at any set interval, but it should be made for meritorious service when such service was evident. The service could lie in the field of clinical anesthesia, experimental research or clinical teaching. The committee also felt it important to create some element of continuity to the committee by dropping only two members annually.

In 1949 the committee, chaired by Ralph T. Knight, M.D., submitted eight stellar candidates to the BOD almost all with equal weight. Dr. Adriani was recommended for his three excellent teaching textbooks and other significant contributions. Dr. Cullen was nominated for his textbook contribution, his excellent investigations of curare and other significant activities. The nomination of Harold H. Griffith, M.D., was for his introduction of curare into anesthesiology and his recognition as a teaching lecturer. The nomination for Charles F. McCuskey, M.D., was for his activities in the advancement of anesthesiology organization and his success as a Consultant in Anesthesiology for the Pacific Theater of Operations during World War II. The name of Henry Ruth, M.D., was put forth for his establishment of Anesthesia Study Commissions and his able editorship of *Anesthesiology*. Meyer Saklad, M.D., was nominated for his development of improved methods of American board



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Recipients of the ASA Distinguished Service Award (1945–2004)

1945 — Paul M. Wood, M.D.*	1965 — Robert D. Dripps, M.D.*	1986 — William K. Hamilton, M.D.
1946 — Ralph M. Waters, M.D.*	1966 — Joseph H. Failing, M.D.*	1987 — Robert M. Smith, M.D.
1947 — Adolph Erdmann, M.D.*	1967 — Frederick P. Haugen, M.D.*	1988 — Gertie F. Marx, M.D.*
1948 — John S. Lundy, M.D.*	1969 — Forrest E. Leffingwell, M.D.* (Posthumously)	1989 — Nicholas M. Greene, M.D.*
1949 — John Adriani, M.D.*	1970 — Henry K. Beecher, M.D.*	1990 — John D. Michenfelder, M.D.*
1950 — Arthur Guedel, M.D.*	1971 — E.M. Papper, M.D.*	1991 — Edmond I. Eger II, M.D.
1951 — Ralph M. Tovell, M.D.*	1972 — Frances F. Foldes, M.D.*	1992 — John S. Hattox, M.D.
1952 — Henry S. Ruth, M.D.*	1973 — John J. Bonica, M.D.*	1993 — B. Raymond Fink, M.D.*
1953 — Charles F. McCuskey, M.D.*	1974 — Perry P. Volpitto, M.D.*	1994 — Jess B. Weiss, M.D.
1954 — Moses H. Krakow, M.D.*	1975 — Albert M. Betcher, M.D.*	1995 — Martin Helrich, M.D.
1955 — Lewis H. Wright, M.D.*	1976 — Daniel C. Moore, M.D.	1996 — Ellison C. Pierce, Jr., M.D.
1956 — Rolland J. Whitacre, M.D.* (Posthumously)	1977 — Leroy D. Vandam, M.D.*	1997 — James F. Arens, M.D.
1957 — Emery A. Rovenstine, M.D.*	1978 — M.T. Pepper Jenkins, M.D.*	1998 — Harry H. Bird, M.D.
1958 — C. Walter Metz, M.D.*	1979 — David M. Little, Jr., M.D.*	1999 — Burton S. Epstein, M.D.
1959 — Harold R. Griffith, M.D.*	1980 — James E. Eckenhoff, M.D.*	2000 — Betty P. Stephenson, M.D.
1960 — Ralph T. Knight, M.D.*	1981 — C. Ronald Stephen, M.D.	2001 — Alan D. Sessler, M.D.
1961 — Virginia Apgar, M.D.*	1982 — John E. Steinhaus, M.D.	2002 — Bernard V. Wetchler, M.D.
1962 — George J. Thomas, M.D.*	1983 — E.S. Siker, M.D.	2003 — Robert K. Stoelting, M.D.
1963 — Dennis E. Jackson, M.D.*	1984 — Arthur S. Keats, M.D.	2004 — William D. Owens, M.D.
1964 — Stuart C. Cullen, M.D.*	1985 — Richard Ament, M.D.*	

* Deceased

examinations and his development of punch-card reference records. The nomination for Brian Sword, M.D., was based on his advancement of lung surgery. Dr. Tovell was nominated for his advancement of the teaching of anesthesiology and his accomplishment as a Consultant in Anesthesiology for the European Theater of Operations and for the Veterans Administration. The selection of the candidate was obviously no easy task. The characteristics in common for recipients of the DSA are a history of service and the advancement of the specialty. Dr. Adriani ultimately received the DSA that year.

Dr. Lundy chaired the 1950 Committee on Awards and Honors. The committee recommended the DSA be given

annually, and each component could nominate one of its members. The committee also was permitted to nominate individuals, but no less than three names would be submitted to the BOD. If more than three names were submitted, the BOD would select the three on the list to be submitted to the HOD.

Frederick P. Haugen, M.D., chaired the 1953 committee and suggested that the HOD be presented with detailed information on the finalists for the DSA before they vote and also that the committee's membership should be more stable. The 1954 committee indicated that the custom had been for the committee to present the three nominees accompanied by an adequate curriculum vitae rather than



The DSA was twice awarded posthumously; here, Albert M. Betcher, M.D., left, accepts the 1969 DSA for Forrest E. Leffingwell, M.D., from 1970 ASA President John E. Steinhaus, M.D., in New York, New York.

expressing any preference on part of the committee.

In 1963 the HOD approved that each ASA component may submit the name of a living individual for the DSA, which must be received 60 days before the Annual Meeting. The component was required to forward a copy of the candidate's curriculum vitae to the members of the BOD 30 days prior to the Annual Meeting. The BOD selected the three nominees to the HOD by secret ballot. If three names or less were submitted, all were forwarded to the HOD. The HOD voted by secret ballot for the DSA award.

E.M. Papper, M.D., was chair of a 1966 ad hoc committee that reviewed present and past selection procedures for the DSA. The committee recommended that the DSA selection committee be a standing committee composed of three past presidents and three DSA recipients. Continued to this day, the term of each is set at three years, and the chair is appointed annually by the president. Qualifications shall be outstanding clinical, educational and scientific achievement or contributions that further the development of the society. Nominations by component or society members of ASA are on the forms to the chair of the DSA committee 60 days

prior to the Annual Meeting. The committee is to review the nominations and make but **ONE** recommendation to the HOD. The HOD may make no additional nominations. No one holding office is eligible. The committee must agree on a nominee by two-thirds vote, and the HOD requires a two-thirds vote of approval.

The DSA is presented to the recipient at the next year's annual meeting. The individuals honored by ASA have been prestigious and diverse. The list is composed of individuals who exemplify the many attributes of ASA and its members. The awardees exemplify the values and qualities esteemed by ASA. The truly distinguished physicians who have been awarded the DSA are listed on page 18 in chronological order.

These individuals represent physicians who excel in the specialty of anesthesiology. Each has an outstanding quality or qualities recognized by his/her peers. There is no finer tribute than to be so hon-

ored by your fellow anesthesiologists. Today, as it was yesterday, the awardees are selected as the best of the best; the list continues to grow. The additions give testimony to the continual striving to advance the specialty. Through their efforts, the awardees have provided an environment to foster the development of the safest care available for patients who require anesthesia.

The practice of anesthesiology is the practice of medicine, the basis of the specialty. The next 100 years will echo the past accomplishments of the DSA group. They are the future's foundation. The specialty continues to advance to higher levels by standing on the shoulders of the accomplished members of ASA. While not all members are recipients of the DSA, many provide distinguished service for their patients and their Society. All members can be proud of the established tradition.

The author wishes to thank Karen Bieterman of the Wood Library-Museum and Roy A. Winkler of the Communications Department for their assistance.



The Rovenstine Lectureship

E.S. Siker, M.D.



Emery A. Rovenstine, M.D.

The Emery A. Rovenstine Memorial Lecture at the ASA 2005 Annual Meeting will be the 44th in the series that began in 1962, soon after the untimely death of Emery A. Rovenstine, M.D. The E.R. Squibb Company endowed the first three years of the Lectureship to commemorate Dr. Rovenstine's lasting contributions to the specialty. What today's generation of anesthesiologists knows about his iconic stature is gleaned largely from the brief biography included annually either during the introduction of the Rovenstine Lecturer or by the lecturer him/herself.

Emery Rovenstine was born in 1895 in Atwood, Indiana, attended Wabash College and obtained his medical degree at Indiana University. As a young man, Dr. Rovenstine had been a teacher, a coach and an athletic director at La Porte High School. The discipline and focus required by such activities may well have tempered him for the difficult tasks he later chose for himself. Following medical school and a one-year rotating internship, he was one of the first two residents to train with Ralph M. Waters, M.D., in Wisconsin. After completing his training, he was invited to join the faculty of the New York University College of Medicine and, additionally, undertook the enormously challenging task of organizing an anesthesiology department at New York's Bellevue Hospital, one of the largest in the nation.

During his 25-year tenure at Bellevue, his clinical skills, research interests and vitality as a teacher were legendary. His proudest legacy, however, would have been the achievements of the physicians who trained with him, including, among others, John Adriani, M.D., E.M. Papper, M.D., S.G. Hershey, M.D., Virginia Apgar, M.D., Stuart Cullen, M.D., Martin Helrich, M.D., Louis Orkin, M.D., Louis H. Wright, M.D., and for a portion of his training, Robert D. Dripps, M.D. These and other Rovenstine trainees were destined to play a major role in the growth and maturation of the specialty.



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There have been 43 Rovenstine Lecturers to date.* Initially the lecturers were chosen by the Annual Sessions Chair, and soon after, by that year's ASA President. It was decided early on, perhaps not as a written "rule," to exclude anesthesiologists as lecturers, thereby avoiding the perception of a popularity contest. In a still young specialty, it also was reasoned that few anesthesiologists had attained the prominence deserving of the recognition that such an invitation would confer. Additionally there were any number of eminent physicians/scientists who, as Rovenstine Lecturers, could impart their own prestige to this new lecture series and further address topics complementary to anesthesiology.

Conforming to this objective, seven of the first eight lecturers included Francis D. Moore, M.D., Surgeon in Chief of the Massachusetts General Hospital, who delivered the first lecture in 1962. His topic was "Hemorrhage." In 1963 Julius Comroe, M.D., addressed the "Regulation of Respiration," and almost in physiological lockstep, Eugene Braunwald, M.D., delivered the 1964 lecture titled "The Control of Cardiac Function." William K. Hamilton, M.D., remembers his participation in proposing the 1965 lecturer. The subject of Louis Lasagna, M.D., "The Principles and Pitfalls in Evaluation of New Drugs," was well-suited for an audience of anesthesiologists.

In 1966 the selection of Dr. Papper, a prominent former resident of Dr. Rovenstine, interrupted the chain of "nonanesthesiologist" lecturers. Dr. Papper paid special tribute to his teacher by choosing one of Dr. Rovenstine's special areas of interest and expertise, regional anesthesia, and more specifically, a critical assessment in its place in therapeutics.

In the following three years, renowned investigators continued the series: Arthur C. Guyton, M.D. ("Regulation of Cardiac Output"); Hermann Rahn, M.D. ("Evolution of Gas Transport Mechanisms from Fish to Man"); and Niels A. Lassen, M.D. ("Cerebral Circulation and the Anesthetist: An Appraisal of Practical Consequences of Present Knowledge").

While no record of refusal to accept an invitation as a Rovenstine Lecturer could be found, an unfortunate episode occurred in the early 1970s. After Linus Pauling, M.D., an eminent Nobel Laureate, had accepted the invitation, it was withdrawn for reasons that remain unclear (personal communications).



Dr. Rovenstine, middle row center, poses with his staff at Bellevue Hospital in 1958.

In 1984 Eugene A. Stead, Jr., M.D., Emeritus Professor of Medicine at Duke University, titled his lecture "Anesthesiologists Come of Age." This reality had been recognized years earlier, though, and in 1970, the era of the anesthesiologist as Rovenstine Lecturer began. The lecture by Robert D. Dripps, M.D., "The Physician and Society," was largely a philosophical treatise and represented a sea change in the direction of lecture subjects. Dr. Dripps served notice that a change in tone had, indeed, occurred by observing that "there is nothing quite so dull as a doctors' party with the practitioners off in a corner reviewing their interesting cases." More seriously he also was prescient in challenging the adequacy of education for both primary and professional school students. A brief return to pure science followed Dr. Dripps' talk the following year with an esoteric presentation by Nobel Laureate Julius Axelrod, M.D., who addressed "Biochemical Factors in the Inactivation and Activation of Drugs."

In his lecture in 1972, Dr. Cullen challenged some basic precepts in anesthesiology residency training programs with "Factors Influencing Education in Anesthesiology." One of the most controversial lectures in the series was delivered in 1973 by William W. Mushin, M.D., who suggested in "The Decline and Fall of the Anesthesiologist" that it was time for the anesthesiologist to get back into the operating room. His concerns would probably have been more strident if the term "perioperative physician" had existed at the time. There were now four anesthesiologists who had delivered the Rovenstine Lecture, and it seemed appropriate to invite Drs. Dripps, Cullen and Papper to join

*A complete list of Rovenstine lecturers and titles is available at: <www.ASAhq.org/wlm>.

Dr. Mushin in a separate Rovenstine panel at the 1973 meeting.

In 1978, the lecture by William K. Hamilton, M.D., "Stress and Anesthesia," challenged the concept, championed by Hans Selye, M.D., that anesthesia was a stress-inducing event, arguing that "anesthesia was not as much a stress as an anti-stress."

Of the remaining lectures, seven dealt with clinical facets of our specialty: Arthur S. Keats, M.D. (anesthesia for cardiac surgery); John F. Nunn, M.D. (risks with newer inhalational agents); Ellison C. Pierce, Jr., M.D. (anesthesia safety); Michael J. Cousins, M.D. (pain: past, present and future); Burton S. Epstein, M.D. (sedation and analgesia for nonanesthesiologists); and Terri G. Monk, M.D. (postoperative cognitive dysfunction). Thomas F. Hornbein, M.D., one of the first Americans to reach Mt. Everest's crest, combined an exciting report of his adventure with, appropriately, oxygen transport and carrying capacity.

Lawrence J. Saidman, M.D., in his "What I Have Learned After Nine Years and 9,000 Papers," reviewed how publications in the journal *Anesthesiology* had evolved during his stewardship as editor.

Twelve of the most recent lectures, while including references to clinical practice, were more devoted to an eclectic list of issues: education, ethics, responsibility, challenges, leadership and manpower, etc. Edward R. Annis, M.D., a past president of the American Medical Association, spoke of new challenges and opportunities in medicine.

Glenn W. Johnson reminisced about education, science and advocacy from the vantage point of his years as ASA's Executive Director.

Lectures addressing concerns about the status of the specialty included "Anesthesiology: The Search for Identity" by John Lansdale, Esq., longtime legal counsel for ASA. In "Neuroanesthesia and the Achievement of Professional Respect," John D. Mitchenfelder, M.D., expressed concern about the lack of respect and understanding from our peers in other medical disciplines, emphasizing the need for anesthesiology to be recognized as a clinical discipline as well as a source of valuable contributions to medical science. In his lecture "The Changing Horizons in Anesthesiology," Nicholas M. Greene, M.D., cited our failure as a specialty to communicate what it is that we do, not only to the laity, but also to our colleagues in other specialties. This was echoed in my 1981 lecture "A Measure of Worth," which explored

how we, as anesthesiologists, viewed our own worth. In 1979, LeRoy D. Vandam, M.D., explored "Anesthesiologists as Clinicians" and ruminated over how other specialties managed to be seen as clinicians while anesthesiologists were identified, pejoratively, as "hospital-based."

In 1996 David E. Longnecker, M.D., cited the dichotomy between an expanding specialty and the decrease in medical student interest in "Navigation in Uncharted Waters: Is Anesthesiology on Course for the 21st Century?" He also lamented an apparent practitioners' preference for efficiency over image.



Thomas F. Hornbein, M.D., far right, in white coat, demonstrates the use of plastic sleeping masks to Sherpas who worked with the American climbing expedition on Mt. Everest in 1963. Dr. Hornbein's Rovenstine lecture in 1989 was titled "Lessons From on High."

In 1999 Carl C. Hug, Jr., M.D., Ph.D., reconciled disparate and sometimes opposing forces in our approach to clinical practice in "Patient Values, Hippocrates, Science and Technology." In "Clinical Challenges for the Anesthesiologist," Robert K. Stoelting, M.D., stressed that learning and education never end and that anesthesiologists should become eternal and vigilant students for the duration of their careers. In 1980 M.T. "Pepper" Jenkins, M.D., spoke about "Responsibility for the Future," and Francis M. James III, M.D., asked in 1998, "Who Will Lead Us? In 2004 Jerome H. Modell, M.D., extolled the advances in clinical anesthesia but worried about the impact of federal bureaucratic rulings in his "Assessing the Past and Shaping the Future."

A number of lecturers were asked to respond to questions about their participation in the Rovenstine series. Questions

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THE ANESTHESIA FOUNDATION

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

ASA President (1950) Rolland J. Whitacre, M.D., died suddenly on February 16, 1956, after having held practically every office within the anesthesia circle. His many friends and colleagues thought that there should be some form of permanent recognition for this pioneer in anesthesiology. It was thought that a memorial to Dr. Whitacre should further the progress of anesthesiology as a specialty of medicine.

“The idea of something to benefit residents in anesthesiology came to the fore.”

ASA President (1955) B.B. Sankey, M.D., organized a meeting of anesthesiologists in Cleveland, Ohio. All in attendance were friends of Dr. Whitacre. They met at the home of Jack Lansdale, Esq., ASA Legal Counsel, in June 1956. Dr. Whitacre was responsible for this law firm being consul to ASA. Over two days, these physicians and Mr. Lansdale discussed a possible memorial for Dr. Whitacre but, at the same time, were lamenting the loss of other prominent anesthesiologists in 1956. Others who died during the first six months of 1956 included R. Charles Adams, M.D., Arthur E. Guedel, M.D., Robert B. Hammond, M.D., Henry S. Ruth, M.D., and Brian C. Sword, M.D., all pioneers in anesthesiology education and stalwarts in the early origins of our specialty.

A Home in Ohio

The idea of something to benefit residents in anesthesiology came to the fore. The result was “The Anesthesia Memorial Foundation.” It was established as a nonprofit organization incorporated in Ohio on September 12, 1956, legally independent of any other group or society but cooperating to the fullest extent with all anesthesiology organizations then in existence. This independence was thought necessary for the Internal Revenue Service to grant tax-exempt status. The original subscribers to the Articles of Incorporation were Mr. Lansdale, John E. Kirkpatrick and Joseph R. Cortese, all attorneys with the law firm of Squire, Sanders & Dempsey. At the meeting on September 12, the original members of the Board of Trustees were elected by the original subscribers of the Anesthesia Memorial Foundation. Those elected were Chair John S. Lundy, M.D.,



Rolland J. Whitacre, M.D.

Urban H. Eversole, M.D., A. William Friend, M.D., Charles S. McCuskey, M.D., Stevens J. Martin, M.D., and Dr. Sankey, plus Mr. Lansdale. They served without compensation or reimbursement, and to this day, the trustees have never received either compensation or reimbursement. The corporate registration was changed in 1981 to the state of Illinois.

The original Articles of Incorporation stated that the Foundation was:

“To loan or give money to deserving persons to assist them in becoming specialists in anesthesia or



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for research or study in the field of anesthesia or related fields.

"Aid in the improvement and advancement in anesthesia and the drugs and other facilities used in connection therewith and to engage in research in connection therewith, and to collect, print and circulate information relative thereto.

"Encourage the improvement of anesthesia, the technique thereof and the drugs and facilities used in connection therewith and to denote or loan funds or other services to others in furtherance thereof.

"To receive funds or property by donation, bequest or otherwise and to hold, invest, sell and disburse the same.

"To own, operate or maintain facilities of all kinds for the performance of surgical, medical and dental procedures and the provision of anesthesia in connection therewith and the care of patients in connection therewith."

"To own and maintain suitable real estate and buildings and to do any and all things necessary or incidental to any of the forgoing purposes."

Making it Official

In October 1956, at the ASA Annual Meeting in Kansas City, Missouri, Dr. Whitacre was awarded the Distinguished Service Award (DSA). This was the first time that the DSA was awarded posthumously. ASA formed a new committee during the same meeting, the Committee on American Society of Anesthesiologists Anesthesia Foundation.

At the ASA annual banquet at this Annual Meeting, it was announced that the Anesthesia Memorial Foundation had been established and that it would be devoted to the advancement of all phases of the specialty and, most importantly, a residents' loan fund. It was during the banquet that the Ohio Society of Anesthesiologists initiated the fundraising with a \$500 donation. ASA granted a loan of \$5,000 that was later forgiven by ASA.

The handbook for the House of Delegates in 1966 contains a report from the Committee on ASA Anesthesia Foundation concerning a meeting in which discussion of a closer relationship between the Foundation and ASA was the topic. The outcome of the discussion was that ASA should not be seen as controlling the Foundation, primarily because of fear of losing the Foundation's tax-exempt status. It was reported, however, that there should remain a close relationship between the two organizations. At that time, the ASA President was nominating (and the Board of Directors approving) the members of the Foundation's Board of Directors. Later the Foundation's trustees were nominated and elected by the standing trustees. The election of new trustee members did not go back to ASA for approval. This difference, in comparison to other ASA



foundations, will be corrected in the near future.

In the early years, individuals and companies were encouraged to give memorial funds, which could be given for special objectives. Mead Johnson, for example, provided funds for the Mead Johnson Scholarship Award

to individuals chosen by the Foundation's Board of Trustees. As to loans, the initial loans were \$1,000 a year, and the amount has been raised on numerous occasions since. Currently the loan amount is for up to \$6,000 per year, which is loaned at \$500 per month.

Growing Up

The Anesthesia Foundation has continued to grow and to provide funds for our anesthesiology residents. As of December 31, 2004, The Anesthesia Foundation had assets of \$1,264,000, all of which was committed to individuals in the form of loans. There have been at least two times in the history of the Foundation that a moratorium on loans had to be put into place due to insufficient funds to meet the many requests. The most recent moratorium, in 2004, was lifted in February 2005 when sufficient funds were again available. The funds primarily came from loan payments.

In addition, to meet other objectives, the Foundation has established the Anesthesia Book Award, which has been given on eight occasions. It now includes publications that involve electronic media as well as print media and has been renamed the Book/Multimedia Award. The award is usually given every four years, the last in 2004.

There are currently 12 members of the Board of Trustees. All but one (the public member) are ASA members. They receive no compensation or reimbursement for expenses. They are expected to provide contributions themselves, and they are expected to solicit funds from others. Members of the Board at this time are Doris K. Cope, M.D., Norig Ellison, M.D., Leonard Fagraeus, M.D., Ph.D., Merel H. Harmel, M.D., Thomas G. Johans, M.D., Ronald A. MacKenzie, D.O., John R. Moyers, M.D., William D. Owens, M.D., Michael P. Smith, M.D., Carol A. Warfield, M.D., and Jess B. Weiss, M.D., with Mr. Vincent M. Bufano as the public member. There also is an Advisory Committee composed of former officers of the Board of Trustees of the Foundation who serve in an advisory capacity.



Visit the AF Web site at:
www.anesthesiafoundation.org

A Historical Review of the Origin and Contributions of the Anesthesia Patient Safety Foundation

Robert K. Stoelting, M.D.

Anesthesiology was the first medical specialty to champion patient safety as a specific focus. The coincidence of multiple factors beginning in the late 1970s led to significant changes in practice that have decreased mortality and catastrophic morbidity caused by anesthesia administration. The Anesthesia Patient Safety Foundation (APSF) was the first independent multidisciplinary organization (practitioners, equipment and drug manufacturers and many related professionals) created expressly to help avoid preventable adverse clinical outcomes, especially those related to human error. Anesthesiology is widely recognized as the pioneering leader in patient-safety efforts.

Although reports were anecdotal and imperfect, from the 1950s through the 1970s, there was a widespread impression that anesthesia care itself caused a mortality in one to two out of 10,000 anesthetics, which was perceived to be unacceptably high. Anesthesiologists constituted 3 percent of physicians and generated 3 percent of the malpractice claims, but those claims accounted for a disproportionately high 12 percent of medical liability insurance payout.

A seminal publication in 1978 authored by Jeffrey B. Cooper, Ph.D., described the use of the aviation-inspired “critical incident analysis” technique to understand the causes of anesthesia-related mishaps and injuries.¹ In the early 1980s, national media publicity turned a harsh spotlight on anesthesia accidents that injured patients.² An important factor in the anesthesia patient safety movement was the presence of strong leadership from Ellison C. Pierce, Jr., M.D. In 1984 Dr. Pierce, as ASA President, constituted the new ASA standing Committee on Patient Safety and Risk Management, which emphasized the need to address the causes of patient injury. That same year, Dr. Pierce and Harvard colleagues convened the International Symposium on Preventable Anesthesia Mortality and Morbidity, which was the first organized examination of what was soon to be known as “anesthesia patient safety.” It was there that the idea for APSF was born.³



“APSF persists in pursuit of its mission of zero tolerance for injury to patients. It serves as a model for the pioneering collaboration and commitment of the entire constellation of anesthesia-related professions to the common goal of patient safety.”

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

'No Patient Shall Be Harmed'

APSF was launched in late 1985 as an independent (allowing organizational agility and the freedom to tackle openly the sensitive issue of anesthesia accidents) nonprofit corporation with the mission of "assuring that no patient shall be harmed by anesthesia." Support came from ASA and several corporate sponsors. APSF directors represent a broad spectrum of stakeholders, including anesthesiologists, nurse anesthetists, manufacturers of equipment and drugs, regulators, risk managers, attorneys and engineers.

APSF grew rapidly in impact. Its highly respected quarterly *APSF Newsletter* has the largest circulation of any anesthesia publication in the world (more than 60,000) and serves to communicate safety-related news, ideas and opinions. The research grant program has funded many projects that provided insight into and suggested solutions for safety problems. The extensive educational efforts included publication of books, co-sponsorship of a large videotape series, organization of the heavily trafficked "patient safety booth" among the exhibits at the ASA Annual Meeting and, more recently, emphasis on the popular APSF Web site <www.apsf.org>.

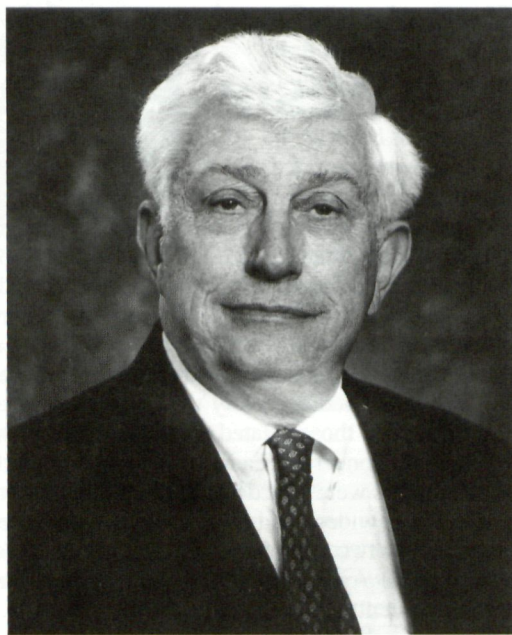
Technology Advances

In the early 1980s, important advances in technology became available. Electronic monitoring that extended the human senses (inspired oxygen measurement, capnography and pulse oximetry) allowed genuine, real-time, continuous monitoring of O₂ delivery and patient ventilation and oxygenation. In the mid-1980s, medical liability concerns continued, and ASA inaugurated the Closed Claims Study, which continues today as an ongoing project and has yielded important discoveries through study of anesthesia mishaps. Also a committee was formed at Harvard to study the causes of anesthesia accidents there. The analysis led to the first standards of practice for minimum intraoperative monitoring. The intention was to codify and institutionalize specific behaviors that constituted "safety monitoring," a strategy for preventing anesthesia accidents.

Guidance Through Guidelines

In 1986 ASA adopted an expanded form as a national standard, a landmark step for a medical professional society; this epitomized the lead role taken by anesthesiology in the nascent patient safety movement. Additional ASA standards and guidelines followed, and ASA later developed evidence-based practice parameters, including the widely respected Practice Guidelines for Management of the Difficult Airway.

The American Association of Nurse Anesthetists (AANA) also has promoted patient safety efforts to its members, e.g., through its recent Standards for Office-Based Anesthesia Practice. Again in the 1980s, other engineering advances made anesthesia delivery systems safer, such as



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

gas ratio protection that prevented accidental shut off of oxygen flow. The Food and Drug Administration's (FDA's) anesthesia apparatus checkout recommendations were developed and widely adopted. Improvements in anesthesia medications afforded more specific and controllable pharmacological actions and fewer dangerous side effects.

Improving Education

Human factor and resource issues also played a key role in improving anesthesia patient safety. In 1990 APSF and FDA convened an unprecedented expert workshop on human error in anesthesia practice that helped to stimulate later advances. The improved quality both of trainees entering the field and anesthesia training programs are certainly important elements of the anesthesia patient safety story. The extension of the residency to three years and the explosion of anesthesia textbooks, journals and meetings contributed via the knowledge base. The incorporation of sessions on safety topics in the scientific program of the ASA Annual Meeting also raised awareness while disseminating research and information.

In the late 1980s, supported by APSF grant funding, realistic patient simulators were introduced into anesthesiology. Further publicity and advocacy from APSF has led to anesthesiology becoming the leader in the application and adoption of simulators, with strong patient safety implications through education (residents attempting new skills for the first time on a mannequin), training (teamwork, critical event management) and research (human performance).

Use of realistic stimulators has now become common in several other specialties.

Due Recognition

The success of the anesthesia patient safety movement was recognized significantly in 1996 when the American Medical Association and corporate partners founded the National Patient Safety Foundation, which was based on the APSF model. Further recognition for safety efforts and leadership came to APSF in the landmark 1999 report *To Err Is Human* from the Institute of Medicine on errors in medical care.

A "culture of safety" has developed in anesthesia practice, highlighted by the hard work of APSF and ASA as well as by the adoption of a more systems-based approach by many anesthesia departments and groups interested in optimizing outcome of anesthesia care. Overall the combined impact of all the initiatives has been a 10- to 20-fold reduction in mortality and catastrophic morbidity for healthy patients undergoing routine anesthetics, an evolution of which the entire profession can be justifiably proud. By the mid-1990s, liability payouts had decreased to a proportionate percentage, and the insurance "risk relativity rating" for anesthesiology compared to other specialties had been dramatically reduced.

Future Challenges

The work of improving anesthesia patient safety is by no means finished. Equipment and systems still fail at times, and also basic preventable human errors still do sometimes occur. Further, increasing "production pressure" in anesthesia practice from expanding clinical demands in the face of diminishing resources may threaten previously won gains. The profession as a whole must consider and address these challenges.

APSF continues to work diligently both on established tenets and new safety principles. Recent emphasis has been on integrating electronic anesthesia information management systems and audible alarms on physiologic monitors into safety strategies. This stimulated major projects to standardize terminology for anesthesia records and definitions for a proposed widespread anesthesia outcome reporting system, which is being debated. Application of a systems approach to anesthesia care continues though research into the success of "high reliability organizations" and how that model can be applied to anesthesia practice. Most recently APSF has taken the lead in organizing a multidisciplinary conference of experts to consider the effects of anesthesia and surgery on long-term postoperative outcome.

APSF persists in pursuit of its mission of zero tolerance for injury to patients. It serves as a model for the pioneering collaboration and commitment of the entire constellation of anesthesia-related professions to the common goal of

patient safety. The success of APSF in the past and the future could not be possible without the vision and financial support of ASA.

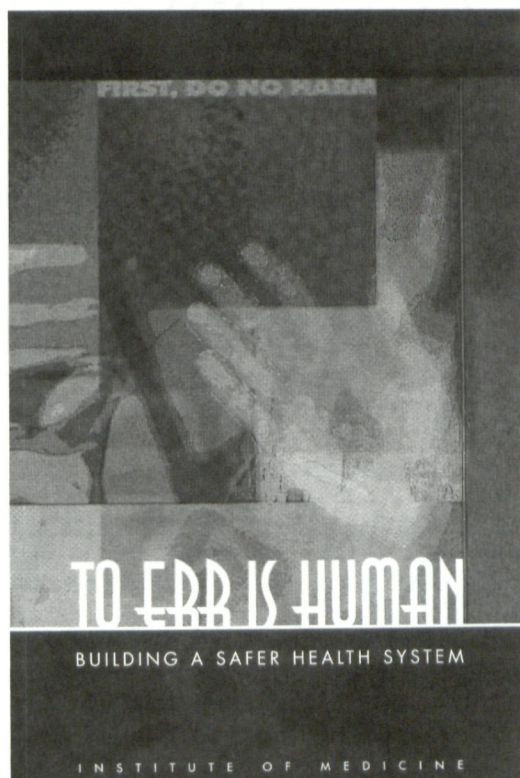
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**This discussion of the history of APSF reflects a document prepared by John H. Eichhorn, M.D., at the request of the APSF Executive Committee to write a history of the foundation.*



Visit the APSF Web site at:
<www.apsf.org>



The 1999 IOM report that praised anesthesiology for its patient safety initiatives.

A Short History of Paul Wood's Anesthesia Collection:

The Wood Library-Museum of Anesthesiology

George S. Bause, M.D., M.P.H., WLM Honorary Curator

*William D. Hammonds, M.D., M.P.H., President
WLM Board of Trustees*



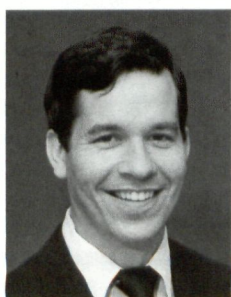
Paul Meyer Wood, M.D., inherited bibliophilia and “the collecting bug” from his Hoosier parents. A love of chemistry took Dr. Wood from the Explosive Chemistry Laboratory at the University of Notre Dame, South Bend, Indiana, to physician-anesthetist training at Columbia University in New York City. In 1933, as a 37-year-old Manhattanite, Dr. Paul Wood suffered a heart attack. While convalescing he donated his entire anesthesia collection of books and artifacts to the New York Society of Anesthetists. By 1937 the collection moved from Dr. Wood’s apartment to the Squibb Building, near Central Park in New York City.



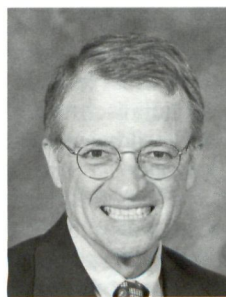
Paul Meyer Wood, M.D.

From 1940-44, Dr. Wood spent his mornings as the anesthesiologist to surgeon-antiquer Robert Bickley and afternoons as secretary of the American Board Anesthesiology and as ASA’s secretary, librarian-curator and *Anesthesiology* business manager. Lewis H. Wright, M.D., a Squibb Company medical director, soon helped Dr. Wood run the ASA Library-Museum committee. Dr. Wright realized that the committee needed a savvy politician such as Albert M. Betcher, M.D. When ASA’s business office shifted to Chicago in 1947, Dr. Wood’s collection remained behind in Manhattan. By 1949 the Wood Library-Museum (WLM) incorporated to receive ASA’s collection. Meanwhile the Squibb Company needed its office space back.

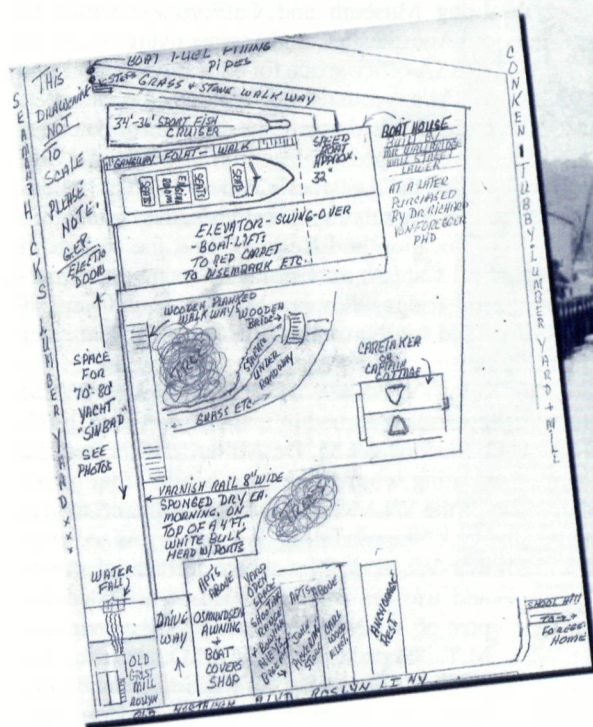
WLM Secretary Vincent J. Collins, M.D., stepped forward at this critical time and located a brownstone at 137 W. 11th St. for the collection to share with the New York State Society of Anesthesiologists. The New York Board of Regents granted WLM a 1950 provisional and 1952



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Foregger's boat house, circa 1958.

absolute educational charter. In late 1952, however, a failed building inspection forced the semi-retired Dr. Wood to move the heavy apparatus of the collection 50 miles north to his garage in Highland Falls, New York. By 1956, an expansion at St. Vincent's Hospital forced a move from 137 to even smaller quarters at 131 W. 11th St. Fortunately anesthesia equipment manufacturer Richard von Foregger, Ph.D., made his Long Island, New York, boathouse available for storage of the collection. That same year, the WLM was designated as the ASA archival repository.

1959 ASA President Daniel C. Moore, M.D., secured WLM's future by purchasing a lot in suburban Chicago for future ASA buildings. This also blocked an effort to move the WLM to San Francisco. In 1960 Dr. Foregger's widow evicted the WLM from her Long Island boathouse, and ASA President Leo V. Hand, M.D., offered the ASA's new building in Park Ridge, Illinois, as a WLM collection annex. Denied storage space by three New York hospitals, Dr. Wood visited Illinois three times to organize his namesake collection. Sadly Dr. Wood suffered a massive heart attack at home and died in May 1963, just six months before the official opening of the library-museum that bears his name.

Cost over-runs downsized the WLM annex from three to two stories. Librarian-Curator Walter Necker was hired a

month before the grand opening of the WLM annex in November 1963. Mr. Necker organized the library-museum over the next three years, including its gallery dedication in 1965. Mr. Necker's disagreements with WLM officers, however, led to his resignation by 1967.

That year WLM inaugurated an annual lecture on the history of anesthesia, the Lewis H. Wright Memorial Lecture, named posthumously after Dr. Wright in 1975. Under Seymour Alpert, M.D., *Anesthesiology Bibliography* and the Self-Evaluation Program commenced in 1968 and 1969, respectively. Because of a nationwide shortage of librarians, anatomy-illustrator Martin Levine, M.S., was hired in 1969 as WLM Curator. WLM President James E. Eckenhoff, M.D., bypassed the library committee of Eugene Connor, M.D., and the museum committee of Louis R. Orkin, M.D., instead adding Mr. Levine to the audiovisual committee. That committee prospered under the technical wizardry of Chair John Leahy, M.D., and the interviewing skill of John William Pender, M.D. Their recordings of legendary anesthesiologists evolved into today's Living History Collection with interviews dating back to 1944.

The next WLM president, bibliophile Charles C. Tandy, M.D., encouraged book conservation and the hiring of Patrick Sim, M.L.S., in 1971. Mr. Sim was educated in

Hong Kong's parochial schools and the United States' premiere Dewey-decimalized graduate librarian program. Service-oriented yet visionary, Mr. Sim helped to inaugurate the WLM's Residents' Reading List and the *History of Anesthesiology* reprints. Six months after Sim's arrival, Curator Levine relocated.

After dissolving its New York charter, the WLM transferred all assets and liabilities to ASA. Dr. Tandy expanded his antiquarian book contacts to acquire rare books on acupuncture and mesmerism. With physician-printer K. Garth Huston, Sr., M.D., Dr. Tandy produced the 1976 bicentennial exhibit and Resuscitation Catalogue.

Succeeding Dr. Tandy, WLM President Huston internationalized the WLM's list of antiquarian bookseller contacts. He prompted Mr. Sim to begin annotating a WLM rare book catalogue. Consultants on bookbinding, de-acidification and special collections hastened the transformation of the WLM from an amateur collection to a professional library-museum. Dr. Huston co-presented papers with founders of the Anesthesia History Association (AHA). Editors C. Ronald Stephen, M.D., and then Doris K. Cope, M.D., began a cooperative effort between WLM and AHA by

jointly publishing the *Bulletin of Anesthesia History*. Other AHA colleagues, William D. Hammonds, M.D., and Selma H. Calmes, M.D., formalized WLM liaisons with Georgia's Crawford W. Long Museum and California's Arthur E. Guedel Memorial Anesthesia Center, respectively.

By the 1970s, ASA office space for educational programs replaced the WLM's ground-floor gallery. Vincent J. Collins, M.D., triaged WLM apparatus in 1983 for potential display, dispersal or disposal. From 1984-86, a growing ASA accommodated the Anesthesia Patient Safety Foundation, the Society for Ambulatory Anesthesia, the Foundation for Anesthesia Education and Research and the American Society of Critical Care Anesthesiologists at the headquarters office in Park Ridge, Illinois. Mr. Sim found himself retrieving discarded museum apparatus from the dumpster in the parking lot.

Harvard's Elliott V. Miller, M.D., was elected WLM President in 1985 and continued in that position until 1997. Architect of the modern WLM, Dr. Miller transformed the WLM by appointing committees to handle the major responsibilities of the WLM and running disciplined trustee meetings with clock-like precision. He also organized popular WLM dinners where influential guests and trustees mingled. He resuscitated the post of WLM Vice-President by convincing M.T. "Pepper" Jenkins, M.D., to take the position. Dr. Miller tapped George S. Bause, M.D., as WLM Medical, then Honorary, Curator. The new curator designed the 50-module museum gallery for the planned new ASA building. 1988 ASA President Harry H. Bird, M.D., and then Executive Director Glenn W. Johnson shepherded the project along.

First Dr. Miller, then Dr. Bause coordinated the WLM's convention exhibits. By 1992 three ASA foundations were combining annual exhibits, anticipating today's Anesthesia Resource Center. Dr. Miller hired Assistant Librarian Sally Graham, M.L.S., in 1988, who later indexed the 1982-95 AHA newsletters edited by Drs. Cope, Calmes and Stephen. Also in 1988, Roderick K. Calverley, M.D., founded the Paul M. Wood Memorial Fellowship program in anesthesia history.

For the new building, major WLM acquisitions included Laennec's 1819 stethoscope and Lawrence's 1821 painting of Sir Humphry Davy; Richardson's 1849 painting of James Robinson; and the Eric Webb Chloroform Collection. In 1992 the three-story ASA building at 520 N. Northwest Highway



Dedication of the Wood Library-Museum of Anesthesiology, November 3, 1963

Left to right: Bruce Wood, son of Dr. Wood; Edward R. Annis, M.D., AMA President and dedication speaker; Diana Bird, grand-daughter of Dr. Wood; Harriett Wood, Dr. Wood's wife; Lewis H. Wright, M.D., President Emeritus of the WLM; Albert M. Betcher, M.D., WLM President; Beatrice Bird, daughter of Dr. Wood; and Prall Bird, grandson of Dr. Wood.

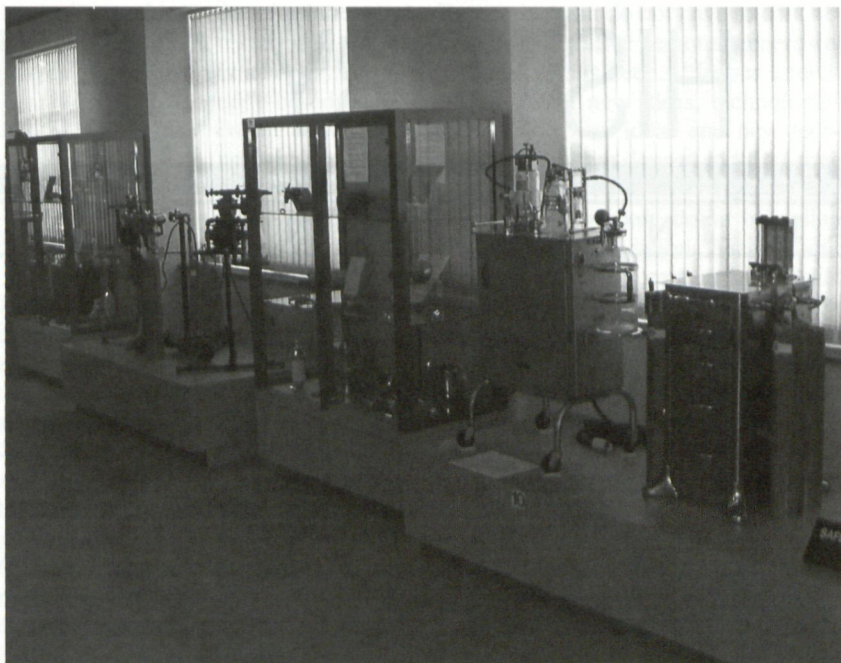
in Park Ridge formally opened. The 1994 centennial of Dr. Wood's birth celebrated the acquisition of diaries by Joseph T. Clover, M.D., and a letter by Joseph Lister, M.D., to J.A. Lawrie.

Succeeding Ms. Graham as Assistant Librarian, Karen Biertman, M.L.I.S., quickly demonstrated her library skills by expertly handling a burgeoning demand for skilled reference research. Library Assistant Carole Siragusa mastered digital imaging along with diverse clerical activities. The two women witnessed a succession of WLM publications chairs (Nicholas M. Greene, M.D., B. Raymond Fink, M.D., Kathryn E. McGoldrick, M.D., and, currently, Donald Caton, M.D.) who published reprints by John Snow and Thomas Keys; English translations of Overton, Bernard and Pirogoff; and the *Proceedings of the Third International Symposium on the History of Anesthesia*. Dr. Greene also inaugurated a Nobel-like quadrennial prize: the WLM Laureate of the History of Anesthesia.

In 1997 Dr. Miller handed the presidential gavel to Dr. Caton, who now faced an ASA demanding financial self-sufficiency by the year 2000. Led by Franklin B. McKechnie, M.D., Dr. Cope, Dr. Caton, and then Jonathan C. Berman, M.D., the marketing committee soon improved visibility and income. Dr. Fink, Kathryn E. McGoldrick, M.D., and Dr. Caton edited *Careers in Anesthesiology*, a series by anesthesiologists about their work.

Organizing the collections became a major priority. Ms. Biertman computer-catalogued the library holdings. The WLM's Virtual Tour appeared on CD-ROM and online. Mobile carriage shelving was installed to relieve the basement clutter. Acquisitions during this time included Charriere's 1847 Ether Inhaler, and A.M. Long's 1884 and S.J. Hayes' 1893 vaporizing apparatus. Collections Supervisor Judith A. Robins, M.A., transformed the jumbled dungeon of archives and apparatus in the ASA headquarters basement into organized collections. Archives Committee Chair Douglas R. Bacon, M.D., encouraged and obtained important archival donations.


Succeeding Dr. Caton as WLM President in 2001, Dr. McGoldrick learned that ASA might terminate its annual contribution to the WLM. Dr. McGoldrick oversaw the naming of the "Mayo Clinic" Curator's Room in 2001 and of the WLM gallery's Bause Collection in 2002. The next



The Wood Library-Museum as it appears today.

year ushered in curatorial exhibits at the ASA's Washington, D.C., office and scripting of the WLM gallery audiotour.

A.H. "Buddy" Giesecke, M.D., then Lydia A. Conlay, M.D., Ph.D., highlighted WLM activities and exhibits in each September's *ASA NEWSLETTER*. New acquisitions during this time included J.M. Churchill's 1821 acupuncture needles, Hooper's 1846 Ether Inhaler, Linus Pauling's 1975 handwritten manuscript, the Maurice S. Albin M.D., Neuroscience Collection and the Tandy Archive of Sir Robert Macintosh. The WLM endowment increased six-fold from 1985-04. After introducing Dr. Caton as the incoming WLM Laureate, Dr. McGoldrick handed the helm to newly elected President William D. Hammonds, M.D., and Dr. Conlay became vice-president.

Throughout the last 34 years, the sustaining force at the WLM has been Head Librarian Patrick Sim. His consummate professionalism, tireless dedication and gracious hospitality have attracted legions of friends and supporters. Mr. Sim has embraced the vision of founder Paul M. Wood of a national repository for anesthesia apparatus and literature and molded it into the ASA's Wood Library-Museum of Anesthesiology. 

Visit the WLM Web site at:
<www.ASAhq.org/wlm>.

HISTORY OF FAER



AN INVESTMENT IN THE FUTURE

Joanne M. Conroy, M.D.
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ASA was founded in 1905 when nine medical colleagues from Long Island, New York, organized the first professional anesthesia society. As its purpose and scope of involvement in anesthesia-related issues grew and attracted other interested physicians nationwide, the Society changed its name to the American Society of Anesthetists in 1935 and then to the American Society of Anesthesiologists (ASA) in 1945. This year we will celebrate ASA's centennial as a professional society. Although FAER will celebrate its 20th anniversary in 2006, ASA's commitment to research and education has a much longer tenure.

In 1962 ASA established one of its most successful programs, an award for excellence in research by resident physicians. ASA awarded two prizes annually from 1962 until 1971. These awards included recognition at the ASA Annual Meeting, a small monetary award and a plaque presented at an ASA House of Delegates meeting. Academic departments and anesthesiologists viewed these awards as very prestigious.

In 1973 ASA began another program to support research in anesthesiology. ASA provided peer review of initial projects by promising young anesthesiologists with the intention that the review would improve their ability to compete for research funding. In 1980 ASA added a \$15,000 award to support the first ASA resident research fellow.

The tremendous member interest in this review process and the research scholarship program created many opportunities to increase valuable and needed research in anesthesiology. Thus in 1986, ASA created FAER to manage funds from industry intended for research in anesthesiology. Consistent with the purposes of ASA to further scientific research in anesthesiology, FAER was committed to fostering research and education in the field through the appropriate solicitation and administration of funds to support these purposes. FAER developed an "arm's length" mechanism to support worthy scientific projects with unrestricted industry contributions.

FAER funding was awarded to postresidency fellows or junior faculty during their first years of academic practice. A 1995 survey of former recipients of these

research funds found them to be both academically productive and successful in obtaining subsequent funding. FAER invested less than \$6 million in recipients who subsequently received funding of more than \$100 million. The National Institutes of Health (NIH) provided 63 percent of this funding, while industry contributed approximately



16 percent. This was an impressive 17:1 return on investment. These former FAER recipients have mentored 1,004 young researchers, have published an average of 17 peer-reviewed papers, spend about 30 percent of their time in research and 96 percent have remained in academic medicine. FAER recipients believed that the ASA/FAER funding made a critical difference in their careers.

Over the last six years, FAER has increased efforts to develop and support both anesthesia research and the development of young scholars. We have increased the award amounts significantly, resulting in a dramatic increase in applications for the Research Starter Grant, Mentored Research Training Grant, the Research Fellowship Grant and the Research Education Grant. The number of applications has nearly doubled since 2003. In 2003 FAER helped to organize the Academy of Mentors in order to recognize 23 anesthesiology researchers who have given selflessly of their time to assist in the mentoring of an entire generation of young academic anesthesiologists. We continue to sponsor more than 60 Resident Scholars at each ASA Annual Meeting with generous support from Abbott Laboratories. We have initiated a new medical student fellowship program. In the first year of this program, we received more than 40 applications. These students represent the future of our specialty as a leader in the new knowledge economy.

Looking forward to the next 100 years, FAER goals are simple:

- Engage students early in their training and keep them engaged;
- Reward and encourage research in resident education and anesthesia fellowships;
- Obtain national recognition for research and work to establish an anesthesia NIH study section; and
- Leverage training grants to support scholarly activity.

FAER's mission requires the support of our entire membership. These investments are not just in the individual researchers ... they are investments in the future of our specialty.

This year during the ASA centennial celebration, ASA members have a unique opportunity to begin a tradition of giving. Invest in FAER or in any of ASA's foundations. Your FAER dollars represent an investment in the future of

anesthesia research. Remember you do not have to conduct research in order to support it. Creative personal generosity is as essential now as it always has been. "In our knowledge-based economy, ideas begat new ideas, technologies ensure newer technologies, and new ideas and new technologies build more of each."* Large donors and first-time givers as well as those who have given steadily, philanthropically, we ask you to continue to support, dollar by dollar, the future of research in anesthesia education. Many of our anesthesia scientists began their research careers with FAER grants. Help us to continue to invest in and create the next generation of scientists, physician mentors and anesthesia leaders.

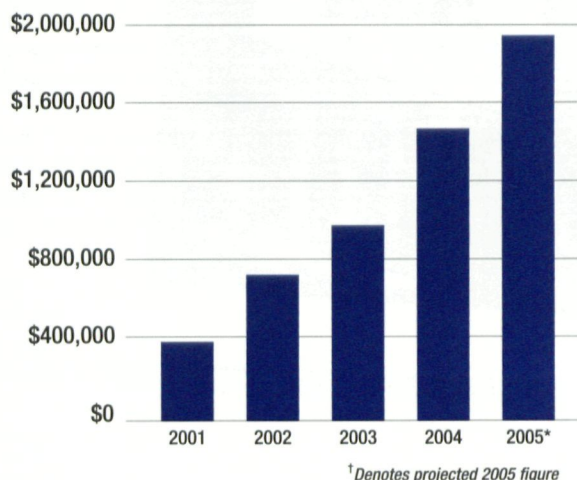
"Most people in the world thinks that Americans are generous because we are rich. But the truth is that we are rich because we are generous."*

Thank you for your past and future support! We look forward to a busy and productive 2005.

From the FAER Board of Directors and staff, congratulations ASA on your first 100 years!



Recent Research Grant Dollars Awarded 2001–2005[†]



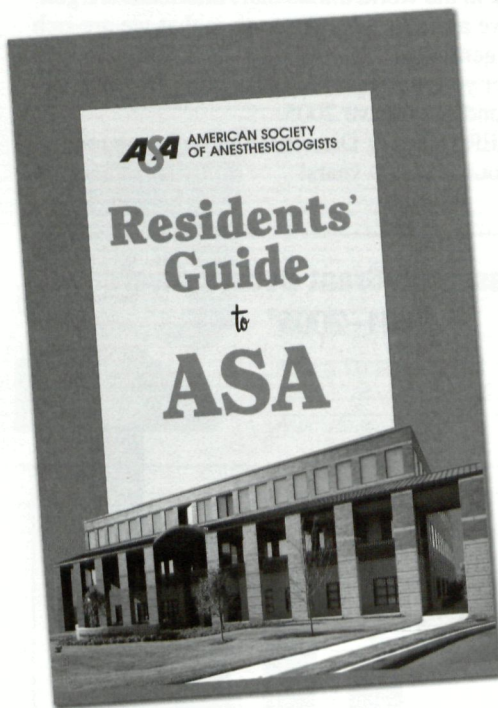
[†] Denotes projected 2005 figure

Visit the FAER Web site at:
<www.faer.org>.

*From *The Greater Good: How Philanthropy Drives the American Economy and Can Save Capitalism* by Claire Gaudiani.

Remembering Our Past: A Look at the Resident Component

Michael F. Aziz, M.D., Co-editor
"Residents' Review"



As we celebrate ASA's centennial anniversary, it is most appropriate as residents to reflect on our involvement in ASA. We can both look back upon the efforts of previous leaders in forming our resident component and also strive toward future growth.

Resident physicians became organized within ASA when the American Medical Association (AMA) reached out to its specialties and asked for broader resident involvement. The ASA Committee on Representation to the AMA formed the ASA Resident Physician Section (ASA-RPS) steering committee, with its first resident Chair Mark F. Trankina, M.D. Initially some ASA leadership resisted the growth of an organized resident component, but several ASA leaders saw ASA-RPS as an opportunity for the Society to become a more established organization.

The residents held their first organizational meeting in Las Vegas, Nevada, in 1986. Nearly 50 residents attended, and important business was quickly addressed. Eric J. Grigsby M.D., then member of the AMA Resident Physician Governing Council, presented an overview of resident involvement in organized medicine. The residents voted to continue under the guidance of the steering committee and to elect new officers at the following Annual Meeting.

In 1988 the ASA Resident Component was officially formed through an amendment to the ASA Bylaws. The resident component was founded with the following goals:

- To encourage resident participation in ASA;
- To develop experience in organized medicine among young physician leaders; and
- To improve resident awareness of the role of the ASA in the evolution of the specialty of anesthesiology.

Maintaining consistent representation proved to be a challenge of the Resident Component as the duration of any anesthesiologist's residency was limited. This concern and others were addressed by our early leadership, and as a result, they kept the Resident Component on



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"The current Resident Component is working hard to secure a strong future for the next residents and for our field."

its feet. Major advances were made in following years. The Resident Component now has five elected governing council members who maintain five votes in the ASA House of Delegates and speak to resident interests at ASA legislative conferences and at AMA resident meetings. Residents have worked tirelessly to draft bylaws. Communication among residents is maintained through a well-established e-mail listserve, a resident component Web site <www.ASAhq.org/asarc/index.html>, a monthly e-Newsletter and the "Residents' Review" column in the *ASA NEWSLETTER*, to which residents have contributed since 1992.

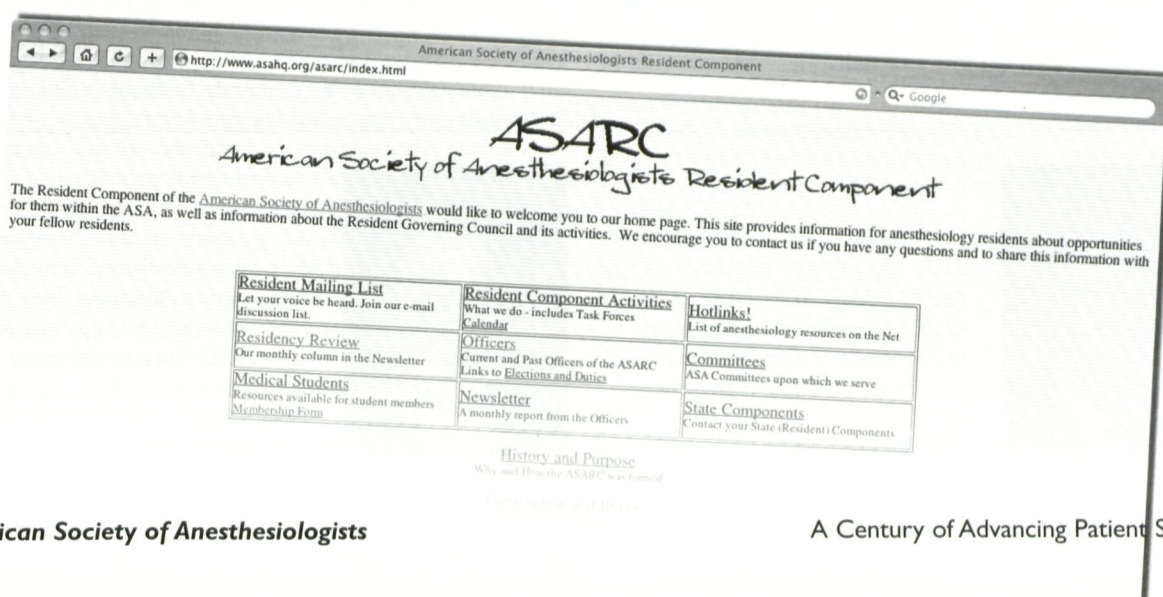
The scope of resident interests at the ASA Annual Meeting has grown well beyond the Resident Component House of Delegates Meeting. Last year's Annual Meeting activities included a leadership training/grassroots advocacy workshop, resident research forum and a resident practice management seminar and resident feedback session. As members of the majority of ASA committees, residents now submit reports of committee meetings to the ASA Resident Component House of Delegates.

The current Resident Component is working hard to secure a strong future for the next residents and for our field. Efforts are being made to coordinate regional practice management seminars so that large groups of residents can learn some of the business aspects of anesthesiology. We always look for new ways to involve our members in the field and to expand their member benefits. Benjamin D. Unger, M.D., will lead an effort to educate our members on the Maintenance of Certification in Anesthesiology (MOCA).

New to the Resident Component is a medical student delegation consisting of five members. As medical students explore avenues to grow a delegation, we have invited them to actively participate in our Resident Component House of Delegates, participate in resident activities and to write for the "Residents' Review" column. In addition to the tremendously popular airway workshops sponsored by the Resident Component and the Committee on Residents and Medical Students, the Resident Component Governing Council plans to start an AMA medical student section airway workshop to further promote anesthesiology to medical students.

One area of continued difficulty to the Resident Component is representation to the Resident Component House of Delegates. Each state is allowed delegate and alternate delegate positions in proportion to that state's resident population. Most states have filled each position, but some states' seats remain empty. We encourage each state society and training program to help their residents financially and with flexibility in scheduling to attend the meeting, as we are sure that there are residents who are interested in participation within ASA.

As residents move from a level of training to a position of leadership, we must pause and pay tribute to those before us who made these opportunities possible. The ASA Resident Component has provided residents an opportunity to broaden our training beyond the operating room and hone our skills in advocating for our patients and our profession on a national scope.



Anesthesiology's Choices for the

NEXT CENTURY

Ronald D. Miller, M.D.

Alexander A. Hannenberg, M.D.

A centennial provides an irresistible occasion for an organization to undertake some self-examination and strategic thinking. Anesthesiology is no stranger to these tasks — ASA, the four Foundations and the American Board of Anesthesiology have independently and jointly brainstormed the future in recent years. Far more than ASA's 100th anniversary, however, recent major challenges to the place of anesthesiologists in health care have produced a compelling need to look toward the future of the specialty.

At the turn of the millennium, ASA was engaged in a multiyear and multimillion-dollar dispute over the appropriate degree of independence of nurse anesthetists under federal rules. The rancor, duration and cost of this battle were unmatched in other medical specialties' dealings with their nonphysician counterparts. Yet this dispute occurred during a period in which the prevalence of physician extenders and the breadth of their practice in numerous specialties had grown dramatically.¹ The contrast between the nature of midwifery practice, as one example, and nurse anesthesia practice, with respect to the degree of direct physician supervision, is striking. With a remarkable degree of safety, midwives manage uncomplicated deliveries under protocols providing for physician consultation as needed.² Is it truly easier to prospectively identify low-risk deliveries than it is to stratify anesthetics by patient and procedural complexity? If not, why does our specialty's view of the care of low-risk anesthetics differ so dramatically from obstetricians' views on low-risk deliveries? As the role of

nonphysicians in other specialties evolves, we will inevitably need to consider whether there is something we can learn from our colleagues, or vice-versa.

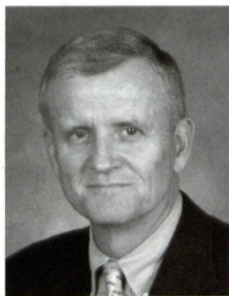
Advances in technology and pharmacology will surely alter the range of services provided by anesthesiologists. Our specialty is currently discussing, with gastroenterologists and others, the appropriateness of sedation by intravenous propofol in the absence of an anesthesia specialist. Anesthesiologists say that the capacity of this anesthetic to produce respiratory and cardiovascular depression demands a trained specialist to manage these potential complications.³ In the (unlikely) event that anesthesiologists prevail in the current dispute, what will the next debate bring if the drug

"Advances in technology and pharmacology will surely alter the range of services provided by anesthesiologists."

involved is not propofol but a potent analgesic-hypnotic without such side effects? Can anyone doubt that such an anesthetic is in our future? Is it not certain that more sophisticated patient monitors will be available soon to control the delivery of anesthetics? If these advances put sedation for endoscopy or imaging in the hands of nonanesthesiologists, what does it mean for cataract surgery, arthroscopy, herniorrhaphy or even more complicated forms of surgery.

Hospitals Changing, Too

Hospitals are undergoing as radical a transition as our drugs and technology. We see movement of patients and selected procedures away from the hospital to specialty hos-



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pitals, outpatient facilities and physician offices. What will be left in the acute inpatient facility? The growing prevalence of critical care beds relative to general hospital beds in tertiary care facilities provides a clue. Nearly all patients, medical and surgical (and the distinction will blur), in the hospital will require complex therapy requiring a critical care setting. They will need preoperative evaluation and management, invasive procedures and postoperative care, including pain management and sophisticated care for acute, multisystem critical illness. None of the existing medical specialties is fully equipped to provide comprehensive care in all of these areas, but anesthesiology is a strong contender for the best qualified. We will not dominate this role, however, without a major commitment made soon. Others, such as internal medicine hospitalists, are already laying claim to the role of the perioperative physician.⁴ A major part of the commitment required to establish anesthesiology's role in the hospital of the future is a willingness to re-engineer our residency training programs to provide future generations of anesthesiologists with the necessary skills. Remaining relevant requires anticipating future demands and opportunities; the greatest impact we can have on the future of the specialty lies in the choices we make about educating our successors.



in the nature of our profession. For example consider the impact that a pharmacological remedy for atherosclerosis will have on a number of other specialties. Those who image, operate on or dilate and stent carotids and other vessels will have the bulk of their livelihood shift to other specialties or disappear altogether. Radiology, neurosurgery, cardiovascular surgery and others will also need to chart new territory before long.

What Lies Ahead?

The prospect that the "bread and butter" core of anesthesiology, operating room practice, will be minimized is terrifying — but critical care units are today being managed remotely with data and video links, and airplanes fly without pilots. Robots are performing complex surgery and could doubtless manage endotracheal intubation if asked. Our drugs will be more pharmacologic-specific and safer. Our equipment and instruments will increasingly become self-functioning. Considering all this, is it surprising that many news


sources predict that anesthesiologists will be unnecessary by 2030? We may ultimately disagree, but the pace of change demands that we consider the question carefully and keep our minds wide open about the future direction of the specialty.

Economic Factors

Economic issues can color our view of what our future role might be in health care. It is obvious that operating room practice, medical direction of nonphysicians, pain management and critical care are not equally lucrative areas of practice. On the one hand, an economically viable specialty is better able to attract trainees and ensure future availability of personnel to provide care. On the other hand, there is great value in assessing our strengths, opportunities and potential contributions to medicine without regard for present-day payment implications. The latter approach must be an important element of our strategic thinking. Fear of the monetary impact of the choices available to the specialty can easily blind us to options offering long-term growth and security.

We should not feel alone when facing dramatic changes

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Medicine and Government Regulation — *the Times, They Have Been Changing*

Ronald Szabat, J.D., LL.M.
Karin Bierstein, J.D., M.P.H.

No matter how old you are or how time may fly, 100 years is still a long time. And, needless to say, a lot has changed, especially in Washington, D.C. In fact, the very nature of our federal government and how physicians can and must relate to it continues to evolve.

Cooling Off

A century ago, modern air conditioning was just being invented, but official Washington still mostly shut down in the long summer months so that our U.S. Representatives and Senators could travel home and avoid the swampy, hot and steamy weather along the Potomac River. By historical accounts, the House chamber was first “cooled” in 1928, and the Senate was “air conditioned” in 1929. Not so for the average worker in Washington, but vast federal agencies still were few and far between, and “the bureaucracy” of career civil servants was miniscule by current standards.

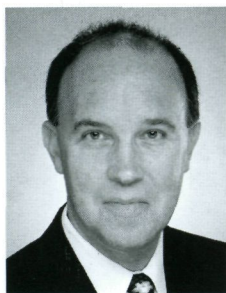
In the first half of the last century, it is hard to think of many items involving the reach of the federal government, particularly those affecting all of medicine, or anesthesiology in particular, that could not wait until cooler fall weather. In fact the very growth of government in Washington waited until some 50-plus years ago and followed World War II and the dramatic growth of federal programs such as Social Security and further social experiments such as the creation of Medicare in 1965.

On The Move

Transportation, too, was difficult and much slower as the 20th century began. When ASA was founded, trains were the order of the day for long travel, and only in 1908 was the Ford Model T introduced. More obviously, there was no hourly airline “shuttle” service to New York and other cities. Close in National Airport (much later renamed to honor



U.S. House of Representatives, circa 1929.



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“... your active involvement in the political side of medicine, and anesthesiology in particular, will ensure that the profession thrives for another 100 years and beyond!”

President Ronald Wilson Reagan), was still mudflats on a bend of the Potomac River at Gravelly Point, not far from the Abingdon mansion, birthplace of Eleanor “Nelly” Parke Custis, stepdaughter of President George Washington. It was not until President Franklin Delano Roosevelt intervened that Congress was forced to move ahead with the building of this Washington transit landmark. Today many visitors to Washington come and go by jets every few minutes, alongside the very members of Congress who have come to be expected to travel back and forth to their districts on a weekly basis.

Lines of Communication

The communication revolution also has gone hand-in-hand with advances in medical technology. Telephone service, growing by leaps and bounds through much of the 50 years following ASA's founding, made everyday contacts between constituents and elected officials faster and increasingly cheaper through the present. Fax machines in the last 20 years made more detailed communications possible as have computers and handheld devices such as today's Blackberrys and PalmPilots. The “Information Age” saw its nearly invisible roots begin when ASA was young, but its increasingly sophisticated technology now has established the means for ensuring that our message from anesthesiology successfully competes for attention with all the other signals crossing a congressional or federal government entity's electronic threshold on a daily basis.

Clearly, what was the norm is no longer the norm. Visitors to ASA's Washington Office stop and marvel at the vintage anesthesia-delivery equipment in our “Eastern Annex” to the Wood Library-Museum of Anesthesiology. These are the relics from our first 100 years. In contrast it is important that we also marvel at the skill and sophistication in the way in which our ASA members and advocacy staff fight to get anesthesiology's message to Congress and the federal agencies.

The very growth of federal payment for medical services since Medicare's inception and the ratcheting down of such reimbursement through the resource-based relative value system (RBRVS) and Relative Value Guide since 1992, and more recent unworkable artifices such as the sustainable growth rate (SGR), should cause every ASA member to stand up and get involved. Government price-setting for

medical care and all its related regulations were virtually unknown before Medicare. Unfortunately this complexity is not going away, no matter what we wish. Congress and the Administration can and must be contacted and lobbied on a continual basis to correct their misconceptions about medical practice and to keep the regulators in check. This is what your Washington Office does on a daily basis, but we cannot get the whole job done alone. The battles of the recent past — protecting Medicare supervision requirements, preventing anticipated payment/diagnostic related groups (RAP DRGs) and other high-profile legislative fights — would not have been won without the concerted efforts of our ASA members working together.

So, too, our ASA has succeeded in calming over-regulation of anesthesiology through strong advocacy. Among ASA's key victories was the inclusion, in the 1989 legislation that launched the Medicare Fee Schedule and the RBRVS, of the requirement that Medicare payments for anesthesia services be based on the ASA Relative Value



The ASA Political Action Committee is the largest medical specialty political action committee in the United States. The ASAPAC booth is a popular stop at the ASA Annual Meetings.

Guide. In 1991, when the Medicare agency was writing the regulations implementing the Fee Schedule, it sought to impose an average time-based system on anesthesia. Together we persuaded them to retain actual anesthesia time in the formula.


Time came under attack again when the Health Insurance Portability and Accountability Act standards for electronic claims were under development. The commercial payer community fought hard to require anesthesiologists to report total minutes rather than units so that private payers and Medicare might be able to reduce payment on the last unit of time. We cultivated allies in the American Medical Association and elsewhere and made the case for retaining the option to bill time units — saving the specialty about \$128 million per year. This is once again being challenged by the payers, and, as we did several years ago, the Washington Office may soon ask for our members' help through individual letters to the Centers for Medicare & Medicaid Services (CMS).

You can see that federal agencies — not just CMS, but also others such as the Food and Drug Administration — are a font of regulations that would control even more of your practice if we were not constantly vigilant. The locked anesthesia carts and the postanesthesia follow-up note issues appear now to be behind us. There is no telling what will be

next, only that there will be a new regulatory challenge in front of us soon.

The Future Is Now!

If you have not checked out our ASA position papers and recently contacted your elected representatives or CMS by fax, telephone and e-mail, you are not helping ASA help you. Old-fashioned letters are just that — old-fashioned and destined for a time-consuming trip to “irradiation” plants in Ohio before delivery to Capitol Hill and other agencies. The modern age demands both electronic messages and *good* “old-fashioned” personal visits with our legislators. More than 400 leaders from across our state component societies did just that in May 2005. Right now every other ASA member should check out our position papers at <www.ASAhq.org/Washington/pospapers.htm> and follow suit with messages and visits.

Only your active involvement in the political side of medicine, and anesthesiology in particular, will ensure that the profession thrives for another 100 years and beyond! Your anesthesiology practice does not exist in a horse-and-buggy era and neither can our lobbying. Embrace the modern age! 


The Rovenstine Lectureship

Continued from page 22

included: How long in advance of your lecture was your invitation tendered? What factors influenced your decision in selecting a topic or title? What message did you hope to leave with the audience? Did you intend your subject, or any of your remarks, to be controversial? In retrospect would you have altered any portion of your presentation? All of the respondents commented that the honor conferred was also an awesome challenge. All lecturers received their invitation at least one year in advance.

Some responses follow: Lawrence J. Saidman, M.D., wished the audience to understand the relevance of ASA in their professional lives and proposed that perioperative medicine should be the direction of our specialty. In choosing his topic, Dr. Epstein was guided (driven?) by 20 frustrating years developing guidelines for sedation and analgesia for nonanesthesiologists. Dr. Modell reminded the audience that anesthesiologists continue to be major contributors to medical science. James F. Arens, M.D., expressed concern in 2000 about inadequate attention to practitioners who had lost their clinical

skills. Dr. Stoelting's choice of topic was based on an opportunity to relate clinical care to continuing education. Dr. Hug's choice of subject was based upon his passion for end-of life issues and perceptions of the need for change in the way we care for patients, especially those facing high-risk interventions near the end of life.

Twenty-nine of the 33 most recent Rovenstine Lectures have been presented by anesthesiologists or by non-physicians closely aligned with ASA (Mr. Johnson and Mr. Lansdale). This has been a fortuitous transition rather than a provincial exclusion of “outside” expertise. Attending the lectures or reading them following publication has provided us with an opportunity to witness the continuing growth and maturity of anesthesiology as seen through the eyes of the specialty's leaders. The content of the talks, filled with wisdom and wit, is a living history of where we began, where we are and the directions ahead. The Emery A. Rovenstine Memorial Lecture remains, and will continue to be, one of the highlights of the ASA Annual Meeting. 



ASA Puts Its House in Order: History of ASA Headquarters

Denise M. Jones, Assistant Executive Director

Brick and mortar do not a home make, but they sure help to keep the rain out!

— Anonymous

ASA as a Society has been, and will always be, defined by the members it serves and, in turn, their service to their patients. Yet we can learn a lot about an organization by looking back at where it planted its roots, in the literal sense — the “whys” and “wherefores” that explain its present state of affairs.

The idea of a national organization of medical professionals dedicated to the welfare of the patient undergoing anesthesia for surgical, medical and obstetrical procedures was indeed born in New York in 1905. The Long Island College Hospital may have served as a meeting place for ASA’s charter members, but many more years would pass before the Society required dedicated office space.

The earliest records of ASA headquarters indicate that the Society’s business was conducted from 1935 to 1947 in rent-free space provided in the E. R. Squibb & Sons building, 745 Fifth Ave., Room 1503, New York City. The newly formed Wood Library-Museum of Anesthesiology (WLM) shared space in the same location. Progress and growth being experienced during the post-war years were welcomed by ASA, but they also prompted Squibb to ask ASA to move to make room for its own growing business.

On the Move

On April 10, 1947, at a meeting of the Board of Directors at the Biltmore Hotel in Los Angeles, California, then ASA President Edward B. Tuohy, M.D., presided over a vote to move the business offices of the Society from New York to Chicago as a more central location for the growing national organization. With confidence that this new loca-

tion would offer additional benefits to the Society, including a lower cost of living and access to convenient air travel from Orchard Field (renamed O’Hare International Airport in 1949), the board voted in favor. Thus the new address of the Society became: 188 W. Randolph St., Suite #909, Chicago 1, Illinois.

The downside to the move to Chicago, however, was that there was no space for the WLM, and so it remained behind in the New York area and moved its collection several more times to temporary housing (including a garage in upstate New York and a boat house on Long Island).

ASA rented 2,172 square feet of office space on Randolph St., but in just over 10 years, it had become inadequate, uncomfortable (no air conditioning), expensive and unworkable for future expansion. In particular there was a new initiative to combine the headquarters with the WLM.

Daniel C. Moore, M.D., who in 1958 was the youngest elected President-Elect of ASA at age 39, had been rallying for support of a bold new plan that would reorganize the administrative side of the Society to be run more like a business. His goal was to combine not only the WLM with the



Denise M. Jones is ASA Assistant Executive Director.



The E. R. Squibb & Sons building in New York City. No rent was charged while both ASA and the WLM resided at this location from 1935 to 1947. Image courtesy of the Wood Library-Museum of Anesthesiology.

ASA headquarters but also the Journal office in Philadelphia.* He was convinced that spending rent on the office space in downtown Chicago would only increase deficit spending without increasing the Society's net worth.

Persistence Pays Off

On November 21, 1958, the ASA House of Delegates empowered the Board of Directors to select a location, purchase land, employ consultants and architects, obtain bids, determine methods of financing and construct a 6,000-square-foot building at a **total** cost not to exceed \$225,000.

Three days later, on November 24, Dr. Moore and ASA Executive Secretary John W. (Jack) Andes met with representatives of the real estate firm of Oliver S. Turner & Co., Chicago. The firm was instructed to review available property in the northern suburbs of Chicago, based on proximity to O'Hare, rail and bus transportation to Chicago and the suburbs, and in an established community with good local government and adequate utilities but not in a highly industrial area.

Sixteen available properties were considered before Park Ridge, 18 miles northwest of downtown Chicago, was selected. On May 16, 1959, the Board of Directors approved the building plans at an estimated cost of \$228,440.70. At the same meeting, the Board also approved the selection of the architectural firm of Graham, Anderson, Probst & White, famous for such landmarks as the Merchandise Mart and the

Wrigley Building in Chicago and the new (being built at that time) State Department building in Washington, D.C.

The budget allowed only \$40,000 for the land purchase. The seller, Mr. Victor Christensen, was offering 3.5 acres for \$95,000 but was willing to sell a 1-acre parcel for the allotted \$40,000. Ground-breaking occurred on August 7, 1959, and by November 16, the outside walls of the new building were completed. In the March 1960 issue of the *ASA NewsLetter*, the new headquarters was officially announced: 515 Busse Highway, Park Ridge, Illinois; Telephone: Talcott 5-5586.

The following month, the building was ready for occupancy, a full 60 days ahead of schedule, despite a steel strike. Initial fears that a move from downtown Chicago to the suburbs would affect the staff, only one of ASA's personnel did not move to the Park Ridge headquarters. The number of staff in 1960: 11.

The new one-story building, with an additional 4,000 square feet of basement storage space, was dedicated on May 21, 1960. Approximately 200 guests attended. The Dedicatory Address was presented by Leonard W. Larson, M.D., of Bismarck, North Dakota, Chair of the American Medical Association Board of Trustees:

"Your stature as a vital member of the great body of medical science has been increasingly evident in the last 30 years. It might be said that anesthesiology is one of the newest sciences, even though its practical application goes back to ancient times. ..."

"Your new headquarters will be a symbol to the medical world — a symbol of your past progress and a symbol of your future achievements. ..."



The building that housed the ASA at 188 W. Randolph St., Chicago, from 1947 to 1960 was built in 1929. Today it is known as Randolph Tower. Photograph © Wayne Lorentz/Artefacts Corp./Used with permission

*Ultimately the Journal office remained in Philadelphia where *Anesthesiology* was being published and continues to be published today.



Only the one-story portion of this building (far right) existed in 1960. The two-story "annex" (far left) was added for the Wood Library-Museum of Anesthesiology and dedicated in November 1963.

Critical Mass

By now the situation for the WLM had reached a critical stage. In August 1960, Mrs. Lily Foregger, the widow of Richard von Foregger, Ph.D., who died on January 18 of that year, informed the WLM trustees that she had sold the boat-house on Long Island, and all WLM materials in storage would need to be removed.

Having resided in its new building for just one year, ASA found itself going back to the drawing board — literally — to design a two-story addition with 9,000 square feet of space to house the library and museum collections. The "annex" for the WLM was budgeted at \$285,000 (actual was \$286,769). On November 3, 1963, the new WLM was dedicated, six

months after the death of its namesake, Paul M. Wood, M.D.

But ASA continued to be the victim of its own success. Membership had grown to more than 10,000, and during the 1970s, it became necessary to convert 3,000 square feet of museum space to office space. The next decade brought another explosive growth in membership, and again, additional space was "borrowed" from the WLM to accommodate the staff support needed for additional membership activities and new programs.

By 1989 the ASA Committee on Planning recommended the appointment of a Committee on Building to evaluate ASA's headquarters requirements. According to Harry H. Bird, M.D., Committee Chair and Immediate Past President, the committee "had a clear task to plan for new space that would be geographically suitable, functional, reasonable in cost and of appropriate quality and appearance to be considered ASA's national headquarters."

Where to build a new building was not an issue. In fact ASA needed to look no further than its own backyard. Forethought and good business sense had prompted the ASA leadership to purchase the remaining 2.5-acre parcel from Mr. Christensen just two years after buying the 515 Busse Highway property. The land was leased back to Mr. Christensen for five years for his Park Ridge Greenhouses business, but those structures and a two-story residence were torn down in 1967. For the next 25 years, the property needed only to be mowed and required little more than annual payments for (minimal) property taxes as unimproved land.

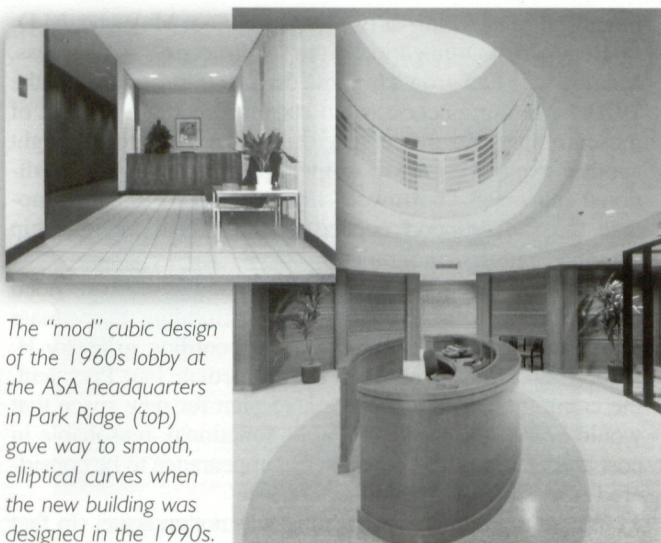
Based on recommendations and studies presented by Dr. Bird's committee, the ASA House of Delegates voted on October 23, 1990, to authorize the building project at a cost not to exceed \$5 million. The Society financed the project



▲ Examining the blueprints for the original Busse Highway building at the ground-breaking ceremony on August 7, 1959, are ASA Presidents Drs. J. Earl Remlinger (1961), Leo V. Hand (1960), Daniel C. Moore (1959) and Albert M. Betcher (1963). Image courtesy of the Wood Library-Museum of Anesthesiology.



◀ Using the same shovel from 1959, 1991 President Betty P. Stephenson, M.D., second from left, breaks ground at the new headquarters location, joined by Executive Director Glenn W. Johnson; Dr. G.W.N. Eggers, Jr., President-Elect; and Dr. Peter L. McDermott, First Vice-President. Not pictured: Harry H. Bird, Chair of the Committee on Building.



The "mod" cubic design of the 1960s lobby at the ASA headquarters in Park Ridge (top) gave way to smooth, elliptical curves when the new building was designed in the 1990s.

with a short-term (five-year) loan and opted to sell its building and property at 515 Busse. The following August, Chipman Design Ltd. of Park Ridge, who had been selected through a competitive bid process to be the architectural firm to design the new building, presented its preliminary plans to the ASA Board of Directors. Selected from five bidders was the building contractor, Pepper Construction Co. of Chicago. Although the ASA building project was considered "small" when compared to its other commercial construction projects, Pepper company officials said they bid on the project in part due to its unique design and architectural challenges. The base construction bid was \$3,264,300.

By 1991 ASA membership had exceeded 30,000 and its budget was more than \$11 million. Staff now numbered 33 full-time employees.

Where the Grass Is Greener

Using the same shovel that broke ground for its then new headquarters in 1959, ASA President Betty P. Stephenson, M.D. (ASA's first and only female president to this day), officiated at the ceremony on July 29, 1991, attended by ASA leaders as well as Park Ridge Mayor Ronald Wietecha, City Manager Gerald Hagman, architect John Chipman and general contractor J. Stanley Pepper.

Construction moved swiftly on the new three-story, 44,000-square-foot building with a full basement for storage. As important, the WLM would occupy approximately 10,000 square feet of the new building with its museum on the first floor and library collection on the third floor.

On May 8, 1992, ASA staff moved into their new home-away-from-home, just five weeks after ASA and the anesthesiology community celebrated the 150th anniversary of the first anesthetic for surgery, performed by Crawford W.

Long, M.D., in Jefferson, Georgia, on March 30, 1842. Dedication of the new headquarters was held on August 15, 1992, with more than 200 ASA officers, district directors, local dignitaries, staff members and guests in attendance.

Since then ASA has added 18 new staff members to manage and carry out the new initiatives approved each year by the House of Delegates and Board of Directors as well as the daily interaction with ASA members who seek continuing medical education programs, publications, literature searches through the WLM and answers to questions about ASA's standards and guidelines.

By the Numbers

During the lean time around 1956, ASA's income over expenses was approximately \$17,000, a figure which fell to a deficit of \$5,000 in each of the next two years. The net worth of the Society then was approximately \$200,000.

When ASA made the decision to move to Park Ridge, all possible cost-savings measures were explored. To build the one-story headquarters, ASA invested \$100,000 of its reserve funds and borrowed the remaining \$125,000. These costs were offset in part by the annual savings of office rent (\$24,000) and an aggressive Building Fund campaign that raised more than \$44,000 from individual members.

"The building program is the largest single financial commitment your Society has ever taken upon itself," Dr. Moore wrote in the June 1959 *ASA NewsLetter*. "Accordingly, we must investigate the means available to raise funds to reduce the mortgage ... We have cleared the big hurdle."

Originally Mr. Christensen offered the entire 3.5-acre parcel to ASA for \$95,000 (\$27,000 per acre), but the budget simply did not allow for any additional land purchase over the \$40,000 that had been approved. Fortunately, two years later (1962), the additional 2.5 acres were still available, though the price had gone up to \$115,000 (\$46,000 per acre). It was purchased without further borrowing.

With careful financing and investing, by 1966, the Society's net assets were reported to be just under \$1 million, including about \$600,000 in real estate and the balance in cash.

If walls could talk, they would loudly proclaim ASA's successes since then. In fact, just two years after taking out the short-term loan for the current ASA Executive Office in Park Ridge, the loan was retired. Today ASA owns its building and property free and clear of loans or liens. The 2005 operating budget exceeds \$20 million with ample reserves and cash on hand.

ASA's house is indeed in order.

References available upon request and on the ASA Web site. Additional photographs on the back cover.



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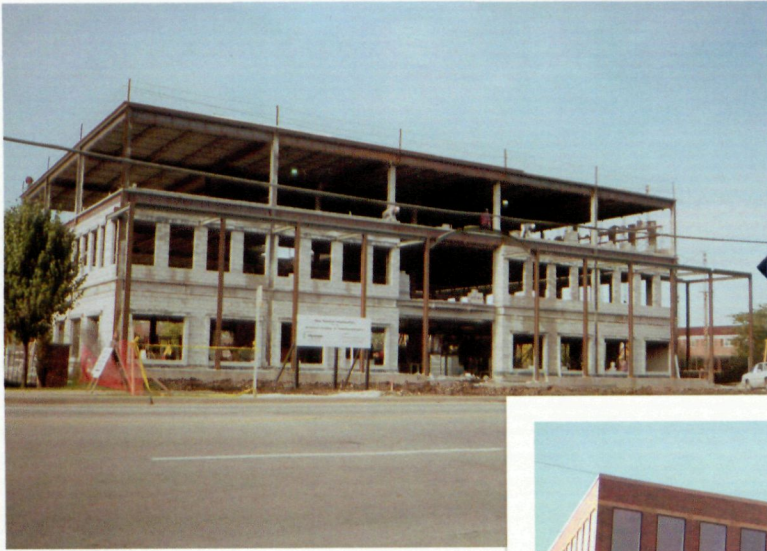
Resident - E. Olita Layton, M.D.

Benjamin D. Unger, M.D.

National Headquarters
for the
American Society of Anesthesiologists

520 N. Northwest Highway
Park Ridge, Illinois 60068

The 2.5 acres adjacent to the Busse Highway property, purchased at 1960's land prices, sat vacant for 25 years until it was necessary for the ASA headquarters to expand.



Site clearing, foundation, framing and concrete work proceeded quickly during the fall of 1991 so the building could be fully enclosed by winter.

111

Interior work continued through the cold months and into the spring of 1992.



18'-8"

Exterior landscaping, interior furnishings and new telephone and computer equipment were installed before ASA staff moved into their new office space on May 8, 1992.

NORTH/SOUTH

The ASA Centennial Web site

To commemorate this milestone, the Ad Hoc Committee on ASA's 100th Anniversary invites you to visit the newly launched ASA Centennial Web site at www.ASAhq.org/centennial/index.html.

Here you will find wonderful fun facts about ASA and anesthesia history; a place to contribute your memories about anesthesiology and our Society; treasures mined from the archives of ASA and the Wood Library-Museum; and special messages from ASA President Eugene P. Sinclair, M.D., and ASA100 Chair Douglas R. Bacon, M.D.

This special Web site also includes information about the special events that are planned for the week of the ASA Annual Meeting in New Orleans, most notably the Centennial Gala and Dessert Reception.



Not going to be at the ASA Annual Meeting?

We'll miss you, but there are many other ways to celebrate the ASA Centennial and keep a memento of this special year!

Visit the ASA Centennial OnLine Store

www.americanbus.com/aces/wbc/browse/category.asp where you will find fun and even practical items (like ASA100 lab coats). Now available are collectible lapel pins with a gold-and-enamel reproduction of the ASA color seal. But when they're gone, they're gone!

**Coming soon to the Centennial OnLine Store:
New apparel items and personalized golf towels!**



Details of ASA's color seal are captured in enamel inlay with gold-tone accents. Limited supply. (Pin shown actual size).

Learn about ASA's history, page by page, in the upcoming book:

The American Society of Anesthesiologists: A Century of Challenges and Progress

This book on the history of the ASA, in celebration of its centenary, edited by Douglas R. Bacon, M.D., Kathryn E. McGoldrick, M.D. and Mark J. Lema, M.D., Ph.D., will be available in October 2005. Twenty-one authors chronicled the century since the founding of organized anesthesiology in America in 17 chapters. Based upon the rich and extensive archives housed in the Wood Library-Museum, individual authors tell their stories either as past participants, or as thoughtful historians, re-enacting complicated historic issues and events in present-day context. A clear departure from traditional history, this book may be read with ease and pleasure as individual essays, or

in its entirety, from its founding by an obscure group of nine in Long Island to the ultimate realization of a vibrant organization a century later. The reader will realize that the struggles and challenges, unique in different eras of the past, were building blocks of success spanning an entire century. What a pleasure it will be to celebrate the centennial of a professional organization by witnessing the pioneers' struggles over time to achieve what benefits all in American medicine today.

Watch for its release in October, 2005!

