



Another Annual Meeting in San Francisco, another record-breaking turnout. Attendance at the 2007 meeting reached 19,473, the highest ever recorded. This issue of the *NEWSLETTER* recaps just some of the highlights of yet another memorable meeting in Everyone's Favorite City.

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The *ASA NEWSLETTER* (USPS 033-200) is published monthly for ASA members by the American Society of Anesthesiologists, 520 N. Northwest Highway, Park Ridge, IL 60068-2573. E-mail: mail@ASAhq.org
Editor: Newsletter_Editor@ASAhq.org
Web site: http://www.ASAhq.org
Periodical postage paid at Park Ridge, IL, and additional mailing offices.

POSTMASTER: Send address changes to the *ASA NEWSLETTER*, 520 N. Northwest Highway, Park Ridge, IL 60068-2573; (847) 825-5586.

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SUBSTANCE ABUSE HOTLINE:

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

Auld Lang Syne, or New Directions: The January Dilemma

*Should auld acquaintance be forgot,
and never brought to mind? Should
auld acquaintance be forgot, and auld
lang syne?*¹

This is the fiftieth time you have opened the ASA NEWSLETTER and hopefully read "From the Crow's Nest," and each time you have learned about my personal take on an interesting problem or issue facing anesthesiology. Many of you have written to me to comment, and the "Letters to the Editor" section has been one of the more interesting in the publication. Unfortunately for you, the readers, I cannot publish all the letters I receive. There are reasons for this, mostly because some letters broach issues that would put ASA at legal risk. Being the NEWSLETTER editor has been a learning process for me; an education gratefully received. Perhaps the best part of this job personally has been that I have met so many committee chairs and members, if not personally, then electronically through articles, letters and ideas for future NEWSLETTER issues.

January is often a time for reflection. For some, that comes upon waking on January 1 and a New Year's resolution to avoid ETOH for the rest of their lives. This January issue is largely retrospective, looking back at our Annual Meeting in San Francisco. In reflecting on the NEWSLETTER over the past year, our new format and full-color pub-



Douglas R. Bacon, M.D.,
Editor

2007 will be remembered as a year of challenges for ASA. Gina A. Steiner, the Director of Communications, resigned last May. Gina was responsible for supervision of the Park Ridge staff that transforms the various articles into a cohesive publication. In September, Dawn M. Glossa was hired to fill Gina's position. Thus, 2008 will be her first year directing the NEWSLETTER staff. One major change, almost unrealized by most members, has already taken place. Deadline for publication is always the first of the month before the issue is actually in the hands of ASA members. Thus, December 1 is the deadline for January. Several small procedural changes have been made in an effort to be timelier, and it is our intent to have the NEWSLETTER in your

hands well before the end of the month.

ASA has undergone some major transitions in 2007. The director of communications change aside, the entire organization is being refurbished. No longer is there one overall executive, but rather two executive vice presidents, one at headquarters in Park Ridge, Illinois, and another in our Washington, D.C. nerve center. With clearly delineated responsibilities, the ability to interact with each other, and with the overall supervision of the ASA president, our Society will only get stronger. In this change, though, two long-term ASA executives have departed, Ronald A. Bruns and Denise M. Jones. As dear friends to many of us, they are "old acquaintances" who will not be forgotten.

Politically, some old friends remain. The teaching rule has, of the writing of this editorial, not been overturned by Congress. Do not view this as a failure of ASA leadership or our Washington office. Rather, in the Byzantine world of national politics, we have made significant inroads and many friends. Unfortunately it will take time and continued effort to change this rule. However, the Centers for Medicare & Medicaid Services did greatly increase Medicare reimbursement for services. While nowhere near approaching the value our services are worth on the open market, it is a major first step and indicates the effectiveness of our lobbying efforts in Washington.

Another longstanding New Year's tradition is to look forward to making resolutions to improve oneself. So what are, or ought to be, the New Year's resolutions for anesthesiology?

"We need to continue our efforts to make this the best specialty society in the world — responsive to the diverse needs of the membership but focused on what is best for the patient."

lication has transformed the periodical in appearance. Content remains excellent, a credit to the authors, derived from the membership, who take the time to write and rewrite information that the membership needs to hear. Our Washington office generally, and Ronald Szabat specifically, contributes both articles and advice that strengthen our NEWSLETTER.

Continued on page 2

First and foremost, we need to rededicate ourselves to our patients. This means we have to make a serious commitment to being the best possible anesthesiologist we can be every day for every patient. A part of this effort has to be dedicated to continuing medical education (CME). We need to be aware of the latest and greatest innovations in our practice and cautiously apply them. It is, in the end, the responsibility of every physician to be the best possible healer. Education is a part of that, as is compassion. Let us not forget this as we speak with our patients and further resolve to spend whatever time we have with them, leaving them feeling that they are the most important people in our world.

As ASA members, we should resolve that we will welcome and work with new Executive Vice President of the ASA Park Ridge Executive office John A. Thorner, J.D., CAE, who will begin work this month on January 7. Clearly, 2008 will be a time of transition in the executive leadership of the Society, yet by working together transparently, we can make ASA better than it has ever been. We need to continue our efforts to make this the best specialty society in the world — responsive to the diverse needs of the membership but focused on what is best for the patient. We need to somehow remain free from the temptation to do what is best for ourselves in the short run and look toward the future with the patient's best interest in mind.

As individuals, every ASA member needs to resolve to bring as many nonmember anesthesiologists as possible back to the Society. How can this be done? Attractive, cutting-edge CME can advertise the state societies and hence bring members to both organizations. Member benefits, too numerous to elucidate here but clearly spelled out on the ASA Web site, ought to be inducements to join. In the end, it is the ability of the Society to speak as the representative of our specialty, strengthened by numbers, that is important in being able to shape our own destiny.

Further, as ASA members, we need to resolve to support, with both time and money, our efforts in Washington. If the teaching rule will ever be changed, it will only come after increased lobbying and education of our legislators. This is a time-consuming process that may not show results for years, but it is an effort well worth pursuing. ASAPAC, the only national group dedicated specifically to anesthesiology issues, is our ally. Anesthesiologists in Alabama have consistently understood the importance of having such an organization weighing in on political issues. All anesthesiologists can learn from their experience. As anesthesiologists, our personal political involve-

ment, which means participating in shaping governmental policy on many levels, may be our weakest link. It is time to resolve that each anesthesiologist will be more politically active in 2008.

A final resolution needs to be made by all anesthesiologists to support research. Each physician needs to report his/her interesting cases. It is through these dilemmas and their resolutions that we learn about rare cases and hopefully a successful way to manage the anesthetic. Oftentimes case reports beget more questions than they answer and thus lead to clinical trials. Finally, bench-top research can lead to innovative technologies, techniques and agents that will allow us to anesthetize our patients better. Quite simply, it is in our own best interest to take an active interest in the scientific and clinical development of the specialty. For many of us, it means writing, developing protocols and doing research. For others, it means investigating interesting questions on a molecular level. For others still, it means donating time and doing extra cases to allow a colleague to leave the operating room or clinical site to "do" research. And for others, it is a gift of cash that helps fund the ongoing drive to understand anesthetics and make our clinical practice both safer and better.

A few weeks ago, my son was performing an exercise in music reading during his violin lesson. The line in the book did not mean anything to me, as I lack the gift to see the written note and hear its sound. Yet, suddenly, "Auld Lang Syne" was recognizable as Tom played. Memory of the moment has helped me to create this editorial and to resolve to be the best possible editor I can be. It has also helped me remember my personal New Year's resolution to be the best possible anesthesiologist I can be, day in and day out, to each and every patient. Finally, as a single father, my resolution to my sons is to be the best possible parent I can be. These are not unique resolutions, yet they are the keys to our success as a Society, as physicians and as people. As the year progresses, let us remember our resolutions and act upon them.

— D.R.B.

Reference:

1. en.wikipedia.org/wiki/Auld_Lang_Syne accessed December 6, 2007.

Pardon Our Dust

Jeffrey L. Apfelbaum, M.D.

We end 2007 having made major strides forward. We are stronger and more focused than ever in serving the needs of our members, profession and, most importantly, our patients. With record attendance at our Annual Meeting, it is clear our members' commitment to ASA is at the core of our strength as a Society. There are several major areas of significant change for ASA that began this year and will continue over the next several years as we build an even stronger ASA.

The Organizational Improvement Initiative (OII) is a two- to three-year *sustained* improvement effort that will implement appropriate "best practices," enabling ASA to deliver exceptional service to its members and our patients.

Of equal importance, the OII will enable us to meet current and future challenges posed by a rapidly changing health care environment. To date, the OII has focused on improving planning and annual meeting processes, developing a human resources function, developing and implementing



Jeffrey L. Apfelbaum, M.D.

"Our goals are ambitious, our change efforts intense, and our commitment to ASA's mission and values steadfast. 2008 will be an exciting year of innovation and building that will ensure an even stronger ASA."

standard management operating practices, and training and developing staff.

ASA's strategic plan has been completely revamped. Committees and staff are currently working on operational plans to achieve the objectives of the strategic plan. We are using our strategic plan to ensure that members and staff are working toward the same goals and that we have the staff capabilities and organizational infrastructure to support the achievement of our strategic objectives.

ASA now has a top-notch human resources professional as our first Director of Human Resources. Starting in January, we will have a performance management process in place that connects staff jobs and individual objectives to accomplishment of the strategic plan. Additional staffing needs are also being assessed to ensure that we have the staff support needed to achieve our strategic plan.

The Washington D.C. office is moving into a new office space designed to meet their needs and provide new capabilities for ASA. To accommodate a substantial increase in personnel at the Park Ridge, Illinois, office, renovations of office space and the parking lot have been initiated.

One of the major efforts in process improvement is the development of procedural calendars detailing tasks pertaining to the Society's governance, internal and external communications, and interdepartmental coordination. This effort will result in increased efficiencies for all aspects of

ASA's operations, yielding an organization that is able to more quickly respond to member and patient needs.

ASA will launch a major branding campaign this coming year. The campaign, which you will hear more about in the coming months, will allow ASA to increase its presence in the

marketplace, determine the messages we need to be sending and position ASA as the preeminent leader among health care associations.

Our goals are ambitious, our change efforts intense, and our commitment to ASA's mission and values steadfast. 2008 will be an exciting year of innovation and building that will ensure an even stronger ASA.

Happy New Year: ASA's Hard Work Pays Off Medicare's 2008 Anesthesia Conversion Factor Takes Huge Step Toward Parity

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

Executive Vice President – External Affairs and General Counsel

After years of concerted efforts and piecemeal gains, ASA has succeeded in convincing Medicare to raise significantly its conversion factor applicable to anesthesia services. The revised 2008 average national Medicare anesthesia conversion factor has been set at \$17.82 starting January 1, 2008. Locale-specific conversion factors for 2008 follow in chart form (see table on next page).

This dramatic 32-percent increase in work values for 2008 and beyond — which narrows by more than half the gap between the average national Medicare conversion factor for anesthesiology as compared to the private pay market — is the result of dogged determination by ASA's leadership,

lobbying staff and particularly the Committee on Economics. Significant ASA grassroots support during the Medicare agency's recent comment period also helped "seal the deal." The result is fairer payments from Medicare, which is all the more important as the tidal wave of early baby boom retirees begins in the next few years.

For the past decade, ASA has made the strong case that the Medicare anesthesia conversion factor was roughly 40 percent less than what is paid on average by private insurers. For example, in 1990 and 1991, the average anesthesia conversion factor was \$19.30, yet when the Medicare Fee Schedule went into effect in 1992, the Medicare anesthesia conversion factor plummeted to \$13.94. Using Department of Labor statistics, if the 1990 and 1992 conversion factors had merely kept up with the general inflation rate, at the end of 2007 they would have stood at \$29.77 and \$20.03, respectively. Now, because of ASA's efforts to force a re-examination of work value based on a sophisti-

cated econometric model developed by ASA and an outside consultant, anesthesiologists will see the average national anesthesia conversion rise to \$17.82 from \$16.19 and probably go closer to the \$20 mark as short-term corrections are made to offset the effects of the sustainable growth rate (SGR) formula's application to 2008 payment, realizing an additional short-term 10-percent increase for which ASA has battled along with the American Medical Association (AMA) and all of medicine.

ASA's current success came by shepherding its study and findings through the AMA/Specialty Society Relative Value Scale Update Committee (RUC) and seeing the RUC's positive recommendation go forward to the Centers for Medicare & Medicaid Services (CMS) for public comment. The success of this skilled modeling and maneuvering stands in stark contrast to two earlier well-reasoned attempts over the previous 10 years. Then, ASA sought relief from this Medicare disparity by participating in the five-year review process dictated by the Medicare statute. In those instances, ASA provided detailed comparisons of the physician work involved in various common anesthesia procedures to procedures commonly performed by other specialties. Not surprisingly, these data showed that anesthesia work was greatly undervalued, but CMS was not then to be moved.

On the first of these two reviews, CMS (then the Health Care Financing



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

ASA Washington Office • 1501 M Street, NW, Suite 300 • Washington, DC 20005 • (202) 289-2222 • mail@ASAwash.org

Administration) modestly adjusted the Medicare anesthesia conversion factor upward, and, on the second, it slightly adjusted a handful of procedures, declining to extrapolate its findings to the full range of anesthesia procedures.

The slashing of Medicare anesthesia payment in 1992, coupled with CMS' subsequent unwillingness to remediate the cut and the previous large gap between Medicare and private anesthesia fees, has resulted in a situation in which anesthesiologists have tended to migrate away from hospitals and localities with disproportionately higher Medicare populations. These hospitals must regularly provide subsidies to the anesthesiology department to retain anesthesiologists and keep operating rooms fully open.

The Government Accountability Office (GAO) report from this past summer confirmed the payment disparity between Medicare and commercial payments for anesthesia services, yet surprisingly did not study the effect of subsidies on the delivery of anesthesiology medical care. As previously reported, GAO concluded that Medicare anesthesia payments through 2007 were 67 percent lower than average commercial payments. Further, the GAO study found that the number of anesthesiologists had decreased as the concentration of Medicare beneficiaries increased in 87 Medicare payment localities.

Against this backdrop, ASA was very pleased that CMS has taken the necessary steps to reduce this gross Medicare underpayment for anesthesia services and significantly increase its conversion factor. In its proposed rule of July 2007, CMS included the 32-percent increase to the work value portion of the anesthesia conversion factor recommended by the RUC.

Continued on page 37

2008 Anesthesia CF

Locality name

Alabama	16.74	Metropolitan Kansas City, MO	17.61
Alaska	18.01	Rest of Missouri	16.63
Arizona	17.50	Montana	16.49
Arkansas	16.17	Nebraska	16.09
Anaheim/Santa Ana, CA	18.62	Nevada	18.00
Los Angeles, CA	18.60	New Hampshire	17.19
Marin/Napa/Solano, CA	18.25	Northern NJ	19.12
Oakland/Berkley, CA	18.57	Rest of New Jersey	18.71
San Francisco, CA	18.97	New Mexico	17.19
San Mateo, CA	19.12	Manhattan, NY	19.65
Santa Clara, CA	19.11	NYC Suburbs/Long I., NY	19.78
Ventura, CA	18.29	Poughkeepsie/N NYC Suburbs, NY	18.14
Rest of California	17.52	Queens, NY	19.35
Colorado	17.22	Rest of New York	16.99
Connecticut	18.62	North Carolina	16.75
DC + MD/VA Suburbs	18.91	North Dakota	16.04
Delaware	17.73	Ohio	17.71
Fort Lauderdale, FL	18.99	Oklahoma	16.33
Miami, FL	20.27	Portland, OR	17.16
Rest of Florida	17.97	Rest of Oregon	16.46
Atlanta, GA	17.90	Metropolitan Philadelphia, PA	18.92
Rest of Georgia	17.12	Rest of Pennsylvania	17.46
Hawaii/Guam	17.71	Puerto Rico	14.83
Idaho	16.41	Rhode Island	18.24
East St. Louis, IL	18.56	South Carolina	16.46
Suburban Chicago, IL	19.10	South Dakota	15.88
Chicago, IL	19.60	Tennessee	16.74
Rest of Illinois	17.49	Austin, TX	17.67
Indiana	16.78	Beaumont, TX	17.76
Iowa	16.68	Brazoria, TX	18.32
Kansas	16.62	Dallas, TX	18.11
Kentucky	16.75	Fort Worth, TX	17.84
New Orleans, LA	17.69	Galveston, TX	17.94
Rest of Louisiana	17.07	Houston, TX	18.47
Southern Maine	16.95	Rest of Texas	17.23
Rest of Maine	16.52	Utah	17.11
Baltimore/Surr. Cntys, MD	18.13	Vermont	16.61
Rest of Maryland	17.43	Virginia	16.91
Metropolitan Boston	18.54	Virgin Islands	17.54
Rest of Massachusetts	17.82	Seattle (King Cnty), WA	17.89
Detroit, MI	20.21	Rest of Washington	17.23
Rest of Michigan	18.03	Wisconsin	16.93
Minnesota	17.14	West Virginia	17.68
Mississippi	16.60	Wyoming	16.75
Metropolitan St Louis, MO	17.68		

Outgoing President Proud to Lead During Pivotal Period in ASA's History

Mark J. Lema, M.D., Ph.D.
Immediate Past President

Madam Speaker, fellow officers, directors, delegates, staff and guests.

ASA is a vibrant and strong organization. One of our greatest strengths is the dedicated members who give unselfishly to accomplish the work of the Society. We continue building our excellent educational offerings and enduring materials. Our support for research has reached record funding levels and is 75 percent more than a few years ago. Membership is at an all-time high with record Annual Meeting attendances of over 18,000. We are financially sound and have increased our reserves by over 15 percent since 2002. Our messages in Washington are being heard, and our opinions are respected. Most importantly, our specialty continues to be the model for safe medical care of patients. ASA's mission and resources have never been more robust.

We must, however, plan for inevitable future health care changes that will challenge our current practice arrangements. We also must ensure that we have the organizational capabilities to effectively manage a large, complex corporation in today's demanding business environment.

We have had a remarkable growth in membership over the last 30 years, almost tripling our size during this time period. Today, ASA is 42,000 strong and growing. However, our Society's infrastructure has undergone minimal substantive changes that enable us to effectively manage a major professional medical society in today's 24/7 business environment.

Consider these statistics. According to an American Society of Association Executives recent study, the average professional society employs one staff person for every 225 to 250 members. Currently, ASA employs one staff person for every 609 members. We are expecting one staff person to provide increasingly complex and expanding services to 360 more members, almost two and a half times more than the average ratio. Clearly, we are understaffed. The lag in infrastructural and member services' capabilities is most severe in key areas such as information technology, the Annual Meeting, financial planning and general reporting systems.

All data and analysis make it clear that our infrastructure capabilities cannot meet current member needs. Our officers and senior staff are experiencing an expanding list of responsibilities and must be able to respond immediately to the rapid transformation of information technology to effectively communicate in a "real-time information" society.

A series of consultations with both outside and inside evaluators from 1995-2005 reported consistent findings of significant areas requiring immediate, as well as long-term, attention. The Executive Committee then sought outside expertise from the Gordon Group, a management consulting firm which specializes in helping organizations *implement* infrastructure improvements. The Executive Committee charged the Gordon Group with conducting an in-depth review and assessment of the organization's management processes, policies, practices and leadership effectiveness.

The Gordon Group identified a number of deficiencies and provided a summary of opportunities for improvement as shown on the projected slide.

Slide 1

Gordon Group Recommendations

- Adequate staff with the needed skill sets.
- Create the following systems:
 - strategic planning process,
 - integrated operational planning and budgeting process,
 - performance management process,
 - internal communication process
 - human resources processes.
- Implement a quarterly operations review to ensure that officers have an accurate organizational profile.
- Integrate the processes of the Park Ridge and Washington offices.
- Hire a human resources professional for ASA's 70 employees.
- Develop a business model to support growth for subspecialty society services management.
- Implement a leadership and managerial development program for all managers.
- Develop formal orientation for the newly elected First Vice-President, new ASA volunteers and the new ASA employees.
- Plan and implement a sustained organizational improvement initiative over a two- to three-year period to ensure successful transformation and implementation of needed changes.

"ASA is a vibrant and strong organization. One of our greatest strengths is the dedicated members who give unselfishly to accomplish the work of the Society."

The current ASA infrastructure does not enable its leadership to fully meet their fiduciary responsibilities. In order to effectuate the improvement strategies outlined in the Gordon Group report, ASA launched its formal Organizational Improvement Initiative, or OII, at the end of March 2007. This transformational improvement is expected to be a two- to three-year change process.

Slide 2

ASA Organizational Improvement Initiative (OII)

- To improve organizational functioning and enable ASA officers and Board of Directors to meet their fiduciary responsibilities
- To develop new planning strategies to meet the future challenges of a changing health care environment
- To excel in meeting members' needs in an "instant communication" world

ASA's OII provides the planning and leadership required to design and build an infrastructure to meet current and future member needs. Consequently, the Executive Committee prioritized the following concerns.

First, ASA needs to achieve improved organizational functioning and enable its officers and Board of Directors to meet their fiduciary responsibilities.

Second, ASA needs new planning strategies to meet the future challenges of a changing health care environment.

Third, ASA must excel in meeting members' needs in an "instant communication" world.

The Executive Committee has already developed a detailed change plan for the OII with timelines and measures to ensure that we are providing the leadership necessary to address critical infrastructure improvements.

Continued on page 8

The Executive Committee selected human resources needs as the top priority for the Organizational Improvement Initiative. In less than 120 days, we have:

Slide 3

OII's 120 Days' Accomplishments

- Recruited ASA's first full time certified human resources professional
- Filled previously unbudgeted positions not hired because of a lack of recruiting capabilities
- Hired essential new staff in accounting, annual meeting planning and information technology
- Recruited a new Director of Communications
- **Negotiating the final stages of a contract to hire the new EVP of the Park Ridge Headquarters.**

Another key accomplishment began with the June Administrative Council retreat that was devoted to updating the ASA's vision, values, mission statement and strategic plan. The revised 2007-09 strategic plan has been developed, analyzed and approved by the Administrative Council. A first draft was distributed to the BOD for comment at the August meeting, and the final document is ready for full BOD and HOD approval in 2008.

Other important improvements have been made, as seen on the projected slide.

Slide 4

OII's Key Improvements

- Key process development for Annual Meeting, BOD and HOD meeting preparation.
- Human resource process documentation.
- Staff orientation program development.
- An orientation program for the First Vice-President.
- Management training and coaching for staff leaders on leadership and teamwork.
- Officer role/job descriptions development.
- Revised compensation and benefits package development for staff.
- Review of human resources policies and practices.
- Improved communication and planning processes within and among staff at Park Ridge and Washington offices.
- Initiation of the development of staff work plans which are compatible with the strategic plan.

Although the ASA has important strengths that make us a world leader in patient safety, we lack the infrastructure to effectively maintain or enhance the current strengths that our members both need and deserve.

ASA is an organization approaching its critical strategic inflection point where needed change can be an opportunity to grow and excel, or where inaction can signal a downward spiral, and the beginning of the end.

Last October, we were not positioned, staffed, organized nor had adequate capabilities as a professional society to help our members meet these challenges that the future of health care will present. Without investing now, we would have been relegated to constant fire fighting and reacting to crisis after crisis.

ASA's Organizational Improvement Initiative is enabling us to build an infrastructure that will not only meet the inevitable challenges to our practice arrangements but will also position us to continue leading needed changes.

We have an advantage that many organizations lack when facing these kinds of challenges. The ASA financial situation is strong due to very capable Board of Directors stewardship over the past several years. ASA has the financial resources and cash reserves to invest in these critical infrastructure improvements.

Slide 5

ASA's 2007 Mission

The American Society of Anesthesiologists is an organization of physicians and other professionals, dedicated to serving the best interests of its members and their patients. ASA supports patient safety by promoting improved quality, ethical behavior, discovery of new knowledge, and involvement of an anesthesiologist with every patient receiving anesthesia services, including perioperative care, pain management, and critical care.

We are all dedicated to the ASA's mission. As leaders of this esteemed Society, we must be equally dedicated to ensuring we have the staff with the necessary skills, structure and systems to meet today's demands so we can build an even brighter future for our members,

our profession, our patients and the communities we serve.

Slide 6

ASA's 2007 Vision

The American Society of Anesthesiologists is the world's premier medical specialty organization, leading through innovation in patient safety, clinical care, advocacy, education, and research.

As I look to our Society's future, I know that we will continue to devote ourselves to achieving our vision for ASA to be the world's premier medical specialty organization, leading through innovation in patient safety, clinical care, advocacy, education and research.

As a medical profession, and as individual professionals, we must continue to develop innovations for our patients, our profession and our members. We set the bar high. No less than being the best of the best is our aspiration. This has been our distinguished 100-year history and will be our promising future. Your leadership and support have never been more critical than they are now. Each of us must take bold action and seize every opportunity to make a difference in the lives of our patients and our communities.

When faced with challenges as a profession and as a society, we have always stepped up and provided the leadership needed to make improvements for our patients and our profession. The ASA Organizational Improvement Initiative provides us with a sustained change process so that as leaders, we can step up, rise to the challenges we face, and lead ASA to new heights of excellence.

It has been my distinct honor to have served as your president during this past year. I have been blessed to have received this president's medallion from an excellent leader, Dr. Guidry, and I am blessed to pass it on to an equally capable leader. I look forward to supporting Dr. Apfelbaum during his term as ASA President. I can assure you that he will guide this organization with a dedicated heart and a steady hand.

I also congratulate and thank Dr. Roger Moore for staying in the loop and providing superb advice and direction during this historic transition period.

Sincere appreciation goes out to Denise Jones and Ron Szabat and their able staffs for embracing what amounts to the most significant change that ASA staff members have ever experienced. Everyone rose to the challenge, and ASA is now on course to successfully reorganize itself for the future.

No president has ever had a better assemblage of officers, division and section chairs, as well as committee chairs who devoted many more volunteer hours than anticipated, to expertly carry out the will of this House.

Without the sage counsel of our outside attorney, Mr. Scott Kragie, ASA's resources would have been dangerously exposed. He provided excellent, practical and unwavering advice throughout this year that has served us well.

Even though the Gordon Group is a contracted partnership with ASA, I must thank Dr. Vicky Gordon, Dr. Barbara Fossum and Ms. Trisha Svehla for going *well* beyond the expectations that any president would have expected from a consulting firm to ensure the success of this transition. Their insight, intense dedication and loyalty to ASA, and their superb organizational expertise is unparalleled. It is to ASA's great advantage that they stuck with this project and continue to guide us through the transition to a new EVP at Park Ridge.

Simply stated, the OII would not have moved so quickly and so far in such a short time if not for the tireless effort of Dr. Gene Sinclair. In my opinion, there is no better person to ever have served ASA, who has the knowledge and practical leadership to make this project happen. Gene, ASA owes you a great deal of gratitude for all that you have done.

Finally, I wish to thank my wife, Suzanne, who served as an honest advisor and support system. She tolerated the many hours and days that this duty took away from family and personal time with understanding and encouragement. She was there when I needed the love and support that only a spouse can provide. I now look forward to being with her on a more regular basis in 2008.

Last year, I stood before this House and said that "just when you make plans, life happens." It was time for ASA to reorganize, and it fell on my watch. I invested my entire effort over this past year to overseeing the transition and was pleased to present our accomplishments to you in 2007. The exciting times are still ahead, and I am enthusiastic about helping Dr. Apfelbaum, along with the other officers, continue the OII development.

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Incoming President Taking Strong 'Initiative' for Society's Future

Jeffrey L. Apfelbaum, M.D.
President

Since my election as First Vice President two years ago, I have had the good fortune to represent ASA leadership at many component and subspecialty society meetings. I have had the privilege of speaking with ASA members from diverse geographic and practice backgrounds and had frank discussions about how ASA could better serve their needs. I am profoundly appreciative for the wisdom, experience and challenges imparted to me from these discussions with our members. From just this type of dialogue with our members, a singular, focused, driven vision has emerged. ASA will become the world's premiere medical specialty organization, leading through innovation in patient safety, clinical care, research (i.e., creation of new knowledge), education and advocacy. Our members recognize patient safety as our paramount "reason d'être." Past ASA President Roger W. Litwiller, M.D. [2004] may well have said it best: "It's all about the patient." During my term as President, ASA leadership will remain focused on our principle long-term strategic objective to promote continued improvement in quality of patient care and patient safety through the involvement of an anesthesiologist in the care of every patient receiving anesthesia services. Simply put, we must ensure that future generations of patients continue to enjoy the safety and quality benefits afforded through the expertise provided by a physician in the medical specialty of anesthesiology. To that end, we will continue to passionately address these specific issues:

- Inequities in the Medicare anesthesiology teaching rule.
- Funding for the creation of new knowledge in all aspects of the medical specialty of anesthesiology (e.g., perioperative care, procedural care, critical care medicine, pain medicine).
- Lack of Medicare payment parity.
- Scope-of-practice issues.

As Chief Executive Officer of ASA, it is important for

me to set as one of my critical objectives the continued implementation of the Organizational Improvement Initiative. We must build the ASA's infrastructure not only to meet the needs of current members but also to ensure that the needs of future generations of ASA members will be met.

One of the major findings of the Gordon Group management consultation is that the current ASA infrastructure does not easily enable its leadership to meet their responsibilities fully. ASA officers are elected to provide leadership for the Society and to ensure that the directives from the Board of Directors, the House of Delegates and, above all, our members, are implemented. Thus, one of the principal goals for my term will be to provide the resources necessary to enable the officers to meet their responsibilities more readily.

One of the most significant accomplishments of the change initiative to date is our updated strategic plan. During the next year, I will do my very best to make our new strategic plan operational. To do so requires the following activities:

- Prioritize yearly initiatives in critically important areas of research, education and training, advocacy, member value and research.
- Ensure that staff operations plans address the objectives of the strategic plan.
- Ensure that the work of the volunteer physicians within committees and other ASA entities (e.g., task forces, sections and divisions) addresses the objectives of the strategic plan appropriately.
- Ensure that the staff has adequate resources to quickly pursue initiatives that are deemed highest priority by the Board of Directors, House of Delegates and general membership.
- Monitor progress toward meeting the objectives of the strategic plan.
- Develop a process for refreshing the strategic plan on an annual basis.

We must continue to create and implement processes that are best practices because our members expect and

deserve *exceptional* service. It has become apparent that given the yearly transition of officers, it is critically important that ASA senior leadership work together effectively, with considerable frequency. During the past year, virtually every management decision, regardless of how large or small, was thoroughly vetted by all three members of the Executive Committee. In order to improve the ability of officers to work together, we will:

- Continue to foster teamwork among the members of the Executive Committee and the Administrative Council with regular and frequent meetings;
- Continue to champion the clarification of officer roles and the development of corresponding “job descriptions” for each of these roles; and
- Develop and implement an orientation process for the first vice president and, eventually, all other newly elected officers.

Finally, the organizational assessment resulted in a finding that will not surprise you: The survival of our subspecialty societies is critical to ASA. Unfortunately, our current business model does not allow us to provide the management services needed by many of the subspecialty societies. Thus, I include as a goal for my term the launching of a process improvement effort that will result in the redesign of the entire set of cross-functional subspecialty support activities within the ASA staff infrastructure, with the aim of better cost-effective subspecialty management and support of subspecialty society and ASA membership growth.

I will continue to work with the Executive Committee, the Administrative Council and ASA staff to ensure that the aforementioned goals and objectives are met. We must ensure that the strength we have today continues, and we must build new strengths if we are going to create the future we all want for our patients and our profession. Management scholar Peter Drucker stated it simply: “The best way to predict the future is to create it.” Together, we will do just that.

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“Simply put, we must ensure that future generations of patients continue to enjoy the safety and quality benefits afforded through the expertise provided by a physician in the medical specialty of anesthesiology.”

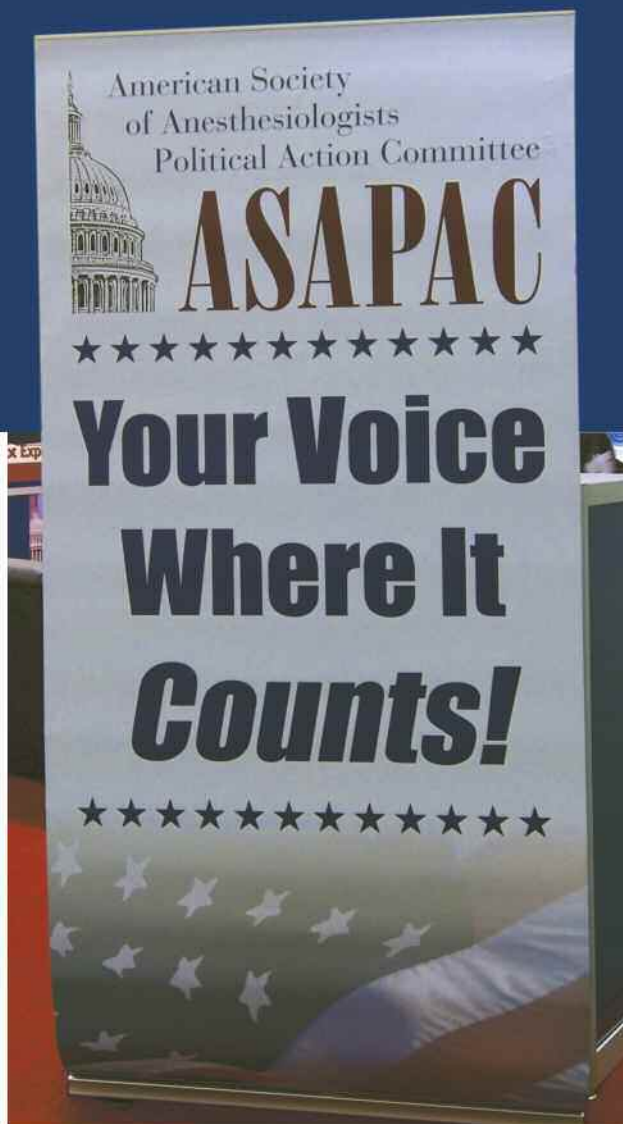


Political and Grassroots Activism: Time to Get Involved

Paloma Toledo, M.D.
ASAPAC Executive Board

New Year's resolutions... It is that time again! Just in case you did not have a chance to pick your resolutions yet, take a look at the United States government Web site (usa.gov), which has a list of the most popular resolutions. Of course, the list includes losing weight, as well as eating right, and reducing stress. However, for anesthesiologists, I would like to add one New Year's resolution — and this is one that you *need* to keep. That resolution is to get involved on behalf of our specialty. Whether making a political contribution to a local candidate, volunteering for his or her campaign or simply serving as a local contact for a lawmaker, there is no time better to jump into our nation's political and legislative processes as they play out in your neighborhood.

Local political and grassroots participation is an absolute **necessity** these days, as our legislators and regulators are increasingly involved in decision-making that affects anesthesia payments and patient care. Examples include the sustainable growth rate (SGR) formula and the Medicare anesthesiology teaching rule. Local activism — one-on-one contacts with lawmakers — ensures that our specialty is heard in the political and policy-making process. Indeed, personal interaction provides an opportunity to educate lawmakers about the issues relating to anesthesia, and it could be the beginning of a long-term relationship with your leg-



islators. Having relationships with key legislators could tip the balance toward anesthesia in these times of budget cuts and deficits. It all starts in your neighborhood.

A more material benefit that affects all anesthesiologists was made possible through the hard work of ASA and its local activists. Last November, the 2008 fee schedule was announced. To provide a little background, your payment is based on the relative value units (RVU) as well as an anesthesia conversion factor. The anesthesia conversion factor is composed of three factors: physician work, practice expense and practice liability insurance. Work is the actual effort expended by the physician to perform a medical service. Practice expense is the cost of overhead to run a practice as well as the cost of supplies, equipment and employed clinical labor. Professional liability insurance is the esti-



Paloma Toledo, M.D., is an obstetric anesthesiology fellow, McGaw Medical Center, Northwestern University, Chicago, Illinois.

mated cost of professional liability. Payers convert the RVU into a payment amount by multiplying the RVU by the conversion factor that defines the monetary unit of the RVU. Then, a budget neutrality adjustor is added. All of these components are placed into an equation, and from it, payment is calculated. This year, the Centers for Medicare & Medicaid Services (CMS) recognized that the anesthesia work value was undervalued, and **we received a 32-percent increase in the physician work portion of the anesthesia**

“Local political and grassroots participation is an absolute necessity these days, as our legislators and regulators are increasingly involved in decision-making that affects anesthesia payments and patient care.”

conversion factor. When the proposal was issued for this increase, anesthesiologists from all over the country bombarded CMS with letters and e-mails in support of the change. So for 2008, the unadjusted anesthesia conversion factor is now approaching \$20. The local voice of our specialty helped to make this happen.

Issues such as the SGR, CMS teaching rule and Medicare reimbursement will affect the future of our specialty, not only in terms of payment but also how our specialty is allowed to grow. This, in turn, will allow us to have enough trained physicians to care for our aging population.

As you can see, by participating you are demonstrating leadership in our specialty and helping to influence the course of our future. You are ensuring that our legislators at both the national and state level continue to hear our voice. Through your actions, you are allowing ASA to continue to advocate for our patients.

Last year, the youngest members of our Society realized the importance of local political and grassroots activism. Residents nationally responded to a challenge to increase our ASA Political Action Committee (ASAPAC) participation. In one year, the resident participation tripled and currently surpasses the general membership participation rate. Several states achieved a 100-percent resident participation rate in ASAPAC. Additionally, residents became active at the grassroots level by meeting with lawmakers and sending letters and e-mails at record

levels. Even more is expected from our residents in the new year.

Every anesthesiologist benefits from the collective work of individual members becoming active at the local political and grassroots level. It is time for more of us to get involved in these efforts. Be active, and stay involved. Your future depends on it!

Learn more by contacting James L. Becker, M.D., ASAPAC Chair, or Jane C.K. Fitch, M.D., Chair of ASA's Committee on Governmental Affairs, the home of ASA's grassroots “Key Contact” program.



Incoming President Taking Strong ‘Initiative’ for Society’s Future

Continued from page 11

In conclusion, I commend Dr. Lema for his decisive action to move ASA to the next level of organizational excellence at this critical time in our history. It is my hope to continue the courageous and exemplary leadership shown by him.

I also wish to thank Dr. Roger Moore, Past-President Dr. Gene Sinclair, and all the members of the Administrative Council, for their yeoman's effort in the past year. I'd like to recognize the members of my department and medical center for their support, and to my administrative assistant, Ms. Julie Garrity. And a special and profound thank you to my wife, Carol, and children, Sean and Sara, for so graciously encouraging me to serve the Society.

During the coming year, I will call upon many of you, the members of this House of Delegates, to share your experience, knowledge and wisdom. Together, we can achieve our goals. Together, we can fulfill our vision to move from an organization of excellence and become the world's premiere medical specialty organization, leading through innovation in patient safety, clinical care, research, education and advocacy. Together we will thrive.

Thank you for your trust and for your confidence in my abilities as I embark on the leadership of the ASA.





2007 Annual Meeting House of Delegates Summary

The 59th ASA House of Delegates met during the ASA Annual Meeting in San Francisco on October 13-17, 2007. Among the significant actions of the House of Delegates were the following:

Officer Elections

- *President*
Jeffrey L. Apfelbaum, M.D.
- *President-Elect*
Roger A. Moore, M.D.
- *Immediate Past President*
Mark J. Lema, M.D., Ph.D.
- *First Vice President*
Alexander A. Hannenberg, M.D.
- *Vice President for Scientific Affairs*
Charles W. Otto, M.D.
- *Vice President for Professional Affairs*
Robert E. Johnstone, M.D.
- *Secretary*
Gregory K. Unruh, M.D.
- *Assistant Secretary*
Arthur M. Boudreaux, M.D.
- *Treasurer*
John M. Zerwas, M.D.
- *Assistant Treasurer*
James D. Grant, M.D.
- *Speaker, House of Delegates*
Candace E. Keller, M.D.
- *Vice-Speaker, House of Delegates*
John P. Abenstein, M.D.

Special Awards

Ronald D. Miller, M.D., of Mill Valley, California, was named as the recipient of the 2007 Distinguished Service Award.

Debra A. Schwinn, M.D., of Seattle, Washington, was presented with the 2007 Award for Excellence in Research.

Marcos F. Vidal Melo, M.D., of Boston, Massachusetts, received the Presidential Scholar Award.

Strategic Plan

The revised ASA Strategic Plan, as approved by the Administrative Council and presented as an informational report, includes the following vision and mission statements:

Vision: The American Society of Anesthesiologists is the world's premier medical specialty organization, leading through innovation in patient safety, clinical care, advocacy, education and research.

Mission: The American Society of Anesthesiologists is an organization of physicians and other professionals, dedicated to serving the best interests of its members and their patients. ASA supports patient safety by promoting improved quality, ethical behavior, discovery of new knowledge, and involvement of an anesthesiologist with every patient receiving anesthesia services, including perioperative care, pain management and critical care.

Values: The values of the Society are: Patient Safety, Integrity, Education, Research, Advocacy, Leadership and Service.

Budget

The 2008 Budget was approved as amended with a total net loss of \$1,928,749 and total expenses of \$28,815,949.

Dues

The following 2008 membership dues (unchanged from 2007) were approved:

Active members	\$450
Affiliate members	\$225
Educational members	\$225
Educational student members	\$25
Resident members	\$25
Medical student members	\$10

Practice Parameters

Approved two new practice parameters, "Practice Advisory for Prevention and Management of Operating Room Fires" and "Practice Guidelines for Neuraxial Opioids Associated With Respiratory Depression." Both new documents will be published in the journal *Anesthesiology*. Hard copies are available on request from the ASA Executive Office.

Other new practice parameters in development will address neuraxial opioids and the prevention, diagnosis and management of infections and bleeding complications associated with the technique; and magnetic resonance imaging related to anesthetic practice. Parameters undergoing revision include Practice Guidelines for Transesophageal Echocardiography and Practice Guidelines for Chronic Pain Management, both scheduled for completion in 2008.

Also approved was a revised Policy Statement on Practice Parameters, which is available on the ASA Web site www.ASAhq.org under "Clinical Information."

Standards, Guidelines and Statements

Approved or ratified previous Board action on the following new or current documents:

- Guidelines for Regional Anesthesia in Obstetrics with updated references (affirmed)
- Optimal Goals for Anesthetic Care in Obstetrics with updated references (affirmed)
- Statement on Pain Relief During Labor (affirmed)
- Statement on Regional Anesthesia (affirmed)
- Statement on Fluoroscopic Guidance for Spinal Injections (new)
- Statement on Reporting Postoperative Pain Procedures in Conjunction With Anesthesia (new).

Perioperative Anesthesiology-Centered ACLS Module

Approved Board action to accept a new committee work product from the Committee on Critical Care Medicine that, with the American Society of Critical Care Anesthesiologists (ASCCA), was developed to supplement the advanced cardiac life support (ACLS) studies that traditionally focus on cardiac arrests and circum-

stances outside the perioperative period. The committee and ASCCA will develop a timeline for periodic review and updating of this information.

Donation After Cardiac Death (DCD)

Approved Board action to accept a new committee work product titled "Sample Policy for Organ Donation After Cardiac Death," which is intended to serve as an educational guide and possible template for DCD organ recovery and transplantation policies for departments or institutions that choose to customize and use it. The document is posted on the ASA Web site under "Clinical Information."

Economics

Approved a recommendation from the Committee on Economics for developing an online presentation to serve as a coding resource for the membership. The committee will create a panel to oversee the development of and exercise editorial control over this new product.

Practice Management

Approved a recommendation from the Committee on Practice Management for ASA to partner with Auburn University to co-sponsor a custom physicians' executive Master of Business Administration (PEMBA) program. Completion of the Certificate in Business Administration course through ASA waives the foundation course requirements in the PEMBA program.

Resolutions

Approved resolutions on Medicare Anesthesia Payment Parity, Patient Safety and Hand Washing, Signing Verbal Orders Within 48 Hours, Chiropractic Spinal Manipulation Under Anesthesia, ASA Pay-for-Performance Action Plan and Confidential Bench Marking as an Alternative to Pay-for-Performance Methodology.

CPOM Update

Approved recommendations from the Committee on Performance and Outcomes Measurement for five performance measures on: Pencil-Point Spinal Needles – Reduction of Post-Dural-Puncture Headache; Management of Postoperative Hypothermia; Patient Education – Postoperative Analgesia; Preoperative Fasting Status (Clear Liquids); and Treatment of Postoperative Shivering With Meperidine. These measures will be posted on the ASA Web site.

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Scientific and Educational Exhibit Award Winners

Andrew D. Rosenberg, M.D., Chair
Committee on Scientific and Educational Exhibits



Dr. Rosenberg, left, congratulates members of a team from New York University on their first-place tie for the 2007 Scientific and Educational Exhibits Award. From left to right, they are: Jovan Popovic, M.D., David B. Albert, M.D., Daniel D. Wambold, M.D., Mitchell H. Marshall, M.D., and Thomas J.J. Blanck, M.D., Ph.D. The other first-place winners appear on the following page.

The Committee on Scientific and Educational Exhibits has announced the winners for the ASA 2007 Annual

Meeting held October 13-17, in San Francisco. More than 50 scientific and educational exhibits were displayed at the meeting. The presentations were of high quality, and there was a tie for first place. In addition, awards for second and third place were presented. The winners were:

First Place (tie)

"Improving the Safety of PCA Opioid Infusions by Integrating Patient Monitors and Infusion Pumps," presented by Julian E. Goldman M.D., Michael W. Jopling, M.D., Frank J. Overdyk, M.D., Sandy Weininger, Ph.D., David Arney, Ph.D., Insup Lee, Ph.D., Susan F. Whitehead, B.S., Philippe-Antoine Cortes, M.Eng., and Shankar Krishnan, Ph.D., from Massachusetts General Hospital/Harvard Medical School, Boston.



Andrew D. Rosenberg, M.D., is Chair, Department of Anesthesiology, New York University Hospital for Joint Diseases, and Professor of Anesthesiology and Orthopedic Surgery, New York University School of Medicine, New York, New York.



Dr. Rosenberg with the first-place tie winners from Massachusetts General Hospital/Harvard Medical School. Left to right, they are: Julian E. Goldman, M.D., Philippe-Antoine Cortes, M.Eng., Tracy Rausch, Gordon Fowler, Susan F. Whitehead, B.S., and David Arney, Ph.D. Not pictured were Michael W. Jopling, M.D., and Frank J. Overdyk, M.D.

First Place (tie)

"A Simulator for Learning Ultrasound-Guided Regional Anesthesia," presented by Jovan Popovic, M.D., Andrew D. Rosenberg, M.D., Daniel D. Wambold, M.D., Thomas J.J. Blanck, M.D., Ph.D., Maki Morimoto, M.D., David B. Albert, M.D., Robert Altman, M.D., Mitchell H. Marshall, M.D., from New York University Hospital for Joint Diseases and the New York University School of Medicine, New York City.

Second Place

"3-D Airway Reconstruction, Virtual Reality and Digital Imaging in Anesthesiology," presented by Frederico G. Osario, M.D., Mauricio Perilla, M.D., D. John Doyle, M.D., Ph.D., Martin Palomo, D.D.S., from the Cleveland Clinic.

Third Place

"Handheld Technology in Anesthesiology: Review of Current Educational and Practical Tools," presented by Frederico G. Osario, M.D., Miguel A. Cruz, M.D., Loran A. Mounir-Soliman, M.D., R. Michael Ritchey, M.D., from the Cleveland Clinic.

Scientific and clinical value, originality, creativity and the quality of the presentation are considered when judging the awards. The committee thanks all those who took the time to develop and present their exhibits.



ASA Annual Art Exhibit 2007: Comments and Awardees

Dr. Arnold in the Art Exhibit booth with newly-elected Vice President for Professional Affairs Robert E. Johnstone, M.D. Dr. Johnstone won an honorable mention in the literature category.

*William P. Arnold III, M.D., Chair
Committee on Art Exhibits*

Chairing the Committee on Art Exhibits for the past four years has been a delightfully challenging task for me. Attendees of the ASA's Annual Meeting see the final prod-

uct, the art display, but are not privy to the behind-the-scenes activities of the committee, which I now think I understand. With that in mind, what follows is an overview of the 2007 exhibit from the inside perspective.

A vital component of our successful exhibits has been the interaction between Carol Klemm (and other members of the ASA staff) and David Alpern, an office staff member of the Department of Anesthesiology at the University of Virginia. The committee thanks them profoundly for their tireless work.

Preparation of the display is the final event of the year-long process. On Friday, October 12, 2007, Dave Alpern and I began to deal with the many boxes of artwork that had arrived at the Moscone Center. During unpacking, it became clear that a major contributor's paintings had not arrived but instead were returned to the original shipping location. That artist, who was en route to the meeting when



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

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ASA 2007 Art Exhibit Award Winners

Best of Show

Dan J. Kopacz, M.D. – “Breathless” (Bridges category)

Viewers' Choice

William P. Arnold III, M.D. – “Web Surfer”
(digital photography)

Theme: Bridges

1st: Dan J. Kopacz, M.D. – “Breathless”
2nd: Heidi L. Witherall, M.D. – “Port au Change”
3rd: David Rudderman – “Bridge Multnoma Falls”
Honorable Mention: Edward Kosick – “Bridge to Anesthesia”

Painting: Oil and Acrylics

1st: Laszlo Gyermeck, M.D., Ph.D. – “Bridge in Venice”
2nd: Susan Giesecke – “Seascape”
3rd: Oak Zi Chi, M.D. – “Grace”

Painting: Watercolor

1st: Alan Levine, M.D. – “Untitled Figure Study #3”

Photography: Color

1st: Jill F. Arthur, M.D. – “Backwards and in Heels”
2nd: Govind P. Garg, M.D. – “Lillypads”
3rd: Frederic K. Orkin, M.D., M.B.A., M.Sc. – “Venetian Façade”
Honorable Mention: Victoria Rudderman – “Two Boats One Oar”

Photography: Digital

1st: David H. Rebuck, M.D. – “Uh-Oh”
2nd: Harry J. Cozen, M.D. – “Hope”
3rd: Jerry A. Dorsch, M.D. – “Old Faithful in Winter”

Photography: Black and White

1st: David J. Rudderman, M.D. – “California Route 120”
2nd: Paul J. Tan, M.D. – “Reflection”
3rd: Gordon R. Haddow, M.B. – “Cado Angelus”
Honorable Mention: Michael Mullick – “Honduras”

Graphic Works on Paper

1st: Jessica A. Alexander, M.D. – “Fisherman”
2nd: Marcel E. Durieux, M.D., Ph.D. – “Camel Feeding”

Sculpture

1st: Alan Levine, M.D. – “Heartline”

Crafts

1st: Norma Jones – “Wise Women”
2nd: Faranack Benz – “Rainbow Bridge”

3rd: Edward Kosick – “Anesthesia Tea Time”

Honorable Mention: Mary S. Maxwell, M.D. – “Gabriella's Smock Dress”

Honorable Mention: Jerry A. Dorsch, M.D. – “Four Seasons”

Junior Exhibitor

1st: Megan Becker – “Opening Up”
2nd: Justin Wong – “Ghost Bridge”
3rd: Kayla Rebuck – “Pine Needle Basket”
Honorable Mention: Mitsuko Kosik – “Anesthesiologist Through the Eyes of a Fourth Grader”

ASA Literature Awards

1st: Maurice S. Albin, M.D. – “Bridges to the Past: Snatches of Wartime and Peacetime Memories.”

A collection of compelling, often delightful anecdotes from a life in medicine, from a tale celebrating the healing powers of virtuoso violinists in wartime to the memory of a generous gesture that proved good preventative medicine when it saved the life of a neurosurgeon.

2nd: Kathryn E. McGoldrick, M.D. – “Inefable Betrayal: Reflections on the Doctors of Death, Torture, and Deception.”

A thoughtful, nuanced discussion of how physicians came to participate in Nazi medical experiments and atrocities, with reference to Robert Jay Lifton's book, *The Nazi Doctors*, and with reflection on the ethics of physician involvement today in military interrogations that may include torture of prisoners.

3rd: Heidi L. Witherell, M.D. – “Hospital Drive.”

An evocative poem that reflects on moments in liminal zones — the predawn hours, the landscape between home and hospital, the passage from life to death — and coalesces around the lovely, strong and meditative image of a solitary heron.

Honorable Mention: Robert E. Johnstone, M.D. – “Bridging from Memories to Hope.”

A sensitive essay on the importance of the physician bridging his personal and professional lives; in this instance, drawing on his own experiences of fear and loss, memories and hope, to help patients and families who are facing similar challenges.

No award (in alphabetical order):

Magdalena E. Kerschner, M.D. – “US”

Magdalena E. Kerschner, M.D. – “Moonlight”

we contacted her, later made digital reproductions of her works at a copy center in San Francisco. One of these won an award. Occasionally, we receive packages that have been damaged. The work that won best of show arrived in a multitude of pieces, having only partially survived what must have been an extremely turbulent voyage. We were able to reach the artist, who reassembled his sculpture in time for the juror's review. The remainder of the unpacking was uneventful until the roof over the exhibit area began to leak during a driving rain storm.

The following morning, the committee arranged the display in time for the judging, which began at 2 p.m. One late submission, which was not considered to be of award-winning importance, deserves special recognition. "Abstract with Markers," submitted by "Caju Smith, M.D.," turned out to be a hoax concocted by two members of the ASA staff as a joke. In spite of its late appearance, the committee deemed it fit for display and hung it in time for the judging without knowing its true origin. That piece is symbolic of the wonderful spirit of cooperation between the committee and the ASA staff. Personally, I was elated when I learned the details.

We were fortunate to have three outstanding jurors. During the late summer, Marcia Day Childress, Ph.D., Associate Director of the Center for Humanism in Medicine at the University of Virginia, judged the entries in the literature category. Meg Shiffler and Derek Powazek were our art jurors. Ms. Shiffler is the program director of the San Francisco Arts Commission Gallery. Mr. Powazek is a well-known photographer and author in San Francisco. Their enthusiasm was infectious during the several-hour period they needed to review the submissions and prepare their comments.

From noon Sunday until mid-Tuesday, the exhibit was open for viewing — less than three days for ASA meeting attendees to see works representing countless hours of work by the artists, not to mention the administrative time spent by Dave Alpern, the staff at ASA headquarters and members of the committee.

The 2008 committee is being chaired by J. Kent Garman, M.D., a good friend and wonderful colleague. I look forward to working with him during the exhibit, which will be held in Orlando, Florida.

2007 Annual Meeting House of Delegates Summary

Continued from page 15

Preanesthesia Checkout Procedures

Accepted for information a report from the Committee on Equipment and Facilities announcing that a committee statement was developed and has been posted to the ASA Web site titled "Recommendations for Preanesthesia Check-Out Procedures." Developed by a multidisciplinary task force, the new recommendations are designed to replace the 1993 FDA-sponsored pre-use anesthesia checklist.

Also, approved a recommendation that the Committee on Standards and Practice Parameters draft a practice alert recommending training and demonstrated competence in the use of any particular anesthesia machine or workstation, as well as completion and documentation of a pre-use checkout of that workstation, before an anesthesia provider uses it to deliver patient care.

Professional Diversity

Approved a recommendation from the Committee on Professional Diversity for the development of a new ASA

Mentoring Program for Diversity that enhances racial, ethnic and gender diversity in membership, committee appointments, executive appointments and leadership development at all levels of the Society.

Medical Student Component

Approved component society status for the Medical Student Delegation, which was founded in 2003 under the auspices of the ASA Resident Component. The Medical Student Component will develop bylaws and be represented within the ASA House of Delegates in 2008.

Board of Directors

Following adjournment of the House of Delegates, on October 17, 2007, the Board of Directors met in San Francisco. Board members were elected to serve on the Board of Directors committees on Administrative Affairs, Professional Affairs, Scientific Affairs and Finance.



Media Inquiries Skyrocket – Pain a 'HOT' Topic

Dawn M. Glossa, M.S.
Director of Communications

ASA saw quite a few changes in the communications department this year. As the new director of communications for ASA, I joined the team just weeks before the ASA Annual Meeting. The Annual Meeting was a terrific opportunity to get myself up to speed, jump in and get started!

Each year, ASA staff and physicians from the Section on Annual Meeting select a handful of presentations from among the hundreds of scientific abstracts submitted for the meeting. The communications department then produces a media kit featuring those topics. Designed to engage and interest reporters, the kit supplies them with information that is new, useful to the general public, and illustrates the breadth and variety of research in which anesthesiologists are involved.

Consumer Topics Bring Much Interest

This year, pain and the management thereof was the hottest topic, along with several others that every reporter wanted to know more and more about. From chili peppers to vitamin D, the variety of research proved that reporters are interested in stories that will apply to the public. The 2007 Annual Meeting media kit featured the following releases:

Drug Derived From Chili Peppers May Reduce Acute Pain After Surgery: This study finds that purified capsaicin derived from chili peppers can provide pain relief without clinically important side effects.

Driving Abilities Not Impaired By Moderate, Long-Term Pain Medication Use: Moderate, long-term use of

opioid pain relievers does not impair a person's ability to drive. Findings reveal that patients with long-term chronic pain may become tolerant to the medication side-effects that could impair function.

Pregabalin Decreases Pain, Expedites Movement in Knee Replacement Patients: The administration of the drug pregabalin before and after knee replacement surgery can significantly reduce patient pain and increase mobility, according to new study results.

Nicotine Patch Decreases Postsurgical Pain: Typically used to help smokers reduce their dependency on nicotine, new study findings indicate that the nicotine patch is also effective in reducing pain after surgery. Patients who self-

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Dawn M. Glossa, M.S., manages communications and marketing for ASA in the Park Ridge, Illinois, office.



administered the nicotine patch had significantly less pain medication in the postoperative period.

Patient Counting During Anesthetic Injections Distracts, Limits Pain: Patients who counted aloud during intravenous propofol injection experienced and recalled less pain at injection, contributing to new understanding of the means of pain control and pain relief.

Vitamin D Inadequacy May Exacerbate Chronic Pain: While low levels of vitamin D can cause pain and muscle weakness, new study results indicate that vitamin D inadequacy may also contribute to chronic and ongoing pain, marking the first time a prevalence of vitamin D inadequacy has been established in a diverse group of chronic pain patients.

Patient "Passport" With Anesthesia History Can Help Ensure Optimal Care: Patients who, upon discharge, receive a "passport" completed by health care providers outlining their anesthetic experience better understand the procedures they have undergone and can learn to avoid surgical or anesthetic complications in the future.

Regional Block Expedites Movement, Limits Pain for Months After Wrist Surgery: This study reports that wrist surgery patients who received a regional anesthetic experienced less pain and regained mobility of their hand and wrist faster than patients who received general anesthetics.

Acupuncture Diminishes Acute Postoperative Pain: A review of 15 studies on the effectiveness of acupuncture to reduce postoperative pain when used along with pain medication finds that patients receiving acupuncture experience significantly less pain, use less opioid medication and have fewer side effects, making acupuncture an effective adjunct treatment for postoperative pain management.

Family-Centered Care More Effective for Managing Children's Pain: Chronic pain can affect 45 percent of children and adolescents from ages 10 to 18. Study findings indicate that treating pediatric pain with a multidisciplinary approach focused on improving and restoring a child's and family's quality of life can result in a significant reduction of chronic pain intensity.

Media attention was impressive, and the following items were featured in the press (during and after the meeting):

Drug Derived From Chili Peppers May Reduce Acute Pain After Surgery

- *HealthDay News*, circulation 4,000, Internet and Intranet Web sites, more than 100 daily newspapers and hundreds of television and radio stations nationwide.
- *The Wall Street Journal-Health Blog. The Wall Street Journal-Online*, circulation 240,000.
- *Associated Press*, wire service. The AP article appeared in more than 90 publications and Web sites, including:

- *Atlanta Journal-Constitution*, circulation 365,011
- *The Modesto Bee* (Modesto, California), circulation 83,387
- *The Baltimore Examiner*, circulation 250,000
- MSNBC.com, circulation 2,400,000
- WBBM-TV (Chicago)
- FOXnews.com
- *Miami Herald*, circulation 306,689
- KGO-TV (San Francisco)
- WTO-TV (Rockford, Illinois)
- KSTP-TV (Saint Paul, Minnesota)
- *Medical Device Week*

Nicotine Patch Decreases Post-Surgical Pain

- United Press International, wire service with circulation/site visitors of 1,662,193
- News-Medical.Net
- *Healthday News* (appeared in a combined article looking at this and the results of "Nicotine Patch Decreases Post-Surgical Pain." Article appeared in more than 25 publications and Web sites, including:
 - Washington Post-Online, circulation 200,000
 - drkoop.com
 - *Springfield News-Sun* (Springfield, Ohio), circulation 31,000
 - *Medical Device Daily*, circulation 500
 - CBC News (Canada)
 - *Austin American Statesman*, circulation 174,734
 - *Atlanta Journal Constitution*, circulation 365,011
 - Forbes.com, circulation 342, 933
 - *U.S. News & World Report*, circulation 2,022,383
 - *Courier Mail* (Australia)
 - *Daily Telegraph* (Australia)

Driving Abilities not Impaired by Moderate, Long-Term Pain Medication Use

- *United Press International*, circulation 1,662,193
- *Medical News Today*, circulation 2,000,000

Pregabalin Decreases Pain, Expedites Movement in Knee Replacement Patients

- Ivanhoe Newswire, client base of more than 250 television network affiliates in the United States, reaching 80 million households every day.
- *Medical News Today*, circulation 2,000,000
- *HealthDay News*. This article appeared in:
- *The Marshall News Messenger* (Marshall, Texas), circulation 6, 871
- Washington Post Online, circulation 200,000
- *Springfield New-Sun* (Springfield, Ohio), circulation 31,000
- National Women's Health Information Center
- *The Daily Sentinel*, circulation 31,495

“While we cannot always predict the interest and media needs during our Annual Meeting, it is important to know that the behind-the-scenes work prior to the meeting, at the meeting and after the meeting make the difference.”

- *U.S. News & World Report*, circulation 2,022,383
- PharmaLive

Patient Counting During Anesthetic Injections Distracts, Limits Pain

- News-Medical.Net

Vitamin D Inadequacy May Exacerbate Chronic Pain

- United Press International, wire service with circulation/site visitors 1,662,193.
- Ivanhoe Newswire, client base of more than 250 television network affiliates in the United States, reaching 80 million households every day.
- Nutraingredients.com, circulation 310,000
- Foodnavigator.com, circulation 310,000
- Newsmax.com, circulation 400,000

Patient “Passport” With Anesthesia History Can Help Ensure Optimal Care

- *Medical News Today*, circulation 2,000,000

Acupuncture Diminishes Acute Postoperative Pain

- *Globe & Mail* (Toronto), circulation 326,248
- HealthDay News, circulation 4,000, Internet and Intranet Web sites, more than 100 daily newspapers and hundreds of television and radio stations nationwide.

In addition to the media kit, each year we feature the AudioLine radio interview program distributed by News Broadcast Network, which provides the public with news on a wide variety of anesthesiology-related topics. This year, participating doctors and topics included:

- Eske S. Aasvang, M.D., “Effect of Single Dose of Purified Capsaicin on Postherniotomy Pain.”
- Jessica A. Alexander, M.D., “Nutraceuticals” and “Stress Management.”
- Asokumar Buvanendran, M.D., “Opioids and Driving.”
- Brenda G. Fahy, M.D., “Evidence-Based Medicine in Perioperative Care — Does It Help Us Improve Care?”
- Tong J. Gan, M.D., “Acupuncture.”
- Ashraf S. Habib, M.D., “Transdermal Nicotine for Analgesia.”
- Tomoko Higashi, M.D., “Effect of Distraction by Counting Aloud on Pain at Injection of MCT/LCT Propofol.”

- W. Michael Hooten, M.D., “Vitamin D Inadequacy May Exacerbate Chronic Pain.”

- Tricia Meyer, PharmD, M.S., “Anesthesia Passport, Providing Information to the Patient on Their Anesthetic Experiences.”

- Charles W. Otto, M.D., “New Approaches to Resuscitation.”

- John E. Tetzlaff, M.D., “Anesthesiology Education (Teaching, Assessment, Competence).”

The audio is distributed to the hometowns of the interviewed doctors, including major metropolitan areas; the 45- to 60-second features reached an estimated audience of 9,267,000 radio listeners.

The Journal and ASA Combine Efforts

In addition to the Annual Meeting public relations efforts, in July, the editors of the journal *Anesthesiology* and the ASA Communications Department launched a formal news release program designed to share medical information with the media and, ultimately, the public on research studies featured in the journal and conducted by ASA members.

Since the monthly program began, media coverage has been tremendous across the country, including placement in print, television and the Web as well as Internet publication postings and international coverage.

An example of a recent study that received extensive coverage is *Dose-Dependent Effects of Smoked Cannabis on Capsaicin-Induced Pain and Hyperalgesia in Healthy Volunteers*.

This release was picked up by the Associated Press and related stories appeared on BBC News, Fox News, MedPage Today, Health Day and Health Highlights on Healthday.com

Given all the exciting medical studies that ASA members are conducting around the country and the world, the journal news release program offers members additional opportunities to show off their breadth of knowledge and research.

Teamwork Makes All the Difference

While we cannot always predict the interest and media needs during our Annual Meeting, it is important to know that the behind-the-scenes work prior to the meeting, at the meeting and after the meeting make the difference. As a team, the ASA Communications Department prepares, contacts and follows up with interested media. Without the follow-up and essential legwork, the success we see each year would not be possible.



San Francisco **2007:** **ASA's Favorite Annual Meeting City**

Beloved the world over, one of San Francisco's many monikers is "Everyone's Favorite City." It may be the most boastful of nicknames, but The City by the Bay always backs up its boasts with numbers: San Francisco has attracted more attendees to ASA Annual Meetings than any other city by far. The city's 1994 attendance record of 18,377 stood until 2004. Chicago in 2006 topped out at 18,497, but that record was to be short-lived, as (guess who?!) San Francisco shattered that record by almost 1,000, with a total of 19,473. That number included 8,029 members, 3,198 spouses, 4,021 exhibitors, 1,932 nonmembers and 2,293 "others" (nurse anesthetists, anesthesiologist assistants, respiratory therapists, nonmember presenters, etc.).

We suspect that the city's environs have much to do with these attendance numbers, but it's also certain that ASA's every-improving educational content draws progressively larger numbers of attendees as well. The growing pains resulting from incorporating all educational content into the learning track system in 2006 have almost completely been overcome. The 10 learning track committees drew upon last year's experiences and efficiently presented attendees with informative, provocative and exciting educational content in

a growing number of subspecialty tracks: ambulatory anesthesia, cardiac anesthesia, critical care, neuroanesthesia, obstetric anesthesia, pain medicine, pediatric anesthesia, regional anesthesia and (new for 2007) fundamentals of anesthesiology and professional issues. The Section on Annual Meeting is already considering new sessions for 2008 in Orlando.

2007 will surely be remembered as a banner year for ASA not just for yet another record-breaking, seamlessly structured Annual Meeting but also for being the genesis year of the ASA Organizational Improvement Initiative. The Initiative is a multi-year project overseen by ASA's officers that seeks to expand and improve best practices at ASA headquarters in Park Ridge, Illinois, and in Washington, D.C. The progenitors of the Initiative understood that to keep up with a changing and increasingly complex health care environment, similar progress needed to be seen in the coming years among ASA staff. The Organizational Improvement Initiative will move ASA far beyond the status quo and strives to cement the Society's reputation as *the* leading subspecialty organization in the world for decades to come.

Other highlights of the 2007 Annual Meeting follow.

Installation of ASA President

Jeffrey L. Apfelbaum, M.D., was installed as 2008 ASA President. Dr. Apfelbaum has previously served ASA as President-Elect (2007), First Vice President (2006), Delegate (2003-present) to the AMA Section Council on Anesthesiology, chair of the committees on Ambulatory Surgical Care (1992-95), Quality Management and Departmental Administration (2001-05) and Refresher Courses (2001-02), and chair of the Task Force on Intraoperative Awareness and Brain Function Monitoring (2005).

He is currently Professor and Chair of the Department of Anesthesia and Critical Care, University of Chicago, and a member of the Executive Committees of Pritzker School of Medicine and Medical Staff, University of Chicago Hospitals.

Dr. Apfelbaum received his M.D. from Northwestern University School of Medicine, and was an intern (medicine) at Hahnemann Medical College and Hospital, Philadelphia. He served his residency and fellowship (anesthesiology) at the University of Pennsylvania.

He and his wife, Carol, live in Northbrook, Illinois, with their two children.

Other ASA Officers

- *President-Elect*
Roger A. Moore, M.D.
- *Immediate Past President*
Mark J. Lema, M.D., Ph.D.
- *First Vice President*
Alexander A. Hannenberg, M.D.
- *Vice President for Scientific Affairs*
Charles W. Otto, M.D.
- *Vice President for Professional Affairs*
Robert E. Johnstone, M.D.
- *Secretary*
Gregory K. Unruh, M.D.
- *Assistant Secretary*
Arthur M. Boudreaux, M.D.
- *Treasurer*
John M. Zerwas, M.D.
- *Assistant Treasurer*
James D. Grant, M.D.
- *Speaker, House of Delegates*
Candace E. Keller, M.D.
- *Vice-Speaker, House of Delegates*
John P. Abenstein, M.D.

Robert E. Johnstone, M.D., newly elected Vice President for Professional Affairs, is a first-time ASA Officer.

Dr. Johnstone is currently a Professor in the Department of Anesthesiology at West Virginia University, Morgantown. He served as chair of that department from 1996-2004.

Previously he has served ASA as Director from West Virginia (2002-07), Alternate Director, Virginia-West Virginia (2001-02), Delegate from West Virginia (1996-2001) and has been Chair of the Committee on Practice Management (2002-07), Chair of the Board Committee on Scientific Affairs (2005-07), Chair of the Committee on Value-Based Anesthesia Care (1996-97) and has been a member of various other ASA committees.

From 1991-2004, Dr. Johnstone served in the U.S. Army Reserve, finishing as Colonel, and serving at Walter Reed Army Medical Center. He has a history of active military service dating back to 1974.

He currently serves as Secretary/Treasurer of the West Virginia State Society of Anesthesiologists (2000-present) and was President of the Alabama State Society of Anesthesiologists in 1986-87.

Dr. Johnstone received his medical degree from the Ohio State University, served his internship (internal medicine) at the University of Cincinnati and his anesthesiology residency and fellowship at the University of Pennsylvania. He completed M.B.A. courses at Troy State University in Alabama.

Awards and Honors

- *Distinguished Service Award*
Carl C. Hug, Jr., M.D., Ph.D.
- *Award for Excellence in Research*
Debra A. Schwinn, M.D.
- *Emery A. Rovenstine Memorial Lecture*
James E. Cottrell, M.D.
- *Lewis H. Wright Memorial Lecture*
Rodney N. Westhorpe, M.B., B.S., F.R.C.A., F.A.N.Z.C.A.
- *7th FAER Honorary Research Lecture*
Mervyn Maze, M.B., Ch.B.
- *ASA Presidential Scholar Award*
Marcos F. Vidal Melo, M.D.

Media Awards

The winners of the ASA Philip S. Weintraub Media Award were Sarah Unis of WFXT-TV in Boston and Rich Maloof for MSN "Health and Fitness." Ms. Unis' November 21, 2006 television segment titled "Who's Putting You Under" featured an interview with Beverly K. Philip, M.D., and covered anesthesia safety during office-based surgery. Mr. Maloof informed readers about rare anesthesia risks in a written piece called "Anesthesia Awareness" for his "Reality Check" column featured on MSN "Health and Fitness." Then-ASA President Mark J. Lema, M.D., Ph.D., was featured in the column.

Personal Protective Equipment in Pandemic/Avian Influenza/SARS:

N95 or PAPR for Intubation?

Bonnie M. Tompkins, M.D.

Committee on Trauma and Emergency Preparedness

The Ontario SARS report on the severe acute respiratory syndrome-coronavirus (SARS-CoV) epidemic in Toronto in 2003 provides an ominous preview of an anticipated influenza A pandemic. Many health care workers (HCWs), including at least one anesthesiologist, became ill and died from SARS. Initially, the N95 respirator, known commonly as the TB mask, was not thought to be necessary. The SARS Report promotes “**The Precautionary Principle**,” wherein “action to reduce risk should not await scientific certainty” in situations of potentially grave consequence. The SARS Report also advises that infection control and health care professionals’ safety should be handled as one instead of as separate entities.¹

A pandemic influenza virus could arise out of the mingling of H5N1 avian influenza and a seasonal influenza A genetic material. The Centers for Disease Control (CDC) infection control precautions for pandemic influenza are the same as those for SARS.^{2,3} The **modes of transmission** of SARS and influenza A are by direct and indirect (fomite) contact, by droplet and, most probably, by short-range airborne aerosol, which arises during **aerosol-generating procedures**. Procedures that generate aerosol include high-flow oxygen delivery, aerosolized or nebulized medication administration, diagnostic sputum induction, bronchoscopy, airway suctioning, endotracheal intubation and extubation, bag-mask positive-pressure ventilation, noninvasive ventilatory methods (e.g., BiPAP, CPAP) and high-frequency oscillatory ventilation.^{2,3,4} Spontaneous coughing and sneezing also generate aerosol.⁵

Jill A. Antoine, M.D.

Committee on Trauma and Emergency Preparedness

The CDC provides a highly informative review of transmission modes, masks and respirators.³ **The N95 respirator is the minimum respiratory protection** mandated by the CDC and Occupational Safety and Health Administration (OSHA) when the health care provider is in close contact with patients with the highly pathogenic respiratory illnesses of SARS or pandemic or avian influenza. Both the CDC and OSHA advise that **additional respiratory precautions are warranted (but not mandated) for health care personnel performing aerosol-generating procedures** on victims of these diseases.^{3,4}

Under test conditions, the N95 inhibits passage of 95 percent of 0.3 micron saline particles. In clinical settings, the optimal level of protection will hold only if the wearer has been successfully fit-tested and if no leakage around the edges occurs at any time during patient care. The N95 increases the work of breathing, making it uncomfortable to wear for extended periods, and it is likely to be adjusted, displaced or periodically lifted. Fit-testing requires trained personnel, specialized equipment and substantial time per subject to complete. Facial hair or facial structure may preclude a satisfactory fit test. The reuse of N95 respirators is discouraged but may be necessary if supplies are insufficient for single use.^{2,3,4}

The powered air purifying respirator (**PAPR**) is a nondisposable full hood or enclosed face cover system that provides a higher level of respiratory protection than the N95 respirator.^{2,3,4} Some of the manufacturers are 3M, Bullard, MSA and North Safety. A blower worn on a waist belt



Bonnie M. Tompkins, M.D., is Clinical Assistant Professor of Anesthesiology, (retired from clinical practice), University of Wisconsin School of Medicine and Public Health, Madison, Wisconsin.



Jill A. Antoine, M.D., is Associate Clinical Professor of Anesthesiology, University of California at San Francisco, San Francisco, California.

draws air through a high-efficiency particulate air filter. The filtered air passes through a corrugated tube into the hood and prevents — contaminated air from entering. PAPRs for chemical protection contain an absorbent cartridge, and the hood is made of a chemical-resistant material.

In addition to providing a higher level of respiratory protection than the N95, further advantages of the PAPR are that it does not require fit-testing, is more comfortable to wear for an extended period, and provides contact protection for the entire head, neck and shoulders when the full hood style is chosen. Disadvantages of the PAPR are that it requires initial and periodic training and practice, is nondisposable, is expensive, requires a regular maintenance program, is not autoclavable, requires cleaning after use, may contain latex, and the blower noise may impede communication.^{3,4}

The University of Wisconsin Hospital requires use of PAPRs for aerosol-generating procedures as does the California State Pandemic Influenza Preparedness and Response Plan.⁶ Other state, local and hospital pandemic influenza plans may not. PAPRs will be in extremely short supply once a pandemic starts. N95 supplies may also be very limited unless hospitals have stocked beyond the usual “just in time” supply. Upon request through the regional 3M sales representative and the 3M Occupational Safety Division, the 3M company can provide education and training assistance with PAPRs and N95s.⁷

The OSHA Pandemic Influenza document is concise, eminently readable and very helpful.⁴ It can be obtained in booklet form by calling your region’s OSHA office listed at the end of the online document. It includes synopses of background information, infection control issues, personal protective equipment (PPE), a description of masks and respirators, Internet resources for diagnosis and treatment, and planning checklists. For all industrial and medical respiratory protection systems, OSHA requires that PPE be used within a context of a respiratory protection program, which includes a written protocol, medical clearance of the PPE wearer, training and at least yearly practice.⁴ 3M has developed an OSHA-compliant respiratory PPE medical clearance form (www.respexam.com) and a record-keeping system.⁷

Contact precautions for SARS/pandemic/avian influenza include gown, gloves, hat, foot covers, close-fitting goggles and a face shield if the N95 is used.^{2,4,6} Both the chosen PPE, whether N95 or PAPR, and the unprotected skin can be contaminated by droplets and aerosols, thus providing a fomite from which the individual may self-inoculate by transferring the infectious agent by hand to the eyes, nose or mouth. It is advisable therefore to cover all exposed skin wherever possible and observe strict hand hygiene following removal of the PPE.

Contamination of exposed skin occurred more often with N95, but breeches in don/doff sequence were more frequent with PAPR.^{8,9} **Training and practice in the don/doff**

sequence and in performing procedures while wearing a PAPR are extremely important aspects of provider and patient safety. The PAPR don/doff sequence involves an assistant or buddy to remove the belt that supports the blower and filter and a re-gloving to remove part of the contact PPE.⁹

The OSHA General Duty Clause mandates that the employer is responsible for providing a safe work environment. For many anesthesiologists, the medical group we belong to is our employer, as opposed to the hospital. Therefore, we ourselves, not the hospital, may be accountable for our colleagues’ and our own safety or failure to provide for that safety. Further, ethical concepts, in addition to OSHA, suggest that the employer may not demand that the employee report for work when available safety protection is not provided.⁴

In contrast to “just in time” PPE training, OSHA implies that if PPE is likely to be needed when performing a procedure common to a specialty, then that specialist is obligated to become familiar and facile with the use of the PPE in advance of the anticipated need.⁴

Anesthesiology departments are advised to prepare for managing SARS and pandemic influenza patients by:

1. Contacting your infection control nurse and the hospital emergency preparedness or disaster committee. Inquire about SARS/pandemic influenza plans, especially the choice between N95 or PAPR for respiratory PPE during intubation and other aerosol-generating procedures. Chances are that you will need to take leadership in physician preparedness for pandemic influenza and other all-hazard events.

2. Contacting critical care physicians, hospitalists, pulmonary specialists and emergency medicine physicians to develop a consensus regarding preparation and PPE for SARS/pandemic influenza.

3. Being aware that physicians are often not hospital employees. You may ask the hospital to budget for PAPRs, but you may in fact need to buy and maintain them yourself and conduct training.

4. Contacting the PAPR manufacturer of your choice for product information and training assistance. 3M is a leader in this area.

5. Obtaining PPE equipment, conduct training and practice until proficient in the PPE don/doff sequence. Perform procedures while wearing PPE. Initiate or join a hospital OSHA Respiratory Protection Program.

6. Becoming familiar with the OSHA pandemic influenza document.⁴ OSHA also has publications on emergency preparedness and on guidelines for hospital-based first receivers of victims of hazardous materials exposure.

7. Writing a section for your anesthesia department policy and procedure manual on intubating pandemic influenza/SARS patients. The Joint Commission has greatly expanded its emergency preparedness requirements.

8. Referring to the ASA Committee on Trauma and

Emergency Preparedness "Statement on Pandemic Influenza Preparedness" posted online at www.ASAhq.org/clinical/PandemicDocument.pdf in December 2006.¹⁰

In summary, respiratory and contact PPE are needed for SARS/avian influenza/pandemic influenza. In addition to full-contact protection of the head and neck, the PAPR offers a higher level of respiratory protection than the N95 respirator. The CDC and OSHA suggest, but do not mandate, use of the PAPR for aerosol-generating procedures. Regardless of which PPE system is used, following correct protocol and performing procedures while wearing PPE will reduce health care provider infection and increase patient safety.

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Outgoing President Proud to Lead During Pivotal Period in ASA's History

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As your 2007 elected president and CEO, I endeavored to carry out the spirit of what this esteemed House and dedicated Board would have wanted me to do during this tenuous period. I hope and trust that you understood the reasons for our quick actions and now support this

initiative. I leave this position with ASA being even stronger and more poised to respond to rapid changes and thank you for the privilege and the honor to work on your behalf.

God bless America and ASA.



CONTINUING MEDICAL EDUCATION: 'We Hear Ya'

Robert M. Savage, M.D., Head
Workgroup on Perioperative Echocardiography
Committee on Outreach Education

Daniel J. Cole, M.D., Chair
Committee on Outreach Education

Mark A. Warner, M.D., Chair
Section on Education and Research

The educational mission of ASA is to elevate the standards of our specialty by “fostering and encouraging education, research and scientific progress in anesthesiology.”¹ The Committee on Outreach Education has an important educational charge — to investigate the needs of the membership for future educational offerings. The members of the committee take seriously their commitment to be proactive and innovative regarding future continuing medical education (CME) needs.

One of the primary drivers of determining education programs that serve to elevate the standards of our specialty is member input. Transesophageal echocardiography (TEE) is increasingly used in a diagnostic role by anesthesiologists. While ASA's Practice Guidelines for Perioperative Transesophageal Echocardiography define “basic” and “advanced” levels of TEE proficiency, no pathway to

achieve and demonstrate “basic” TEE proficiency is currently available.

In October of 2006, the House of Delegates approved the development of a basic echocardiography education program and resolved “...that ASA uniquely or collaboratively explore a pathway for supporting privileges in basic perioperative echocardiography for anesthesiologists.” This charge came as a direct result of member input detailing institutional encumbrances anesthesiologists were experiencing in gaining privileges to use echocardiography as a basic perioperative monitor.

This article details ASA's involvement in developing a solution to the above problem and will provide an update on the second year of an exciting new Web-based CME program — Annual Meeting Highlights.

Daniel J. Cole, M.D., is Professor of Anesthesiology, Mayo Clinic College of Medicine, and Chair, Department of Anesthesiology, Mayo Clinic, Phoenix, Arizona.



Robert M. Savage, M.D., is Head, Section of Perioperative Echocardiography, Departments of Cardiothoracic Anesthesia and Cardiovascular Medicine, Cleveland Clinic Health System, Cleveland, Ohio.



Mark A. Warner, M.D., is Professor of Anesthesiology, Mayo Clinic College of Medicine, and Dean, Mayo School of Graduate Medical Education, Mayo Clinic, Rochester, Minnesota.



Perioperative Echocardiography

At the conclusion of the ASA 2006 Annual Meeting, the Committee on Outreach Education developed a workgroup, led by Robert M. Savage, M.D., to develop a strategic plan regarding basic perioperative echocardiography. The workgroup immediately organized a weekend workshop on Basic Perioperative Echocardiography that was held in Phoenix in November 2007. The workshop was oversold, and attendees had the ability to obtain a "Certificate of Completion" at the conclusion of this workshop. Though credentialing is a local hospital process, the "Certificate of Completion" may serve as a starting point for our members seeking hospital credentials in basic nondiagnostic TEE.

Long term, ASA, in collaboration with the Society of Cardiovascular Anesthesiologists (SCA), has developed a strategic plan that would ultimately make available to ASA members a CME course on basic perioperative echocardiography four times a year. Two of the courses would be integrated into existing SCA meetings: 1) the SCA's Annual Comprehensive Review and Update of Perioperative Echocardiography, which is held in February, and 2) SCA's annual meeting, which is held in the spring of each year (see www.scahq.org).

The other two courses will be ASA-sponsored events that will occur on weekends during the last half of the year. The four courses will be held in geographically diverse locations, thus increasing the accessibility of a course to ASA members.

ASA and SCA have also agreed to share Web site links to various electronic educational resources such as the SCA Echo Rounds (scahq.org/sca3/rounds), University of California-San Francisco TEE Web site (ucsf.edu/teeecho) and e-Echocardiography.com.

Finally, ASA is close to finalizing an agreement with the National Board of Echocardiography for a Certificate in Basic Perioperative Echocardiography. You will hear more about the details of this certificate in the future. This was a phenomenal effort and would not have been possible without the outstanding work of Dr. Warner, Dr. Savage and Daniel M. Thys, M.D.

Annual Meeting Highlights

This past year, in coordination with the Committee on Annual Meeting Oversight, the Committee on Outreach Education launched a Web-based CME program titled "Annual Meeting Highlights." This program debuted in January 2007 and was highly popular.

The program planned for 2008 consists of the following topics with a maximum of 19.5 hours of CME credit:

- Staying Out of Trouble in the Office

- CAD and Stents: Perioperative Management for Cardiac and Noncardiac Surgery
- Clinical Approaches to Complex Coagulation Abnormalities
- Intensive Insulin Therapy
- General Anesthetic Neurotoxicity: Can It Be Bad When It's So Good?
- What's New in Obstetric Anesthesia
- Treatment of Cancer Pain
- Spinal Cord, Peripheral Nerve and Peripheral Nerve Field Stimulation for the Treatment of Pain
- Sedation/Analgesia for Diagnostic and Therapeutic Procedures in Children Outside of the Operative Room
- ASA Closed Claims Registries and Patient Safety
- Regional Anesthesia: No Pus, No Blood, No Pain
- 2007 Emery A. Rovenstine Memorial Lecture: James E. Cottrell, M.D.
- 2006 Annual Meeting Plenary Session: Sten G. Lindahl, M.D., Ph.D.

The above detail just a few of the recent activities of the Committee on Outreach Education. The success of our committee's activities would not be possible but for the talents and commitment of its members. If an ASA member has an idea or feedback concerning a specific CME activity, that member may contact me as chair or any member of the committee.

Members of the 2008 Committee on Outreach Education include:

Daniel J. Cole, M.D., Chair
 Audree A. Bendo, M.D.
 Casey D. Blitt, M.D.
 Brenda A. Gentz, M.D.
 Nikolaus Gravenstein, M.D.
 Glenn P. Gravlee, M.D.
 Leslie C. Jameson, M.D.
 Linda J. Mason, M.D.
 Mohammed M. Minhaj, M.D.
 Robert M. Savage, M.D.
 Armin Schubert, M.D., M.B.A.
 Paul B. Yost, M.D.
 Ellen Bateman, Ed.D., ASA Liaison.

Reference:

1. Educational Mission Statement of ASA. Approved by the ASA House of Delegates on October 17, 2001, and amended on October 25, 2005. www.ASAhq.org/aboutAsa/EducationalMissionStatement.pdf.

Nominations for Distinguished Service Award

The House of Delegates has established policies governing the selection of a recipient for ASA's Distinguished Service Award. Procedures for the submission of nominations and selection of a candidate for 2008 will be as follows:

Any member of ASA or a component society may submit the names of individuals for consideration for this award.

Nominations must be submitted on the nomination forms, which may be obtained from the ASA Executive Office, together with a current curriculum vitae.

Nomination forms should be submitted to:

Orin F. Guidry, M.D.
Committee on Distinguished Service Award
American Society of Anesthesiologists
520 N. Northwest Highway
Park Ridge, IL 60068-2573

Nomination forms must bear a postal mailing date prior to **June 18, 2008**.

The committee will review the names of nominees submitted and recommend to the House of Delegates the name of no more than one candidate. Selection of a candidate shall require a two-thirds vote of the full committee. The Distinguished Service Award may be given to an ASA member for outstanding clinical, educational or scientific achievement or contributions to the specialty and/or exemplary service to the Society.

No officer of ASA shall be eligible for selection.

Should the committee select a candidate to enter into nomination in the House of Delegates, the name of the candidate shall not be disclosed until placed in nomination before the House of Delegates.

Final selection of the recipient of the Distinguished Service Award shall be made by the House of Delegates by secret ballot and shall require a two-thirds vote of those seated in the House of Delegates.

2008 ASA Scientific Papers: Call for Abstracts

The submission procedure for the ASA 2008 Annual Meeting scientific papers is the same as that used in 2007. For 2008, ASA has once again partnered with Marathon Multimedia, which specializes in online abstract submissions.

The abstract submission program will be accessible on the Annual Meeting section of ASA's Web site <www.ASAhq.org/AnnMtg> by clicking on the "Submit an Abstract" link. All accepted abstracts will be published in their entirety in electronic format, and a summary of the abstract will be published in the 2008 Annual Meeting program book. Submission instructions are available on the ASA Web site and will not be mailed to authors. It will not be necessary to request a packet of abstract submission material.

The following outlines the 2008 scientific papers submission process:

- **The submission Web site will be available in early January 2008. The deadline for submitting all abstracts is Tuesday, April 1, 2008, at 11:59 p.m. Central Standard Time.**
- **To submit your abstract using the online submission form, you must be using Netscape Navigator or Communicator, version 7.0 or higher, or Microsoft Internet Explorer, version 5.2 or higher.**
- All submission instructions will be available on the

ASA Web site and accessible from any point during the submission process. No separate submission packet will be mailed.

- Authors may input and revise submissions until the deadline or until the abstract is officially submitted by clicking the "Submit" button. Entries will be checked automatically for completeness once officially submitted. After the closing deadline, entries that are not in compliance with all of the submission requirements will be assumed to be in draft format and will not be considered by the graders.

- A brief summary of the study must be included with the submission and, for abstracts that are accepted, will be published in the 2008 Annual Meeting program book. The summary will not be considered when the abstracts are graded. The September supplement to *Anesthesiology* will consist of a CD-ROM containing the full text and graphics of all accepted abstracts.

- The use of scientific characters and common style elements such as bold, italic and underline will be permitted. Font specification, with some limitations, will be available.

The ASA Web site will contain more complete information regarding the process for submitting abstracts.

Residents Invited to Enter Research Essay Contest

ASA resident members are reminded that **March 31, 2008**, is the deadline for receipt of entries in the Residents' Research Essay Contest. Three prize winners will be invited to present their papers at the ASA Annual Meeting in Orlando, Florida, in October 2008. The rules for entry are:

Eligibility

1. **The entrant must be a member of ASA at the time of submission.** Any co-entrant(s) may or may not be a member of ASA.

2. The work reported should have been completed during residency or research fellowship training. Research performed as a student may be considered.

3. Papers should be submitted during or within one year following completion of the training.

4. A previous entry or award does not preclude eligibility.

Submission of Entry

1. A letter from the residency program director confirming eligibility must accompany each submission.

2. Concurrent submission of an abstract of the work for presentation as a regular scientific paper at the ASA Annual Meeting is required. That submission should be prepared using the ASA abstract submission material in accordance with the rules and deadlines for submission of regular ASA scientific abstracts and submitted independently of the essay contest application.

3. Manuscripts should follow the format provided in the "Guide for Authors" of the journal *Anesthesiology*. The work should not have been presented, published or submitted to any other meeting, journal or residents' essay contest prior to this submission. A limit of 25 double-spaced pages, including all figures, tables and references, will be enforced; manuscripts that exceed the page limit will not be reviewed.

The original and 21 copies of the manuscript must be received by **March 31, 2008**, by the office of the Chair of the Committee on Research, Paul R. Knight III, M.D., Ph.D., 245 Biomedical Research Building, University at Buffalo, SUNY, 3435 Main St., Buffalo, NY 14214.

Complete guidelines for application are available from residency program directors or from the ASA Executive Office, 520 N. Northwest Highway, Park Ridge, IL 60068-2573. Guidelines for the submission of ASA Annual Meeting scientific papers are also available from the ASA Executive Office and the ASA Web site. The "Guide for Authors" for the journal *Anesthesiology* can be found in the January issue of the journal.

34th National In-Training Exam Set for July 12, 2008

The American Board of Anesthesiology-ASA Joint Council on In-Training Examinations encourages all trainees in anesthesiology to participate in the 34th national In-Training Examination to be given July 12, 2008.

The examination last year was challenging and stimulating to trainees and rewarding to program directors. The 2008 examination will be identical in format. Keyword feedback will be supplied to examinees and program directors, and scores will be provided to enable the examinees to compare their performances to that of all other residents at the same training level and to track their own growth in knowledge. Each program director will receive from the ABA a summary of the performance of all trainees in that program, including all years a trainee has participated. There is a fee of \$100 per can-

didate, and the roster must be received by ABA by May 1, 2008, or a late fee of \$50 will be charged. No applications for the In-Training Examination will be accepted after May 15, 2008.

Application information related to the In-Training Examination is available to program directors from ABA, 4101 Lake Boone Trail, The Summit, Suite 510, Raleigh, North Carolina 27607.

Canadian program directors and requalifying candidates will receive their rosters or applications from ASA in early January. A deadline date for receipt will be May 1, 2008, and no applications will be accepted after the May 1 deadline. A fee of \$100 is required per applicant. Applicant information is available by contacting the ASA office at (847) 268-9141 or j.jacobson@ASAhq.org.

MHAUS Bestows Awards Advancing Education, Treatment and Research

Gloria Artist

MHAUS Hotline Coordinator

At last October's ASA Annual Meeting in San Francisco, the following outstanding contributors were recognized by the Malignant Hyperthermia Association of the United States (MHAUS).

MH Hotline Partnership Awards

James W. Chapin, M.D., University of Nebraska Medical Center, Omaha, and Dorming Wong, M.D., California Anesthesia Associates Medical Group, Newport Beach, California, were the recipients of the 2007 MH Hotline Partnership Awards.

This award recognizes special cases in which the 24/7 MH Hotline was used to solve MH cases in real time via telephone or Internet.

Dr. Wong called the hotline because he was dealing with signs of MH during a surgical procedure in a 72-year-old woman undergoing off-pump cardiac surgery. After much discussion, they eventually concluded that the case was probably MH, and she was recommended for a muscle biopsy at UCLA.

Dr. Chapin has volunteered his time as a hotline consultant for more than 20 years.

Special Recognition for Outstanding Dedication to MH Award

Harvey K. Rosenbaum, M.D., Clinical Professor of Anesthesiology at the David Geffen School of Medicine at UCLA, received a Special Recognition for Outstanding Dedication to MH Award for his leadership and vision in promoting the development of the MH Case of the Month on the Malignant Hyperthermia Web site www.mhaus.org. Henry Rosenberg, M.D., MHAUS President, said that Dr. Rosenbaum, who has been a co-director of the MH biopsy center at UCLA, took the case of the month idea and developed the presentation and structure of the challenge. He personally wrote the first 14 cases.

Special Recognition Awards

Paul D. Allen, M.D., Ph.D., Brigham and Women's Hospital in Boston, received the Special Recognition Award for his outstanding work in understanding the pathophysiology of MH and the development of a new animal model for MH.

Susan Hamilton, Ph.D., Baylor College of Medicine,

Houston, also received the Special Recognition Award for her outstanding work in understanding the structure and function of ryanodine receptors and the development of a new animal model for MH.

Dr. Rosenberg said that Drs. Allen and Hamilton have been investigating the special characteristics of cellular structure and function in MH-susceptibles. They worked through the details of developing an animal model that expresses the mutations responsible for rendering an individual animal MH-susceptible. The animal model has already suggested that environmental temperature can modulate the development of an MH episode. The animal model will serve to provide greater information concerning the relation of DNA changes to the expression of MH.

Special Mention Manuscript Award

Laura Schleelein, M.D., Children's Hospital of Philadelphia, received the Special Mention Manuscript Award for her manuscript "Hyperthermia in the Pediatric Intensive Care Unit — Is It Malignant Hyperthermia?" Dr. Schleelein and co-workers used MH Hotline data to explore how often MH is expressed in the pediatric intensive care unit. An abstract of her work may be found in the compilation of Annual Meeting abstracts posted on the ASA Web site at www.asaabstracts.com/strands/asaabstracts.

Media Award

This year's MHAUS Media Award recognized Robert C. Morell, M.D., editor and chief for the Anesthesia Patient Safety Foundation, for his support of the educational mission of MHAUS by encouraging the publication of information that relates to the clinical findings in MH.

Daniel Massik MHAUS Anesthesiology Resident Award

The Daniel Massik MHAUS Anesthesiology Resident Award was established through the generosity of an MHAUS founder, George Massik, in memory of his son Daniel. First place went to Frank Schuster, M.D.,

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Changes for 2008

Sharon K. Merrick, CCS-P
Coding and Reimbursement Manager

ASA members should be very familiar with the final rule on the 2008 Medicare Physician Fee Schedule published in the November 1, 2007 *Federal Register*. The Centers for Medicare & Medicaid Services (CMS) — the agency that oversees the Medicare program — announced a long-awaited increase to the conversion factor used to determine payments for anesthesia services provided to Medicare beneficiaries. As a result of ASA's efforts, the 2008 Medicare conversion factor for anesthesia services is \$17.82 per unit. More information on this exciting update can be found in the "Washington Report" on page 4 of this *NEWSLETTER*.

What Else Is New for ASA in 2008?

Anesthesia Conditions of Participation

Anesthesiologists should take note of another final rule, also published on November 1. In this ruling, CMS finalized changes to Medicare's Anesthesia Conditions of Participation (CoP), which were announced in an August 2007 proposed rule. CMS establishes the CoPs, which are standards that a hospital must meet in order to participate in and receive payments from the Medicare or Medicaid programs.

These changes were put forth as a response to the many questions CMS has received about the timing of the postanesthesia note. It is CMS' belief that the revisions will provide needed clarification, and ASA supported these revisions. In comments submitted in September, we stated that "ASA endorses the changes as proposed by CMS. We agree that they are in the best interests of our patients and provide a necessary update to the current requirements without placing any undue burden on the anesthesiologists' provision of medical care."

2007 Text:

§482.52(b) *Standard: Delivery of services. Anesthesia*

services must be consistent with needs and resources. Policies on anesthesia procedures must include the delineation of preanesthesia and postanesthesia responsibilities. The policies must ensure that the following are provided for each patient:

1. *A preanesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, performed within 48 hours prior to surgery.*
2. *An intraoperative anesthesia record.*
3. *With respect to inpatients, a postanesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, within 48 hours after surgery.*
4. *With respect to outpatients, a postanesthesia evaluation for proper anesthesia recovery performed in accordance with policies and procedures approved by the medical staff.*

The CoPs define an individual qualified to administer anesthesia as:

- *an anesthesiologist;*
- *a doctor of medicine or osteopathy (other than an anesthesiologist);*
- *a dentist, oral surgeon or podiatrist who is qualified to administer anesthesia under State law;*
- *a certified registered nurse anesthetist (CRNA);*
- *an anesthesiologist's assistant (AA) under the supervision of an anesthesiologist.*

In the text as published in this Final Rule and effective on January 1, 2008, §482.52(b) (1) has been revised to read as follows:

A preanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, performed with 48 hours prior to surgery or a procedure requiring anesthesia services.

§482.52(b) (3) now reads:

A postanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, no later than 48 hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.



Sharon K. Merrick, CCS-P manages coding and payment issues for ASA in its Washington, D.C. office.

§482.52(b) (4) has been deleted.

The CoPs no longer include an inpatient/outpatient distinction for the postanesthesia evaluation. §482.52(b) (3) applies to anesthesia services delivered in either setting. CMS has determined that this is appropriate given the fact that many of the procedures that require anesthesia, which had been provided strictly in an inpatient setting, have now migrated to the outpatient setting.

The members of the ASA Committee on Quality Management and Departmental Administration (QMDA) monitor any issues or changes relevant to the CoPs. In analyzing these revisions, QMDA members have observed that:

- The discharge criteria from the postanesthesia care unit (PACU) are unchanged. These revisions are an affirmation that the postanesthesia note can be written prior to discharge from the PACU. In an outpatient setting, many anesthesiologists write this note immediately after the PACU handoff since that could be the only time the anesthesiologist sees the patient before discharge. A postanesthesia note has always been required. The revised CoP affirms that this timeframe is appropriate.

- The note detailing anesthesia recovery need does not need to be written at the time of discharge from the location in which the patient recovers. It must be written no later than 48 hours after the surgery or procedure that required anesthesia services. The new rules offer flexibility. The anesthesiologist has 48 hours after the procedure to write the note no matter where the recovery occurred.

CPT® Code Changes for 2008

Anesthesia

2008 Current Procedural Terminology (CPT) includes two new anesthesia codes and one deleted code. Code 01905 – anesthesia for myelography, discography, vertebroplasty (five base units) has been deleted and replaced with two new codes:

01935 – *Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic.*

01936 – *Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic.*

Codes 01935 and 01936 both have five base units. Code 01935 should be used to report anesthesia for myelography and discography. Use 01936 to describe anesthesia for vertebroplasty, kyphoplasty and chemonucleolysis.

Code 01931 has been revised to make its definition of “TIPS” (see below) consistent with that used throughout CPT:

01931 – *Anesthesia for therapeutic interventional radiologic procedures involving the venous/lymphatic system (not*

to include access to the central circulation); intrahepatic or portal circulation (e.g., transvenous intrahepatic portosystemic shunt[s] [TIPS]).

The old descriptor defined TIPS as “transcutaneous portocaval shunt.” The change did not impact the base unit value assigned to the code.

Pain

While there are no new/revised/deleted pain codes, some of the modifiers that may be appended to these codes have been updated. 2008 CPT’s definition for modifier 22 is now “Increased Procedures Services.” CPT includes notice that when using this modifier, physicians should have documentation that not only describes the additional work but also explains why it was necessary. Other modifier changes include instruction that modifiers 22 and 59 (Distinct Procedural Service) not be appended to an evaluation and management service.

New ASA Position Statements

ASA has received reports that some payers may be inappropriately denying claims for postoperative pain procedures reported in conjunction with an anesthesia service. Furthermore, we still hear of some cases where insurance companies bundle the payment for fluoroscopic guidance into the payment issued for spinal injection procedures. The ASA Committee of Economics authored position statements on each of these issues that were approved by the ASA House of Delegates at the Annual Meeting held in October 2007.

The ASA statement on Reporting Postoperative Pain Procedures in Conjunction With Anesthesia can be found at: www.ASAhq.org/publicationsAndServices/standards/43.pdf.

The statement on Fluoroscopic Guidance for Spinal Injections is at: www.ASAhq.org/publicationsAndServices/standards/44.pdf.

Physician Quality Reporting Initiative

Anesthesiologists can continue to participate in CMS’s Physician Quality Reporting Initiative (PQRI) program and remain eligible to receive a bonus of up to 1.5 percent of their total Medicare allowed charges. The 2008 PQRI program includes 119 measures, up from 74 in 2007. Some of last year’s measures have been deleted from the program while others have been revised, but the delete/revised measures do not apply to anesthesiology. Reporting will continue to be claims-based while CMS explores registry-based reporting options for the future.

Independent Practice for Montana Nurse Anesthetists

Lisa Percy, J.D.

Manager, State Legislative & Regulatory Issues

The Montana Supreme Court affirmed a lower court's decision authorizing nurse anesthetists to independently administer anesthesia. The Montana Society of Anesthesiologists (MSA) sought to invalidate amendments to regulations issued by the nursing board that define the scope of practice of nurse anesthetists as "independent and/or collaborative." MSA argued that the nursing board did not have statutory authority to administratively modify the scope of practice of nursing and that the amendments to Rule 303 were void and unenforceable because the nursing board violated the Montana Administrative Procedures Act (MPA) in seeking to enact the amendments. The Montana Association of Nurse Anesthetists (MANA) intervened as a defendant. MANA argued that the amendments to Rule 303 merely clarified the scope of practice, and the Montana Legislature specifically declined to require physician supervision of nurse anesthetists.

Background

In 2004, the district court, agreeing with the nursing board and MANA, held that Montana law does not require physician supervision of nurse anesthetists. While it also concluded that the nursing board did not have the authority to expand or even define scope of practice, the court held that the amendments to Rule 303 did not expand nurse anesthetist scope of practice. Shortly after the district court issued its decision, former Governor Judy Martz opted out of Medicare's physician supervision requirement.

MSA appealed the district court's decision. The Montana Medical Association (MMA) and Association of Montana Health Care Providers (MHA) filed briefs as amici curiae in support of MSA and the nurses, respectively. MANA argued that MSA's claims are moot because Rule 303 did not create any new rights for nurse anesthetists but merely clarified existing practice in Montana. MHA argued

that MSA's appeal is moot because Governor Martz had already opted out. The Montana Supreme Court rejected their contentions that the case was moot. Even though Governor Martz opted out, not all patients are Medicare/Medicaid patients. Furthermore, one element of an opt-out is that it is consistent with state law. Therefore, if the court were to conclude that state law prohibits independent practice, such condition of an opt-out would not be met.

Court's Analysis

Issue 1: In its analysis of whether the Montana Legislature authorized nurse anesthetists to administer anesthesia to patients without physician supervision, the Montana Supreme Court reviewed 1) both Montana state law and 2) the actions of the Montana Legislature.

First, the court Montana's Medical Practice Act defines the "practice of medicine" as:

the diagnosis, treatment, or correction of ... human conditions, ailments, diseases, injuries or infirmities, whether physical or mental, by any means, methods, devices, or instrumentalities. If a person who does not possess a license to practice medicine in this state ... and who is not exempt from the licensing requirements of this chapter performs acts constituting the practice of medicine, the person is practicing medicine in violation of this chapter. §37-3-102 (8).

MSA argued that administering anesthesia is a form of medical diagnosis and treatment and that nurses may not engage in either pursuant to the Montana MPA. The court held that MSA's reliance on numerous attorney general opinions were not on point nor did MSA set forth any provision in Montana law requiring physician supervision of nurse anesthetists.

However, the MPA provides a list of acts that are exempt from medical licensure requirements, one of which is the "rendering of nursing services by registered or other nurses in the lawful discharge of their duties as nurses ... under the conditions and limitations defined by law." MCA § 37-3-103. The court looks to the Nurse Practice Act to determine whether it places any "conditions and limitations" on nurse anesthetist scope of practice. In reviewing the statute that defines the practice of an advanced-practice registered nurse, nurse anesthetists may practice in their specialized field as long as they meet the licensing and qualification requirements for a nurse anesthetist.¹ The court concludes



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

that the licensing and qualification requirements are the only condition or limitation on their scope of practice.

Second, the court reviewed the actions of the Montana Legislature to determine whether nurse anesthetists are authorized to administer anesthesia without physician supervision. The court states that the only statutory requirement for physician supervision of nurse anesthetists is with respect to individuals who are granted temporary approval while they await their certification results. Furthermore, the Montana Legislature rejected attempts to require physician supervision. A 2003 bill that would have required physician supervision was withdrawn by its sponsor. A subsequent attempt in 2003 failed. The House Human Services Committee voted 13-0 to oppose amendments that would have included physician supervision. In fact, the committee chair wrote a letter to Governor Martz stating that physician supervision is not in Montana's best interests.

Issue 2: MSA asked the court to review whether the nursing board complied with the Montana Constitution and MPA when it adopted amendments to Rule 303. MSA argued that the nursing board's amendments are an "executive usurpation of legislative power by an unelected executive body." Additionally, MMA argued that the nursing board did not have the authority to adopt an administrative rule allowing nurse anesthetists to practice independently of physician supervision. Conversely, MANA argued that prior to the amendments to Rule 303, the rule did not contain any requirement for physician supervision of nurse anesthetists; therefore, the rule did not redefine their scope or create a new authorization for nurse anesthetists to administer anesthesia independently.

The court rejected the cases that MSA cited as not on point. The cases involved criminal cases where the individuals were prosecuted for practicing without a license or using an inappropriate title rather than for practicing outside their scope of practice. Moreover, the court agreed that the legislature did not provide the nursing board with the authority to redefine or expand the scope of practice of a nurse anesthetist established by their enabling legislation. However, it held that the amendments to Rule 303 did not redefine or expand their scope of practice. Rather, the amendments merely clarified existing practice in Montana.

This case cannot be appealed. Montana is unique in that its judiciary system does not have an intermediate appellate court. Therefore, the supreme court hears direct appeals from all of the district courts across Montana and is the last state court of review.

Reference:

1. M.C.A. § 37-8-409 Advanced practice registered nursing — when professional nurse may practice. A person licensed under this chapter who holds a certificate in a field of advanced practice registered nursing may practice in the specified field of advanced practice registered nursing upon approval by the board of an amendment to the person's license granting a certificate in a field of advanced practice registered nursing. The board shall grant a certificate in a field of advanced practice registered nursing to a person who submits written verification of certification by a board-approved national certifying body appropriate to the specific field of advanced practice registered nursing and who meets any other qualification requirements that the board prescribes.

Washington Report: Happy New Year

Continued from page 5

And, in response, ASA launched a massive grassroots drive for comments to CMS.

ASA is very grateful to the several thousand anesthesiologists who, as one trade rag put it, "bombarded" CMS with positive comment letters. Indeed, ASA was able to make great strides with only some 4,000 members, or about 10 percent of our membership, responding to our call to action. At the same time, as ASA President

Jeffrey L. Apfelbaum, M.D., recently wrote to all members, imagine the force ASA could be by doubling, tripling or even quadrupling that number when called to act and lobby Congress or the Administration.

As all ASA members receive well-deserved Medicare payment increases for 2008, please stop to think about ways that you can use your voice to help the profession.

The 14th World Congress of Anaesthesiologists: Cape Town, March 2-7, 2008

John R. Moyers, M.D., Secretary

Committee on Representation to World Federation of Societies of Anaesthesiologists

Archbishop Desmond Tutu will be the keynote speaker at the opening ceremony of the World Congress of Anaesthesiologists. Desmond Mpilo Tutu (October 7, 1931) is a South African cleric and activist who rose to worldwide fame during the 1980s as an opponent of apartheid. Tutu was elected and ordained the first black South African Anglican Archbishop of Cape Town, South Africa, and Primate of the Church of the Province of Southern Africa (now the Anglican Church of Southern Africa).

He received the Nobel Peace Prize in 1984, the Albert Schweitzer Prize for Humanitarianism in 1986 and the Magubela Prize for Liberty in 1986. He is committed to stopping global AIDS and has served as the honorary chairman for the Global AIDS Alliance. In February 2007, he was awarded the Gandhi Peace Prize by A.P.J. Abdul Kalam, M.D., a past president of India. He was generally credited with coining the term "Rainbow Nation" as a metaphor for post-apartheid South Africa after 1994 under African National Congress rule. The expression has since entered mainstream consciousness to describe South Africa's ethnic diversity.

The schedule for the Opening Ceremony on Sunday, March 2 is as follows:

Doors open: 4:30 p.m.
 Ceremony begins: 5 p.m.
 Ceremony closes: 6:45 p.m.
 Cocktail reception: 6:45 – 8:15 p.m.

Anesthesiologists throughout the world convene every four years at the World Congress of Anaesthesiologists. The 14th World Congress will be held in Cape Town, South Africa, in March 2008. It is anticipated that more than

10,000 anesthesiologists from more than 135 nations will attend. The 14th World Congress of Anaesthesiologists (www.wca2008.com) boasts the world's foremost educational program for anesthesiologists. The World Congress faculty will present more than 320 lectures and discussion sessions covering a wide range of topics in anesthesiology and related medical fields as well as workshops in areas of technical expertise. Through the scientific sessions, social program, exhibits and satellite meetings, the congress will bring anesthesiologists from all over of the world together in the "Rainbow Nation" — the perfect setting for the global anesthesia family. There is still time to visit the congress Web site and register now.

"Through the scientific sessions, social program, exhibits and satellite meetings, the congress will bring anesthesiologists from all over of the world together in the 'Rainbow Nation' — the perfect setting for the global anesthesia family."



John R. Moyers, M.D., Professor,
 Department of Anesthesia, Carver College
 of Medicine, University of Iowa, Iowa City.
 He is the ASA Director from Iowa.

AUA: Remaining True to Its Heritage of Advancing Academic Anesthesiology

Roberta L. Hines, M.D., President
Association of University Anesthesiologists

The Association of University Anesthesiologists (AUA) — originally called the Association of University Anesthetists — was founded in 1953 by four individuals with a vision and passion for developing a vehicle for “exchanging information regarding research.” The founding members included such luminaries as Drs. Papper, Beecher, Dripps and Lamont. As originally conceived, “this would be a small and informal group, comprised of the anesthesiologists in some of the universities.” Today with a membership of more than 800, AUA continues to champion the values put forth by our founders. A look at AUA’s current mission statement exemplifies the Association’s important role in providing a venue specifically devoted to highlighting the missions of academic anesthesiology. “The object of the Association shall be the advancement of the Art and Science of Anesthesiology by 1) the encouragement of its members to pursue original investigations in the clinic and the laboratory; and 2) the development of methods of teaching (anesthesia) and 3) free and informal exchange of ideas.”

The AUA Annual Meeting remains the principal vehicle for stimulating academic discussions and providing unique cultural programs.

This year’s annual meeting will be held in Durham, North Carolina, from May 15-18, 2008. The meeting will be hosted by the Duke University Department of Anesthesiology. Mark F. Newman, M.D., and his faculty have worked in conjunction with the AUA Council to create a meeting that has broad scientific and cultural appeal for both members and their guests. One of the highlights of the annual meeting is the plenary scientific session. C. Michael Crowder, M.D., Ph.D., Chair of the Scientific Advisory Board, has assembled an innovative scientific program highlighting the basic, translational and clinical research efforts of our specialty. Dr. Crowder has put together a variety of oral as well as scientific poster presentations. This year, Debra A. Schwin, M.D., Professor and Chair of the Department of Anesthesiology at the University of Washington, will present “Passion and Fire: Building the Foundation for an Academic Department of the Future.”

Robert E. Shangraw, M.D., Ph.D., from Oregon Health and Science University, has recently assumed the chairmanship of the Education Advisory Board (EAB). For its part of the program, the EAB will host two panels. The first focuses on the topic of acquiring additional graduate degree

training for faculty as an effective avenue for bolstering their academic careers. The second panel is titled “How to Create a Better Anesthesiologist.” I am confident these presentations will engender passionate and energized discussions.

Realizing that the success of the academic enterprise is linked to our ability to recruit, develop and nurture our future physician scientists, AUA is actively involved in initiatives focused upon engaging these individuals. For the



past several years, there has been a concerted effort to include residents and fellows in the AUA annual scientific meeting program and social activities. Each year, two residents are selected (based upon the scientific merit of their submissions) as “resident scholars.” These individuals receive special recognition at the annual meeting and are given a travel award to help defray the cost of their meeting expenses. At last year’s meeting, the resident/fellows program was expanded to include a luncheon attended by both residents and members of their sponsoring institutions. Residents and faculty sponsors engaged in informal and energetic discussions centered on various strategies for embarking upon a career in academic anesthesia.

In keeping with the tradition of their founders and the desire to further the “exchange of information,” this year’s President’s Panel will focus on ways in which anesthesiology has played and can continue to play a vital role in developing health policy and ensuring the health of our nation. In this election year, the topic is one that is both timely and provocative.

It has been my distinct honor and privilege to serve as president of AUA for the past two years. Working with the AUA Council and members of the ASA staff has been a

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Roberta L. Hines, M.D., is Nicholas M. Greene Professor and Chair, Department of Anesthesiology, Yale University School of Medicine, New Haven, Connecticut.

2007 ASA Resident Research Forum

José L. Díaz-Gómez, M.D.

In July 2004, the Resident Component Governing Council, the ASA Section on Annual Meeting and the ASA Section on Education and Research were proud to announce the addition of a Resident Research Forum to that year's Annual Meeting program in Las Vegas. During the first few years, areas were opened up for any resident who had an accepted abstract and was willing to participate.

For the fourth year in a row, the Resident Research Forum has been included in the ASA Annual Meeting. This time, the forum was unique for several reasons. First, the membership was made aware in advance as to which residents would participate. There were 473 residents whose papers were accepted, and 216 papers were presented. Around 45 percent of the projects were presented by residents coming from outside the United States. The forum occupied a prominent space in Hall D at Moscone Center North on October 13. The space was appropriate to accommodate all attendees to the sessions. Anesthesiology residents from the United States and 16 countries had the opportunity to display their abstracts in 16 theme sessions (the order of the foreign countries are based on the number of posters presented per nation: Germany, China, France, England, Belgium, India, Denmark, Canada, Switzerland, Austria, Thailand, Tunisia, Taiwan, Netherlands, Portugal, Colombia and Italy).

Secondly, thanks to the leadership of First Vice Chair of the Section on Annual Meeting Patricia A. Kapur, M.D., the residents responded directly to ASA as to their ability to be there on Saturday as well as their regular scheduled time. As a means of further encouraging resident participation in research and scholarly activity, Dr. Kapur could recruit more than 30 well-known senior academic anesthesiologists as moderators, representing the best scientists in anesthesiology (Timothy J. Brennan, M.D., Ph.D., Michael K. Cahalan, M.D., Keith A. Candiotti, M.D., Jayant K. Deshpande,

M.D., John B. Downs, M.D., James C. Eisenach, M.D., Alex S. Evers, M.D., Lee A. Fleisher, M.D., Adrian W. Gelb, M.B., Ch.B., N. Martin Giesecke, M.D., Rona G. Giffard, M.D., Ph.D., Allan Gottschalk, M.D., Ph.D., Joy L. Hawkins, M.D., Thomas K. Henthorn, M.D., Roberta L. Hines, M.D., Therese T. Horlocker, M.D., Evan D. Kharasch, M.D., Ph.D., Samsun Lampotang, Ph.D., Jerrold Lerman, M.D., Lawrence Litt, M.D., Ph.D., Gerald A. Maccioli, M.D., Aman Mahajan, M.D., Ronald D. Miller, M.D., Terri G. Monk, M.D., Johnathan L. Pregler, M.D., M. Christine Stock, M.D., Avery Tung, M.D., David B. Waisel, M.D., and Charles W. Whitten, M.D.).

The residents had the exhilarating experience of interacting with a "who's who" of academic anesthesiology. In addition to the traditional anesthesiology subspecialties, the sessions included unique subjects such as anesthetic action and biochemistry, drug disposition, engineering and technology, patient safety and practice management, geriatric anesthesia, experimental neurosciences, history and education, among others. The forum did not prevent residents from also presenting their research at the usual venues. In fact, it was a good opportunity to practice the poster presentation before the scientific session during the afternoon.

In its fourth year, this event continues to evolve. The session has grown to include all residents participating in an abstract. From the inaugural event in Las Vegas, the forum provided a single place where residents gathered with faculty to present their posters in a forum of peers, see the research in which other colleagues are involved and to exchange ideas with some of the leaders in anesthesiology research. The interaction between residents may enhance their sense of belonging to the specialty.

The number of residents invited to participate is certainly suggestive that the Resident Research Forum is healthy and growing. Future directions for the forum could include additional recruitment of residents to participate, organizing a schedule that allows residents to present at the forum, additional scientific sessions, improved notification on the annual meeting database to increase participation, and perhaps incentives such as awarding participants special recognition and prizes (educational materials, refresher course passes, etc.).



José L. Díaz-Gómez, M.D., is a CA-3 Resident Research Coordinator, Anesthesiology Institute, Cleveland Clinic, Cleveland, Ohio.

2007 in San Francisco: A Meeting to Remember

Erica J. Stein, M.D., President-Elect
Resident Component Governing Council

Like many others, I arrived in San Francisco late Friday night, October 12, after an exhausting day of traveling and being stranded in airports because of rain delays. I had never been to San Francisco and wanted to take in the famous sites of the city: Chinatown, Fisherman's Wharf and the Golden Gate Bridge, to name a few. As it turned out, attending my first ASA Annual Meeting was even more exciting.

The ASA Resident Component (ASARC) activities began Friday evening with the Grassroots Advocacy/Leadership Training Workshop. The panelists, Jeffrey S. Plagenhoef, M.D., Paloma Toledo, M.D., and ASA staff members Chip Amoe, J.D., and Sarah Paff, M.A., highlighted the political issues facing our specialty. They discussed the importance of contributing to ASAPAC—ASA's bipartisan political component—and of lobbying to protect our specialty's interests on Capitol Hill, such as passing the Medicare Anesthesiology Teaching Rule (H.R. 2053, S. 2056). In 1994, the Centers for Medicare & Medicaid Services (CMS) revised the teaching payment policy *only* with respect to anesthesiologists. As a result, Medicare payment was reduced by 50 percent per case when a teaching anesthesiologist supervised two residents on overlapping cases. No other medical specialty was affected in this way. For example, teaching surgeons who supervise residents during multiple overlapping cases collect full fees for each case. Since 1994, payment reduction for anesthesiologists has resulted in an estimated loss of approximately \$400,000 to \$1 million annually per anesthesiology teaching program and a 20-percent decrease in the number of anesthesiology teaching programs. In the past seven years, ASAPAC, through support from ASA members, has achieved unprecedented strides in advocating for the safety of our patients and for the protection of our specialty. Currently, resident contribution to ASAPAC is \$20 per year. Resident participation in the PAC was approximately 14 percent this past year; nonresident ASA members had 12 percent participation. For further information on ASAPAC, visit www2.ASAhq.org/pac/web or follow the links through the "Members Only" section of the ASA Web site at www.ASAhq.org.

The ASARC House of Delegates, which convened Saturday morning, engaged in lively debate and passed several resolutions aimed at increasing resident and medical student involvement in ASA. Those resolutions included the following: increasing resident participation in the ASA Legislative Conference and Leadership Spokesperson Training Program; recommending the establishment of a

residency fair for medical students during the Annual Meeting; improving the current anesthesiology fellowship application process with a universal process that standardized the time period for interviews and contracts; and improving ASARC participation through increases in funding and scholarships. Of particular importance, the ASA House of Delegates acted upon the ASARC recommendation to create a Medical Student Component that would function as a separate component society within ASA.

During the course of the meeting, elections for the ASARC Governing Council were held. Congratulations to Todd R. Gleaves, M.D., Resident's Review Junior Co-Editor; Joshua L. Lumbley, M.D., American Medical Association (AMA) Alternate Delegate; and Cheri A. Camacho, M.D., Secretary. I also offer my sincere thanks to the resident delegates for supporting me as your new President-Elect. Governing Council officers continuing their terms include Christopher R. Cook, D.O., President; Joseph A. Walker III, M.D., AMA Delegate; Todd J. Smaka, M.D., Residents' Review Co-Editor; and Samuel C. Seiden, M.D., Accreditation Council for Graduate Medical Education Residency Review Representative. We are grateful for the contributions and leadership of Immediate Past President Paloma Toledo, M.D., AMA Delegate Jesse M. Ehrenfeld, M.D., Secretary Melissa Matte, M.D., and Residents' Review Co-Editor Michael S. Axley, M.D.

Saturday afternoon was devoted to the Resident Research Forum and the Resident Practice Management Seminar. The research forum emphasized the importance of resident involvement in research. Many residents showcased their research and competed for scholarships from the Foundation for Anesthesia Education and Research. The Resident Practice Management Seminar addressed the question "Private Practice or Academics?" The pros and cons of both fields were presented, and contract negotiations and billing



Erica Stein, M.D., is a CA-2 resident, University of Chicago Department of Anesthesia and Critical Care, Chicago, Illinois.

standards for reimbursement were reviewed. Other resident events held during the Annual Meeting were the Resident Regional Anesthesia Workshop and the Resident Communications Workshop. At the regional anesthesia workshop, residents were able to practice first-hand techniques in regional anesthesia using ultrasound-guidance and nerve stimulator techniques. The Resident Communications Workshop suggested the skills needed for improving interpersonal communication with colleagues, interviewers and patients. This workshop has received rave reviews from former attendees, and I believe it is a "must-attend" for all residents. To round out the ASARC events, several social functions gave us the opportunity to experience San Francisco and, more importantly, build contacts with residents across the nation.

I found the ASA Annual Meeting to be much more than I had expected. After examining the program itinerary on the plane, I had anticipated the meeting to be like many conferences that I had attended in the past. I was wrong. I was

amazed to see so many people taking pride in their careers, whether through teaching at the review sessions, presenting research posters, conducting workshops or simply attending the many workshops that were offered. I met so many people who had worked and are still working toward the advancement of patient safety and our specialty. It is my hope that resident involvement in ASA will soar within the coming years and that residents will take advantage of the leadership, service and scholarship opportunities that ASARC has to offer.

I encourage everyone to become involved in ASARC and to visit the ASARC Web site www.ASAhq.org/asarc/index.html for a calendar of events for this year. Be sure to look for the monthly *ASA NEWSLETTER* and sign up for the ASARC listserv to receive updates on ASARC activity. I look forward to an exciting, rewarding year ahead as president-elect. Please feel free to contact me at estein@dacc.uchicago.edu if you have any questions, comments or suggestions.

MHAUS Bestows Awards Advancing Education, Treatment and Research

Continued from page 33

Department of Anesthesiology, University of Wurzburg, Wurzburg, Germany, for his manuscript "A Minimally-Invasive Metabolic Test Detects Probands at Risk for Malignant Hyperthermia."

Dr. Rosenberg said the work of Dr. Schuster and his colleagues have creatively applied physiologic information about MH to developing a minimally invasive diagnostic test for MH that might reduce the use of the standard open muscle biopsy.

About MHAUS

MH is an uncommon, inherited disorder, whereby patients who are at risk may develop life-threatening temperature elevation, muscle breakdown and changes in body chemistry, usually upon exposure to certain anesthetic gases. With rapid recognition of the changes accompanying the syndrome and administration of dantrolene sodium, mortality is averted.

MHAUS (www.mhaus.org) is a not-for-profit patient advocacy organization that is dedicated to reducing morbidity and mortality from MH and related syndromes by 1) improving medical care related to MH, 2) providing support information for patients and 3) improving the scientific understanding and research related to MH and other kinds of heat-related syndromes. In its first 25 years of existence, MHAUS has contributed to the reduction of the MH-related death rate from 80 percent to less than 5 percent.

ASA Appoints Change Agent as New Executive Vice President in Park Ridge

A critical component in ASA's Organizational Improvement Initiative structure has been solidified with the hiring of John A. Thorner, J.D., CAE, into the new position of Executive Vice President of the Park Ridge Executive Office. He officially began service to ASA on January 7, 2008.

Thorner's hiring proves ASA's strong intent to remain competitive and serve members at a time that will likely challenge everyone in health care.

"We know what we need to do to become the best medical specialty organization in the world," said ASA President Jeffrey L. Apfelbaum, M.D. "And we know the obstacles we need to overcome. The missing piece of the puzzle was finding the talent, skill and expertise that would fit ASA's current and future needs.

In John Thorner, we've found a leader in association executive management who can take us to that next level of success."

As Executive Director of the Optical Society of America (OSA) from 1998-2002, John oversaw an almost 16,000-member, high-level scientific organization that included 22 Nobel laureates among its ranks. OSA published eight peer-reviewed journals monthly that focused on the military, communications and medical applications of optics. He also worked with a medical group within the society made up almost entirely of physicians who specialized in vision applications of optics and lasers. During John's tenure there, OSA's annual revenue grew from \$19 million to \$34, and its membership increased by 30 percent.

Building upon his successes at OSA, Thorner took the reins at the National Recreation and Park Association (NRPA) in 2003, and in less than five years the association's assets increased by 83 percent — from \$6 million to \$11 million. After having lost \$1.5 million over the two years before his hiring, he steered NRPA to five straight years of positive bottom lines. John was instrumental in keeping the organization focused on a three-year strategic plan that helped to improve the image of the field, to score significant legislative victories in Washington, and to transform it from a weak federation into a strong national organization.



John A. Thorner, J.D.

On top of his extensive experience in association management, Thorner is licensed to practice law in two states and the District of Columbia. His early career was spent as a journalist writing for *The Washington Post*, the Associated Press, *Atlanta Journal-Constitution* and *Legal Times*.

Thorner received a Juris Doctorate from the University of Georgia School of Law, a Master's degree in journalism from Columbia University and a Bachelor's degree in history and political science from Duke University.

He is a certified association executive and is an active member of the American Society of Association Executives, where he serves on the Board of Directors. Thorner also was Executive Director of the Air and Waste Management Association

from 1994-1998 and has been an Executive Committee Board Member for the American Institute of Physics, a Board member of the American Association of Engineering Societies and a member of the Council of Engineering and Scientific Society Executives.

Eugene P. Sinclair, M.D., President's Executive in Charge of the Organizational Improvement Initiative, shares Dr. Apfelbaum's enthusiasm about the hiring of John Thorner, and he is similarly looking forward to what he will bring to ASA. "Mr. Thorner is a seasoned association executive with a track record of outstanding leadership and change management at the highest level in other organizations before coming to ASA. We are fortunate to have recruited a person of his experience and caliber."

In his spare time, John enjoys spending as much time as he can with his wife Judy, his five daughters and his dog. He is a fanatical Duke University basketball fan and enjoys hiking, trail biking, reading historical novels and movies.

Eager to pick up where his predecessors left off, John is excited about playing a lead role in helping ASA to realize its limitless potential for success. "I look forward to working with Ron Szabat, ASA staff and volunteer leaders to help the Society best serve its 43,000 members. ASA has been a good association for its first 100 years — working together, it can become a truly great one in its second century."

Dr. Berry Presented With New ACCME 'Hero' Award

Arnold J. Berry, M.D., M.P.H., is a recipient of a new award from the Accreditation Council for Continuing Medical Education (ACCME) — the Robert Raszkowski, M.D., Ph.D. ACCME Hero Award. The award is given in "recognition of long-term and exemplary volunteerism to the accreditation system for continuing medical education in the United States." The Hero award is named for the late Dr. Raszkowski, a long-time, dedicated ACCME volunteer.



Arnold J. Berry, M.D., M.P.H.

Dr. Berry received the award for his service as a member of the ACCME Board of Directors and previously on the Accreditation Review Committee.

2008 Meeting Dates for ASA Governing Bodies

ASA President Jeffrey L. Apfelbaum, M.D., has announced that the Interim Meeting of the Board of Directors will be held in the Chicago area on February 23-24, 2008. The Annual Meeting of the Board of Directors will be held in the Chicago area on August 16-17, 2008. The deadline for submitting reports for the February meeting of the Board is Monday, January 21, 2008. The deadline for submitting reports to the August Board meeting is Monday, July 14, 2008.

The first meeting of the House of Delegates will be held in Orlando, Florida, on Sunday, October 19, 2008.

The Speaker of the House of Delegates has provided regulations

in the Rules of Order to provide that all reports and resolutions for the House of Delegates must be in the hands of the ASA Executive Vice President no later than 5 p.m. Tuesday, September 2, 2008. When possible, all individuals are requested to submit their reports by August 19, 2008 to provide sufficient time for the Executive Office to prepare the reports for distribution. This is also the deadline for receipt of reports from directors. Director reports will be included in the first mailing of the House of Delegates on September 5, 2008.

The 2008 House of Delegates will not consider reports or resolutions received after 5 p.m. Tuesday, September 2, 2008.

ASA Seeking Simulation Applicants

ASA invites applications from simulation centers and programs seeking endorsement by the ASA Simulation Education Network. A network for CME-granting simulation programs providing interactive, state-of-the-art training for anesthesiologists.

For more information, or to apply, please visit: www.simapps.ASAhq.org.

ABA Announces ...

ASA Solicits ABA Directorate Nominations

The American Board of Anesthesiology (ABA) has announced that the Directorates now held by Orin F. Guidry, M.D., Patricia A. Kapur, M.D., Cynthia A. Lien, M.D., and Mark A. Rockoff, M.D., end with the Annual Meeting of the Board of Directors in fall 2008. Drs. Lien and Rockoff are eligible for reelection.

In accordance with the policy established by the ASA representatives to the ABA-ASA-AMA Joint Committee at the ASA Annual

Meeting on October 20, 1961, the component society secretaries and directors of ASA have been notified regarding the procedure to be followed in submitting the name(s) of a candidate or candidates for the guidance of the ASA representatives to the ABA-ASA-AMA Joint Committee.

These names must be mailed to the Executive Vice President, ASA Executive Office, 520 N. Northwest Highway, Park Ridge, IL 60068-2573, with a postal mailing date prior to **March 1, 2008**.

Call for PBLDs

Catherine Kuhn Lineberger, M.D., Chair

The 2007 Problem-Based Learning Discussion (PBLD) program consisted of 150 cases that were selected from more than 350 submitted during the open-call process. Each was offered twice during the 2007 Annual Meeting in San Francisco, thus allowing attendees more opportunities to be involved in the PBLD program. The tables were full, and discussions were lively. The Committee on Problem-Based Learning Discussions again wishes to continue the open-call process, which

allows for greater participation by members and contributes to the vibrancy and overall success of the PBLD program.

The PBLD Committee is seeking submissions for each of the anesthesia tracks that will be offered during the 2008 meeting in Orlando: ambulatory anesthesia, cardiac anesthesia, critical care medicine, fundamentals of anesthesiology, neuroanesthesia, obstetric anesthesia, pain medicine, pediatric anesthesia, regional anesthesia and professional issues. Cases

will be reviewed by several members of the committee for relevance, content, scholarship and conformity to the guidelines that appear on the ASA Web site. Ideal submissions are cases that are provocative but not esoteric, with multiple decision points in management. All cases must be submitted online in the Annual Meeting section of the ASA Web site www.ASAhq.org.

The deadline for submission is February 4, 2008.

In Memoriam

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

Philip B. Burton, M.D.
Decatur, Illinois
July 8, 2007

Thomas R. Kain, M.D.
Phoenix, Arizona
May 18, 2007

William J. Stapleton, M.D.
Seattle, Washington
February 21, 2007

Tae-Sup Chung, M.D.
Lake in the Hills, Illinois
August 5, 2007

Arthur S. Keats, M.D.
Houston, Texas
August 28, 2007

Charles C. Stitman, AA-C
Brighton, Michigan
August 31, 2007

Oscar L. Elizondo, M.D.
Laredo, Texas
January 28, 2007

George J. Lesikar, M.D.
Tulsa, Oklahoma
October 26, 2007

James S. Taylor, M.D.
Fresno, California
June 5, 2007

Roy C. Giles, M.D.
Ferndale, Washington
May 8, 2007

John L. Margreiter, D.O.
Kirkwood, Missouri
October 28, 2007

Geoffrey L. Way, M.D.
Surrey, England
August 20, 2007

Fletcher Hester, M.D.
Sweeny, Texas
December 12, 2006

Robert N. Miller, M.D.
St. Louis, Missouri
August 16, 2007

William C. Howrie, Jr., M.D.
Rumford, Rhode Island
August 30, 2007

David G. Nelson, M.D.
Palm Springs, California
May 7, 2007

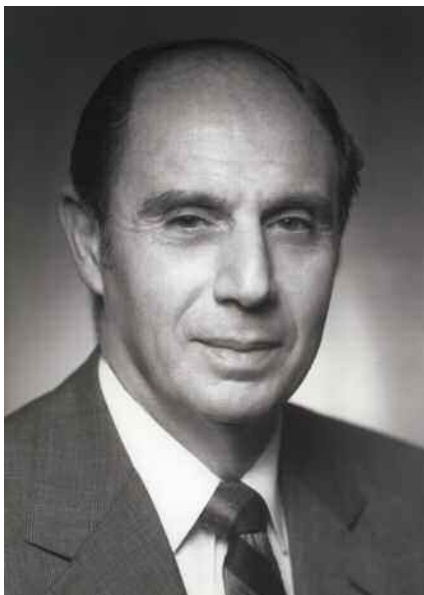
Louis S. Blancato, M.D. — 1920-2007

Daniel M. Thys, M.D.

On October 23, 2007, Louis S. Blancato, M.D., 1982 ASA President, passed away in Rye, New York. Lou was an outstanding practitioner of anesthesiology and a dedicated member and leader of our professional organizations. He was born in New York and attended college at Fordham University. Upon graduation, he began his medical education at Flower Fifth Avenue Medical School. During World War II, he was a proud officer of the U.S. Army Medical Corps.

He joined the attending staff of St. Luke's Hospital in 1953 and became director of anesthesiology in 1963. As director, he was an enthusiastic teacher and maintained an outstanding residency program. He rose to the rank of professor in the Department of Anesthesiology of the College of Physicians and Surgeons of Columbia University.

In addition to his hospital activities, he engaged passionately in organized anesthesiology and, in 1974, became president of the New York State Society of Anesthesiologists. He was a director of ASA for numerous years and became president of ASA in 1982. Recognizing his remarkable contributions, the New York State Society of



Louis S. Blancato, M.D.

Anesthesiologists awarded him its distinguished service award in 2001.

The award was presented to him on December 8, 2001, during the 55th Postgraduate Assembly in Anesthesiology in New York.

"Dr. Blancato's family, country and Italian-American heritage were the foundations of his life. He was a lifelong New Yorker and a citizen of the world through work, travel and many friendships." Those were the words used by U.S. Congressman Charles Rangel to memorialize Dr. Louis S. Blancato in the Congressional Record on Tuesday, October 30, 2007.

Dr. Blancato was the beloved husband of the late Nancy. He is survived by Louis S., Robert, John and Amy, three daughters and one son-in-law, and beloved grandchildren Celia and Carly. Dr. Blancato

was laid to rest in Rye, New York, on October 27, 2007. May he rest in peace.

Daniel M. Thys, M.D., is Chair, Department of Anesthesiology, St. Luke's-Roosevelt Hospital Center, New York, New York.

Subspecialty News: AUA

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pleasure. It is their dedication and commitment that truly exemplifies the spirit of AUA. I would like to thank them for their wisdom, counsel and guidance. Christine Dionne, from the ASA headquarters office in Park Ridge, Illinois, deserves a special note of thanks and gratitude for her expert administrative support.

At this year's annual meeting in Durham, I will be turning the presidency over to Ronald G. Pearl, M.D., Ph.D., Professor and Chair, Department of Anesthesia, Stanford University. I am confident that Dr. Pearl and the AUA Council will continue to challenge us in productive and rewarding ways.

‘Opportunities Can Build a Career’

Allison M. Fernandez, M.D.

You never know where life’s opportunities will lead you. As a medical student at Stony Brook University in New York, I had the chance to observe attending physicians in the anesthesiology department. Joy E. Schabel, M.D., the medical student program director, organized opportunities for me to shadow anesthesiologists in obstetrics and the operating room. It was a great experience. The consultants and residents were helpful, taking me under their wings and exposing me to the excitement of anesthesiology. One of my most vivid recollections was walking into the operating room of a patient who was going to have a total knee replacement. As part of my exposure, I was allowed to assist in placing an epidural using a sterile technique. Participating in and witnessing the effects of anesthetics on this patient was an amazing experience and a major factor for my decision to enter into anesthesiology residency after graduation.

During my first years of medical school, students had only limited opportunity for exposure to anesthesiology. In response to our desire to learn more, Michelle DiGuglielmo, a medical student colleague, and I strengthened our involvement with the department by reinitiating the anesthesiology interest group for medical students. The interest group benefited from the support of Dr. Schabel, department chair Peter S.A. Glass, M.D., and other staff members of the department. We held monthly meetings where anesthesia topics ranging from airway management to pain management were discussed. The department further supported our quest for growth by sponsoring a student workshop designed to teach students how to secure an airway using an endotracheal tube and a laryngeal mask airway.

During my fourth year of medical school, I received another unexpected opportunity to expand my growing knowledge: the FAER Medical Student Anesthesia Research Fellowship (MSARF) program. I submitted an application and to my delight was accepted as one of the first FAER medical student fellows. Members of Stony Brook University’s anesthesiology department were again very supportive and excited to help me with my research. For two months, I worked on several ongoing clinical projects and also on a personal project. I developed a questionnaire



Dr. Fernandez with MSARF Program Director Donn M. Dennis, M.D., at the 2007 Annual Meeting in San Francisco.

used to obtain patient outcome information following ambulatory surgery. It was intended for use in obtaining institutional review board (IRB) approval for pending research. By the end of my MSARF experience, I had developed the preliminary questionnaire and had submitted the request for IRB approval.

A second part of the MSARF program was my attendance at the ASA 2005 Annual Meeting, where I had the opportunity to give an oral presentation of my research project and to learn more about the specialty and the Society. The meeting was an eye-opening experience into the field of anesthesiology. I met residents and anesthesiologists who were encouraging and gave good advice about future career plans. Presenting my research project to a roomful of experts in the field of anesthesiology was very intimidating; however, it was an excellent personal growth opportunity. I

Allison M. Fernandez, M.D., is a CA-1 resident, Georgetown University Hospital, Washington, D.C.

gained insight from developing a project, obtaining data, presenting the project to an audience and experiencing the challenges common to such an undertaking.

In 2007, I was given the opportunity to attend the ASA Annual Meeting as a resident in the FAER/Abbott Volwiler and Tabern Resident Scholar Program. Although this was my second ASA meeting, I felt as if it was the first time I was attending the meeting. The resident component was very helpful with discussions ranging from the nuances of regional anesthesia to the differences and similarities of academic and private practice anesthesiology. Additionally, as a FAER scholar, I was able to attend refresher courses and meet experts in the field. It was a revelation to learn more about anesthesiologists involved in clinical practice as well as education, research, business and even law.

From Stony Brook University to the FAER MSARF program to the FAER Resident Scholar program, opportunities, one after the other, have led me to a career in anesthesiology. Today, I am a first-year anesthesiology resident at Georgetown University. Thus far, it has been an exciting, albeit at times overwhelming, experience. Most importantly, however, I am extremely glad to have chosen this specialty as a career. To the many anesthesiologists with whom I've interacted, thank you for sharing your time, expertise and enthusiasm; and a thank you goes to FAER for giving me the opportunity to expand my experiences and subsequently strengthen my resolve to become a clinician and future leader in anesthesiology.

FAER is deeply grateful for the participation of the following corporations and family foundation for their continuing sponsorship of our programs.

Abbott Laboratories for their sponsorship of the FAER/Abbott Volwiler and Tabern Resident Scholar Program.

Award Recipients approved by FAER from the August 15, 2007 application deadline.

Research Fellowship Grant

- Sara S. Cheng, M.D., Ph.D., University of Colorado Health Sciences Center
- Jesse M. Ehrenfeld, M.D., Massachusetts General Hospital, Boston
- Hannah Wunsch, M.D., Columbia University

Mentored Research Training Grant

- Jae-Woo Lee, M.D., University of California, San Francisco
- Tobias Moeller-Bertram, M.D., University of California, San Diego
- Peter Nagele, M.D., Washington University, St. Louis
- Senthilkumar Sadhasivam, M.D., Cincinnati Children's Hospital Medical Center

Research in Education Grant

- Sesh Mudubmbai, M.D., Stanford Medical Center

These seven new awards represent a funding commitment of \$1,270,000.

The FAER Medical Student Anesthesia Research Fellowship Program is sponsored in part by grants from The Ronald L. Katz Family Foundation and Merck & Co., Inc.