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Dining Out

He stood motionless 10 feet from the top of the goal crease, his helmet removed, holding it over his heart while his other arm balanced his blocker and goal stick. Staring up at the American flag which hung from the rafters of the arena (see picture), Tom silently showed his respect for all the things the flag represents as the national anthem played. While all the coaches had removed their hats, Tom was the only player to remove his helmet, the only person on the ice with an uncovered head, and he seemed to be the only one who understood the symbolism of the moment and who was willing to pay proper respect. A day earlier, when the public address announcer had reminded everyone in the rink to remove their headgear while the Star Spangled Banner was played, one of the referees yelled at the boys to keep their helmets on their heads, fearing no doubt a small delay while the three straps were refastened when the music stopped. In a larger sense, what was the referee telling the boys, all between 9 and 11 years of age, about one of the most important rituals at the start of a hockey game, or any sporting event?

At the ASA 2008 Annual Meeting in Orlando, the Uniformed Services Society of Anesthesiologists (USSA) held a “dining out.” The mess, the military term for officers dining together, was held in one of the meeting hotels. Outside of the uniforms, during the cocktail hour, little difference could be seen between this group and any other subspecialty society meeting at ASA. Many of the anesthesiologists present were in their class A dress uniforms, medals and ribbons in place, adding an atmosphere that was different than the Anesthesia History Association dinner held the next night. It was a unique honor walking among those who had seen the worst of the wars in Iraq and Afghanistan, and who are responsible for saving many lives and for developing innovations in the care of the wounded. Conversation flowed easily, as it does among friends.

However, once the doors to the ballroom were opened, the dinner meeting was “unusual.” An honor guard presented the colors, and all stood at attention, both the officers and civilians like me who were invited guests. The emotion was palpable in the room – the flag meant something very important to each and every person present. I thought of my father, who left the confines of western New York and went out to Kwajalein Atoll in the middle of the Pacific Ocean to defend the United States during World War II. Deep inside, every person there had some thought, some special connection and commitment to the United States that went beyond the simple confines of employment. The presentation of the colors was simple yet moving, as only the military can make it. I thought also of the cold March day some 60 years later when a folded American flag was presented to my mother by an Army sergeant, with words about a grateful nation giving last respects to one of its citizen soldiers.

The evening progressed, starting with a most fascinating ceremony of the blending of the grog. There again was plenty of symbolism, from the sock used to strain the liquid to the very ingredients themselves. And the very term “grog” refers to a long naval tradition when there was an actual grog ration. What was fascinating to me, as an outsider, was the use of the grog as a “punishment” for offenses against the mess – a decoration in improper order,
a comment made in jest taken far more seriously than the author intended, and so on. It was clear that this was not only a society of serious anesthesiologists, but also a group of good friends. As a civilian guest, being sent to the grog was an honor – for it meant acceptance as one of the group. As the evening went on, a good-natured interservice rivalry was present, including pushups for the Navy, and jokes about golf courses and Air Force bases. For many, it was a night away from the horrors they had witnessed and a chance to relax among friends who shared their experience and understood their needs.

After dinner, there was a guest speaker who delivered a talk about the importance of military anesthesiologists in World War II and the subsequent development of the specialty. Titled “90 Days – Enough Time to Learn Anesthesiology?”, the speaker detailed the course curriculum and the methods used to teach young physicians enough of the specialty to care for the wounded on battlefields and on ships. Most interestingly, these young men, approximately 40 percent, came home and became specialists. This boost, along with the exposure of surgeons to the physician practice of the specialty, was responsible for the tremendous post-war growth of anesthesiology. More information can be found on the site www.hirevetsfirst.gov, which is linked on the ASA Web site. The USSA has a director position and is represented at the Board of Directors and the House of Delegates, as many of its members do not have a permanent state affiliation. Thus, USSA functions as a component society for our military colleagues.

We have elected and sworn in the first president from a minority group in the United States. Thomas Jefferson's promise that all men are created equal (and perhaps more politically correctly stated as all people are created equal) has been fulfilled in a new way. And, as always, the transfer of power from President Bush to President Obama was done without violence and bloodshed. Our military was not involved, continuing the traditions laid down by George Washington when he became commander-in-chief of the Continental Army and which are continued to this very day. Our military colleagues are part of the defense of those customs. One of the great symbols of those assurances is the stars and stripes – our flag. May we as anesthesiologists be like Tom, ready to honor that which is good, and like our colleagues in the armed forces, ready to work to improve the lives of those whose care has been entrusted to us. The seal of USSA says it best: “In Combat and in Peace, We Stand Ever Vigilant.” The seal, presented in the form of a medal, sits next to the computer monitor in my office. It is a constant reminder of one of my most memorable evenings at an ASA Annual Meeting; but more importantly, it reminds me of the valor and the friendship of men and women who defend my right to write this column. It is one of my most cherished possessions.

– D.R.B.

Editor's Note: Like ASA itself, the NEWSLETTER continues to grow. Beginning with this issue, we’ve expanded the NEWSLETTER’s size and streamlined its look to accommodate both the inclusion of advertisements and increased editorial content. We hope you like the new look, and we hope that you enjoy each month’s issue as much as we enjoy bringing it to you.
On January 6, the 111th Congress was sworn in, even as a cloud hung over the Minnesota Senate race and a replacement for the open Illinois seat. Two weeks later, President-Elect Barack Obama was inaugurated, ushering in a new era in presidential politics and perhaps a modern day Camelot. At the same time, and despite the traditional honeymoon extended to all new presidents, grievous national and international problems continue to hold sway, testing the mettle of the newly enhanced Democratic majorities in both the House and Senate, as well as our new president.

Taking stock again of where we have been points to the urgent need to cement new and lasting relationships with our new national leaders. It now can be said openly that the recent Bush years saw no special regard for physicians and our issues. Despite years of good faith efforts by the American Medical Association, ASA and many others to convince the Centers for Medicare & Medicaid Services (CMS) to administratively fix the Medicare Sustainable Growth Rate (SGR) formula, there was no major reprieve until recent sustained efforts by Congressional Democrats through short-term legislative fixes. And now, the clock is ticking and the calendar is moving toward new Medicare cuts in 2010.

The fate of the economic stimulus bill is instructive and points to a world in which physicians must individually and collectively show new value for their work. That may sound harsh, but it is the emerging economic order in America. Few if any are likely to be paid more or the same unless added value is shown. A recent Congressional Budget Office (CBO) report tells us why by predicting a federal deficit of $1.2 trillion in fiscal year 2009, amounting to more than 8 percent of our U.S. GDP, not including the stimulus bill. As with other forecasters, CBO foresees a continued economic recession for 2009 and only a slow recovery beyond.

Regarding health care, CBO now estimates that spending on the three largest entitlement programs – Social Security, Medicare and Medicaid – will increase by a record rate of 8 percent in 2009. This extraordinary growth is attributed to the “relatively high rate of inflation recorded early in 2008, which boosted cost-of-living adjustments for retirees and the overall cost of health care,” particularly for Medicaid recipients. The writing is on the wall: The path ahead will be tough.

And back to the SGR, CBO has forecast that Medicare and Medicaid outlays over the next decade will grow 7 percent annually without SGR reform but be markedly higher if reform is enacted. Damned if you do, and damned if you don’t.

Bleak as this picture is, the drive toward universal access to health insurance availability, as well as Medicare reform, in the weeks and months ahead presents golden opportunities to tell the story of anesthesiologists as the lifeline of modern medicine, if we seize the initiative. All politics is local and personal, so please look for ways to invite your member of Congress to tour your hospital, ambulatory facility or pain practice. Showing and telling through education are indispensible parts of good lobbying and good government.

Please sign up now to become an ASA grassroots activist to learn more about how you can help yourself, your patients and the profession through direct and grassroots advocacy. The future of health care is being shaped rapidly by new and energetic forces in Washington and the states. You can only be a part of it by active involvement. For more information or to get involved, go to www.asahq.org/government.htm and click on “Grassroots.”
It was 1986 – I was fresh out of anesthesia training at George Washington University and a critical care fellowship at the Maryland Institute for Emergency Medical Services (“Shock-Trauma”). It was in my first year as a new staff consultant at the University of Colorado that I became interested in the Army Reserve. Before I knew it, I had put up my right hand and taken the oath of office. After working with several active-duty military people in Washington, D.C. during residency, I was giving anesthesia at Fitzsimmons Army Hospital in Denver. It gave me a wonderful chance to see some of the operations of military medicine. What stuck out in my mind was the extra effort that everyone in the military put out. It was a “brotherhood,” or one big family, a concept that we would look out for one another.

A year later, I had made a job change and was on the staff at the Cleveland Clinic. I had received orders for my first Army school of officers’ training and found myself on a bus at 5 a.m., en route to the field for training. There I met an individual with whom I became friends. He happened to be the chief anesthesia resident at the Mayo Clinic, and he commented to me that since I had critical care training, Alan D. Sessler, M.D., would like to talk to me. I couldn’t believe that I would be interviewing for a staff position at the Mayo Clinic (where my mother had been a patient in 1956) on the basis of a chance meeting on an Army Reserve field training exercise. Before I knew it, I was in Rochester, Minnesota, and was very impressed. While I stayed at Cleveland Clinic for 13 more years for personal reasons, the connection was one I kept and nurtured for years to come.

While in Cleveland, I served with the 256th Combat Support Hospital (“the 256th CASH”). I served there with other Cleveland Clinic personnel, in particular one of my own anesthesia residents. He and I became interested in flight medicine and sought orders for Fort Rucker, where the Army Aviation Center and School is located. While getting a flight physical at the 179th Air National Group medical squadron, I suddenly found myself surrounded by three Air Force physicians. Well, they told me all about jets, and I very quickly saw the benefit of a “Branch Transfer,” and soon I was wearing a blue uniform.

Subsequently, I attended the Aerospace Medicine course at Brooks Air Force Base in San Antonio, Texas, where I met and trained with several international physicians. Many shared my interest in critical care medicine. I later attended the Combat Casualty Care Course (“C4”) which focuses on field medicine, battlefield trauma and evacuation, and I was afforded the opportunity to fly in an F-16 in Oregon. Also, I experienced “simulation” training in aviation, which made for an easy transition with simulation trainers for critical care and anesthesia.

Through the years I served both in the Air National Guard, which is associated with individual states, as well as the Air Force Reserve, a nationwide asset. I was afforded travel, training opportunities and an experience that I would not have obtained in the civilian sector. I met people who were extremely dedicated, loyal, selfless and patriotic. One was the late Gerald Burger, M.D. (then a Captain, Medical Corps, U.S. Navy). While he is unfortunately no longer with us, his leadership serves as an example to which we should all aspire. Dr. Burger was a 1975 graduate of the U.S. Naval Academy as well as a chairman of the anesthesia department at Naval Hospital San Diego. I do miss him very dearly.

In 2000, I decided to move closer to my New Orleans roots and took a job offer at the Mayo Clinic in Jacksonville, Florida. There I worked for Michael J. Murray, M.D., as my chairman. Mike is a colonel in the U.S. Army Reserve and has served with ultimate distinction on many occasions. Due to this move, I transferred my service affiliation to the Florida Air National Guard (ANG), along with a former surgical colleague, Kirk Martin, M.D. Kirk is now retired from Mayo, having been recently promoted to brigadier general in the Florida ANG.

In 2006, I received an offer of an assignment to become an Individual Mobilization Augmentee at the anesthesia department of the Uniformed Services University of the Health

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Recently, a friend of mine asked me to provide the ASA general readership with a glimpse of life as a Navy anesthesiologist deployed during Operation Iraqi Freedom. My involvement in this war is long, extending from my time as Battalion Surgeon (General Medical Officer) of the 2nd Assault Amphibian Battalion, through residency, to my current deployment as a member of the surgical company attached to 1st Maintenance Battalion stationed in Al Taqaddum, Iraq. Although I have worked throughout the various echelons of care, I must point out that I am certainly not the most clinically experienced physician/anesthesiologist when it comes to battlefield treatment. Many of my fellow Navy and Army colleagues spent significant amounts of time and energy treating scores of acutely injured combat casualties.

The military has established a tried and proven framework of casualty evacuation based upon a concept of echelons of care, beginning with the most basic medical treatment all the way through complex tertiary care. Five levels of care have been designated for the evacuation chain. Upon being injured, a Marine or soldier renders “self aid” or receives “buddy aid” from a squadmate or a Navy hospital corpsman or an Army medic. Subsequently, the five echelons of care denote ever-increasing inherent medical/surgical capability. The Battalion Aid Station (BAS) is Level I, wherein basic non-surgical care is rendered. The BAS is responsible for maintaining the overall health and primary care of the personnel within its purview. During combat, the BAS staff focuses on stopping massive bleeding, splinting extremities, applying dressings and other necessary measures to permit rapid evacuation to the next level of care. In the Navy, Level II consists of two parts: a Shock Trauma Platoon (STP) and a Forward Resuscitative Surgical System (FRSS). The STP provides field emergency room capabilities for initial resuscitation of casualties, while the FRSS comprises the operating room capability and is the organization to which the anesthesiologist is attached. As the FRSS is where I currently serve, I will discuss it in greater detail below. Follow-on care then occurs in Level III facilities that are located within theater of operations, but which have capabilities for somewhat more complex subspecialty care (including neurosurgery and plastics) and ICU capability. After patients are stabilized, they are flown to Landstuhl, Germany, a Level IV facility that can provide most elements of tertiary care. The final step in the evacuation chain is to Level V facilities that include all of the tertiary care military facilities within the United States where the wounded may receive definitive care. Anesthesiologists work at all levels of care except Level I. However, as a General Medical Officer, that is where I began my time as a Navy physician.

Deploying for the first time ranks as one of the most emotionally and mentally taxing experiences in the military, especially when your first deployment corresponds with an invasion. As a young physician having just completed internship, I coped with the reality of life in the military in addition to knowing that we would soon be in Iraq. In attempting to prepare, I read several accounts of how physicians prepared and performed in other wars; however, these did not prove as useful as I had hoped. The best preparation actually involved maximizing the health and medical readiness of the Marines in my care. In this, I was assisted by a fantastic group of competent Marine officers and “Gung-Ho” Navy hospital corpsmen, whose efforts proved invaluable. Our hard work paid off, and we reaped the benefits of having well-trained and healthy troops during the invasion.

From the medical standpoint, the Marines were fairly fortunate as a reinforced division as we attacked from Kuwait to Baghdad, for the entire division of roughly 20,000 Marines sustained fewer than 100 killed in action. Our battalion of more than 1,200 sadly lost two Marines and sustained only a handful of direct battle injuries that varied from shrapnel to gunshot wounds. As a Battalion Surgeon, I ended up taking care of “disease and non-battle injuries,” or DNBIs, more than anything else. The injuries included primarily broken bones and lacerations — lots of them. At one point, our battalion also provided transport for approximately 60 enemy prisoners of war, and I was called upon to evaluate all of them and treat those with injuries. As I had no surgical capability, I was forced to splint a couple of simple fractures and dress the non-life-threatening injuries in these non-combat patients.
injuries to tide them over until we could have them evacuated to a hospital the next morning. In addition to a few various maladies that would trickle in throughout the week, we did have a period of about a week when almost our entire battalion suffered from a diarrheal illness, most likely attributed to Norwalk virus, which kept the BAS quite busy.

Between my two deployments, I had the privilege of completing the National Capital Consortium Anesthesiology Residency at National Naval Medical Center (NNMC) and Walter Reed Army Medical Center (WRAMC). My time at these two institutions coincided with the highest casualty rates of the war, leading to a high volume of wounded heroes at these centers. Given the advances in body armor, triage, evacuation and resuscitative care, many more of our troops have survived than would likely have in past conflicts, albeit with horrible injuries such as traumatic brain injury and amputations. Through O.R. work, critical care and pain control, the anesthesia departments at NNMC and WRAMC contributed significantly to every facet of definitive care.

After completing residency and achieving board certification, I volunteered to return to Iraq for another tour. And, as I mentioned, I became attached to Bravo Surgical Company of the 1st Maintenance Battalion. Our unit works out of Al Taqaddum, a forward-operating base almost due west of Baghdad between Fallujah and Ramadi. Our unit took over in September 2008 at this Level II facility. The good news is that the security situation has improved significantly, with the Iraqi police taking an ever-increasing role in providing for the safety of the Iraqi people. As a result of the improvements, the number of casualties has continued to diminish over the past year and a half. Despite this, combat injuries still occur occasionally. At our Level II facility in Al Taqaddum, our operating rooms are equipped with a portable version of the Narc-O-Med anesthesia machine, which has all of the functions found on a machine in an average operating room. While we generally use oxygen generators in the field to run ventilators, we also have the capability of using cylinders filled on site should there be a power failure. Thus, anesthesia in Al Taqaddum is essentially similar to a bare-bones community hospital. A more sparse type of Level II facility does exist – the mobile version. I am writing this article from just such a location far west of Baghdad.

Conducting anesthesia is a bit more challenging out here. I have included a picture of the operating room we have established. Fortunately, members of the local Navy construction battalion (the famous “Seabees”) were able to provide us with a rudimentary building replete with all the basics (that is, power and climate control). The mobile FRSS does not have an anesthesia machine, so we conduct general anesthesia in a couple of ways: via total intravenous anesthesia technique, and via a draw-over vaporizer attached in series with an impact ventilator. For monitoring, we use a Pro-Pack with

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end-tidal carbon dioxide capability and a separate portable gas and oxygen analyzer. This is useful when the patient either breathes spontaneously (no impact ventilator attached) or is paralyzed and the ventilator is utilized with the vaporizer. The only problem with both of these techniques is that the concentration of oxygen cannot be raised much above 21 percent, because only 4 liters per minute of oxygen may be added via a side port on the vaporizer. Thus, for patients with an oxygen requirement, this setup becomes inadequate. I have had excellent success with this setup for the several patients I have taken care of, save one who sustained gunshot wounds to the chest, abdomen and all extremities. In his case, it became necessary to switch him to 100 percent oxygen and use the impact ventilator without the vaporizer and switch to an intravenous technique. Overall, I have found it relatively easy to provide appropriate anesthetics in this environment, as have my colleagues who have been in similar situations on other mobile FRSS teams.

Having experienced all levels of the evacuation chain, from the battlefield BAS, the FRSS, the Level III facility in Baghdad, and Levels IV (Germany) and V (NNMC and WRAMC) during my residency training, I can attest to the fact that the system works well. As with any large organization, we are always trying to streamline and further maximize the care provided to the wounded. Over the six years of Operation Iraqi Freedom, we have significantly improved treatment of our wounded warriors from acute care through definitive care. As they have throughout their history, anesthesiologists have taken a leadership role in providing innovative care, whether through the delivery of anesthesia in the operating room, developing regional anesthesia acute pain services, or treating chronic pain via the pain clinics and chronic pain services within each of the medical centers. I thank all of my colleagues and teachers who have been marching every step of the way with me in this journey.
In the current conflicts in Iraq and Afghanistan, military anesthesiologists continue to be called upon to perform their duties under the harshest of conditions. They often find themselves taking care of complicated and challenging patients in a quick-paced, high-stress environment. Some of this care has been rendered under mass casualty conditions, with the ever-present threat of nuclear, biological and chemical (NBC) contamination. Such conditions are hardly unexpected for clinicians working in a war zone; however, civilian anesthesiologists have on occasion been forced into similar scenarios. Given modern terrorists’ interest in obtaining weapons of mass destruction (WMD), anesthesiologists are likely to face such threats in the future. In looking back at historical WMD and mass casualty situations, it is clear that proper preparation pays off. If this readiness is absent, not only will patient care not proceed in an effective and timely manner, but the health of the clinician and his or her family is also in jeopardy. With these concerns in mind, a team of anesthesiologists and NBC experts from the United States Army, Air Force and Navy conducted an afternoon workshop at the 2008 ASA Annual Meeting, teaching interested anesthesia providers the fundamentals of preparing for and safely practicing in an NBC or mass casualty event.

The necessity for civilian providers to function effectively in a contaminated environment is anything but new. In March 1995, terrorists from the fanatical religious group Aum Shinrikyo released containers of sarin gas into several subway cars during a morning commute in downtown Tokyo. In an instant, thousands of people were exposed to this deadly cholinesterase inhibitor. In the hours that followed, these victims flooded nearby hospitals. The majority of these victims bypassed the decontamination efforts of Japanese authorities. The result was emergency rooms overrun with contaminated patients met by physicians unprepared for an event of this magnitude. Consequently, signs and symptoms of the cholinergic syndrome developed in roughly half of the responding physicians. Moreover, almost 40 percent of providers in the intensive care units developed sarin toxicity. During the debriefings that would follow this historic event, it was found that lack of knowledge regarding personal protection resulted in the astoundingly high rates of secondary exposure. Likewise, workers taking care of the sickest patients in the intensive care units were particularly at risk.

NBC preparation can also pay dividends during a natural epidemic. During the 2004 epidemic of severe acute respiratory syndrome (SARS) in Toronto, anesthesiologists themselves were found to have contracted the disease. A retrospective review revealed that 9 percent of anesthesiologists who intubated SARS patients during the Toronto epidemic contracted the disease themselves. Sadly, one of those anesthesiologists succumbed to SARS. The Tokyo subway attack and Toronto SARS epidemic highlight the importance of planning and preparing for NBC events, epidemics and other mass casualty situations not only to protect the anesthesiologist, but also to preserve the ability of the anesthesiologist to work effectively in these situations.

Preparation for an NBC or mass casualty event occurs in three phases: knowledge of the specifics of the particular threats,
knowledge of the available personal protective measures, and knowledge of the overall disaster plan. Participants in the ASA workshop were introduced to each of these phases through lectures, interactive case scenarios, hands-on skills practice and a live “personal protection” fashion show.

Personal protection begins with standard precautions. The use of appropriate measures, sometimes as simple as gloves, gown, mask, eye protection and copious hand washing, are essential during an NBC event and can save lives. During an NBC event, personal protection may be escalated to so-called level A, level B and level C precautions. As the level of protection increases, barriers to respiratory and skin contamination become more sophisticated, heavier and interfere more with the functioning of the health professional. A simple familiarity with these levels of protection can significantly improve performance and survival during an NBC event.

Prompt identification of the pathogen can also drastically improve response to an NBC event. Once the pathogen is known, precaution levels can be appropriately set, and personal protection can be standardized. The treatment of a patient infected with pandemic flu is vastly different from the treatment of one exposed to chlorine gas. In order to safely care for the patient, the anesthesiologist must have at least cursory understanding of the most common threats to the population as a whole.

The civilian population continues to be threatened by the use of WMD. In December 2008, a finding by the Congressional Commission on the Prevention of Weapons of Mass Destruction, Proliferation, and Terrorism emphasized the continuing threat of WMD to the safety of the world. According to the report’s executive summary, “it is more likely than not that a weapon of mass destruction will be used in a terrorist attack somewhere in the world by the end of 2013.” Furthermore, the committee surmised that a future attack would likely be through the use of a biologic weapon. Attendees of the ASA workshop discussed the specific biologic and chemical weapons likely to be used and learned not only how to treat patients affected by these agents, but how and when to treat themselves.

Finally, the workshop emphasized the role of the individual anesthesiologist in the overall disaster plan. Participants learned from military anesthesiologists who had actual experience in mass casualty and natural disaster response. During any disaster, anesthesiologists are an essential part of a hospital’s response plan; however, it can be extremely difficult for clinicians to function effectively in these situations when the safety of their families is in doubt. Therefore, having and using a family disaster plan is just as important as knowing the hospital’s disaster plan.

Significant time is spent during anesthesiology residencies teaching future clinicians to recognize and respond to the most infrequently occurring clinical situations. Most anesthetics are conducted safely and without complication, though we are taught to vigilantly monitor for the “zebras,” as such knowledge may someday save a patient’s life. For instance, while malignant hyperthermia has an extremely low incidence, residents will often receive hours of lecture and discussion on the topic. Conversely, anesthesiologists, especially those practicing in large urban areas, may be just as likely to encounter a WMD or mass casualty event, though virtually no time is devoted to such topics during residency. A relatively small amount of knowledge on NBC threats as well as personal protection during mass casualty events can significantly improve the safety and efficacy of the practicing anesthesiologist.

We invite any interested clinician to attend our next workshop this year in New Orleans! Practice safe, stay alive!

References:
Having returned recently from a year-long deployment to Afghanistan as a member of a U.S. Air Force medical Embedded Training Team (ETT), I was asked to write something about my experiences there. This was my third deployment as an Air Force anesthesiologist, having previously spent five months in Iraq on a Mobile Forward Surgical Team and five months flying on a Critical Care Air Transport Team out of Afghanistan. However, this most recent deployment was very unique, both because of its duration and its mission. Our team’s job was essentially to educate, train and mentor Afghan National Army (ANA) medical personnel, working side by side with them each day at an ANA regional hospital in eastern Afghanistan. When I sat down to write this article for inclusion in the ASA NEWSLETTER, I truly didn’t know where to begin. So, I thought the best way might be to allow ASA readers to read a letter I had written to my family after one of my days there. The letter (slightly edited for publication) is as follows:

Well, after a day like yesterday, I feel compelled to update everyone on Shane’s vacation at the beautiful luxury resort in Gardez, Afghanistan.

O.K., so the day started like most others … I woke up via my watch “alarm clock” (not too loud to wake up the neighbors in my B-hut, but loud enough to end my dreaming). I moseyed over to the showers … took my shower, shaved, and walked back to my hut to change into my uniform and start my day. I mixed my protein shake for my walk to the hospital and the subsequent never-ending morning meeting with the ANA hospital staff. A little side note here … the Afghans handle their hospital leadership and administration much differently than what I am accustomed to back in the States. Instead of having a small group of key hospital personnel who meet periodically with the hospital commander to bring up issues and then disseminate information to the rest of the hospital staff, the Afghans have a huge meeting each morning with almost all of the hospital staff. So, it usually turns into a huge cluster of what I like to call the “never-ending complaining session.”

Anyway, this morning the meeting was unusually short, and there were amazingly few complaints or gripes. The main reason was that this day was a Thursday (the day immediately before the Muslim holy day of the week called Juma’h, which is our Friday). Since almost all of the hospital staff live in Kabul, and go home for Juma’h, Thursday morning here is like our Friday afternoon in the States. People are “high-tailing” it home … and since there really aren’t any set work hours, they don’t have to be “clock watchers” like back home. They pretty much leave whenever they want, which is usually about 10 a.m. or so on a Thursday, especially since this was the beginning of their New Year (they go by a different Muslim calendar – it’s now the year 1387 by their calendar).

As the hospital was minimally staffed, and it was a Thursday, I didn’t have any mentees to mentor. So, Dr. F. (an Emergency Medicine physician – the only other physician on our team), Col. D. (our team’s commander, a Medical Sciences Officer) and I toured some of the new construction occurring in our area. That took the better part of the morning, which brought us to lunch.

We were just settling down for a nice quiet lunch on a nice quiet Thursday afternoon, when Sgt. H. runs into the Dining Facility with a horrified look on his face. Never one to waste words, Sgt. H. came directly to our table and said: “I need one of you to come with me NOW” – more of a statement than a request.

Dr. F. and I followed Sgt. H. over to the ANA hospital E.R., and here’s the story (in present tense because that makes for better storytelling):

We learn that an ANA soldier’s 18-month-old daughter had swallowed something at some point. No one has any idea what was swallowed or when. O.K., so let’s see the child. Her name is Naziah. It is immediately apparent that Naziah only attempted to swallow something, because she is horribly stridorous. She is lethargic, inconsolable, and in acute respiratory distress. She appears younger than stated age. She is using all of her accessory muscles of respiration, and is displaying huge sternal retractions, subcostal retractions, nasal flaring, and she is tachypneic. The one ANA “doc” in the hospital has a 7.0 ETT in his hand and a very frightened look...

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Michael Shane Garrett, M.D., is an anesthesiologist at David Grant Medical Center, Travis Air Force Base, California.
on his face. (For those non-medical folks who may be reading this, the size of the endotracheal tube in the ANA doc’s hand is significantly too large for this child – not even close really, but at least there was some recognition of impending loss of airway.)

We rush Naziah to our radiology department for a CXR (chest X-ray). We can usually get plain radiographs if we cross our fingers and sacrifice a live chicken. Someone must have been praying the rosary, because even though our machine was “broken,” we got a clear picture of a circular, radiopaque object somewhere in the child’s proximal esophagus.

So now all we have to do is page the ENT surgeon on call and prep the child for a trip to the O.R. Oh, wait … we’re in a hospital in the middle of Afghanistan. There are no ENT surgeons … there aren’t ANY surgeons. Dr. F. and I look at each other with the same knowing look … this is a really BAD situation.

There are few situations in medicine which demand truly immediate action, lest the patient suffer a horrendous outcome. A small child with a compromised airway is the worst of these scenarios that I can imagine. The child really looked like she was on death’s door, and Dr. F. and I both knew (without a word being exchanged) that we couldn’t just transfer her to another hospital. She likely would lose her airway before reaching a hospital with an ENT surgeon.

As I’m the anesthesiologist (read “airway expert”), all eyes are on me. But there are different looks in these eyes. The Afghan medical personnel have looks that say “please do something.” The U.S. medical personnel have looks that say “how can I help?” I can’t put into words how tremendously helpful these varied and different Americans, all from different parts of the U.S., all with very different personalities, would be over the next several hours. The word “teamwork” seems woefully inadequate to describe how perfectly all of these people acted. I have not in my lifetime yet encountered a situation like this, where so much was communicated so perfectly with so few words. There was undoubtedly an angel present among us on this day, in this small operating room, in this most remote village of Afghanistan.

We carry Naziah to the operating room, and lay her on the table. The anesthesia machine (not FDA-approved in the U.S.!) has an adult circuit and mask, and I turn to request a pediatric mask and airway equipment, when I see my anesthesia cart being wheeled into the room with pediatric stuff on top of it. I search for an appropriately sized ETT and laryngoscope, but as I feared, I cannot find a tube small enough.

This ANA hospital is woefully inadequately supplied in many respects, but especially when it comes to pediatric supplies. “The powers that be” didn’t consider pediatric patients when they were considering supplies for a hospital designed to care for ANA soldiers wounded in battle. These ANA soldiers have families … usually large families with many children.

I remember that my predecessor had made a trip to Air Base B during his deployment here, and that he had brought back some supplies that we didn’t have. Sure enough, Dr. F. finds two 3.5 mm ETTs, but I don’t have a stylet small enough to fit inside the internal diameter of the tube. Dr. F. disappears and returns with something that works. (I still have no idea exactly what this flexible rod was, nor where he got it. But I’m sure that it wasn’t originally designed for this purpose.) We don’t have any other sizes, except for a 5.0 – too big.

We get a 22-gauge peripheral I.V. in her hand, and I push 50 mcg of atropine I.V. I draw up a syringe of ketamine and another of decadron. I find a vial of vecuronium and draw that up, too. I dilute out a 1 mg vial of epinephrine into two 10 cc syringes. One is 100 mcg/cc epinephrine, and another is 10 mcg/cc epinephrine. My drug choices are limited by cost and local availability. I find a MAC 2 laryngoscope blade that works, and I send someone to get a dental suction tip from the dental clinic.

When all is assembled, I push 30 mg of ketamine, and I watch Naziah drift off into anesthesia land. She maintains spontaneous respiration, which I support with small positive pressure breaths timed to her own breathing efforts. I turn on the isoflurane vaporizer (another gift from my predecessor – only other choice was a broken halothane vaporizer). When I think the patient is adequately anesthetized, I perform direct laryngoscopy and see black soot and saliva in her
posterior oropharynx. I suction the saliva out and can tell that her glottic anatomy is distorted by soft tissue edema. I can barely make out the tip of a metallic object in her proximal esophagus, which I remove with Magill forceps. It’s one of those circular batteries – like a watch battery maybe 2 cm in diameter, and the black soot is burned/damaged tissue from the alkaline battery.

When I remove the battery from her throat, the Afghans seem elated. They are very relieved and congratulatory. I, however, am not relieved. I think that my time with this young girl is only beginning.

I think that this child has an esophageal electrical burn, and I think that her airway will likely get worse before it gets better. I give her 2 mg of decadron I.V., and I let her emerge from her anesthetic to see how she does. As I suspected, she does poorly. She’s breathing much as she did before the procedure – stridorous, with substernal retractions. I watch her for a short while to see if she shows any signs of improvement, but alas, she does not. I realize that she will need to be intubated and flown to an ENT surgeon.

Dr. F. preps her neck with betadine and finds a scalpel. This is our alternative airway plan – two non-surgeons trying to perform an emergent surgical airway on an 18-month-old girl. We both know that we had better not get to that point. I pre-oxygenate her as best as I can and give her more ketamine I.V. I turn the isoflurane back on and deepen the child’s anesthetic. I watch for a short while to see if she shows any signs of improvement, but alas, she does not. I realize that she will need to be intubated and flown to an ENT surgeon.

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Dr. F. preps her neck with betadine and finds a scalpel. This is our alternative airway plan – two non-surgeons trying to perform an emergent surgical airway on an 18-month-old girl. We both know that we had better not get to that point. I pre-oxygenate her as best as I can and give her more ketamine I.V. I turn the isoflurane back on and deepen the child’s anesthetic. In my head, I debate whether or not to push succinylcholine. I decide not to. I look and see swollen, posterior arytenoid cartilage. I aim anteriorly with the 3.5mm ETT, never see vocal cords, but feel the tube pass. I remove the stylet, connect the tube to the circuit and begin to bag her. She desaturates into the 80s. I do not have a gas analyzer nor a disposable CO₂ detector. So, exhaled carbon dioxide is not an option for confirming endotracheal intubation.

I wait, and continue to bag her … she desaturates into the 70s. I cannot appreciate chest wall movement nor breath sounds. There are two possibilities … esophageal intubation, or severe bronchospasm from intubating a lightly anesthetized child. I bet on the latter, and keep the tube in place. I turn the isoflurane up and push 10 mcg of epinephrine I.V. She improves in seconds and is quickly saturating 100 percent. I wonder briefly what would have happened to the child had I removed the appropriately positioned ETT and attempted reintubation.

Once I am confident in the tube’s location within the trachea, I push 1 mg of vecuronium I.V. Jerry H. (an excellent old-school O.R. nurse who has seen more surgeries and anesthesiologists than all of the others in the room combined) brings a ventilator from the ICU and connects it to an oxygen H cylinder. We transfer the child to the ventilator, and she does well. Jerry brings in a NATO litter on a transfer stretcher with thermal blankets and a transport monitor.

Dr. F. is already working on a plan to get the patient transferred to Air Base B. Our communication systems are VERY limited. He is using the most reliable system we have – a cellular phone operating on an Iranian-owned and operated cellular system (you can’t make this stuff up, folks). Dr. F. speaks to an ENT surgeon at Air Base B who accepts the girl and has a plan for minimizing the chances of esophageal stricture.

I sedate Naziah with I.V. morphine, benadryl and ketamine and prepare her for transport via UH-60 Blackhawk. We bundle her up (cold in the helicopter), find a small oxygen tank with oxygen in it (more difficult than it might sound), and Dr. F. locates the only pediatric ambu bag we have in the entire hospital. Then, we wait. We explain to Naziah’s father
everything that happened, and tell him he may accompany her to Air Base B. He seems VERY appreciative of all that we are doing and repeats (via translator) “Thank you” over and over.

There is talk that maybe the helicopter isn’t coming, because the AH-64 Apache attack helicopters are busy supporting “troops in contact” (a Blackhawk doesn’t fly without a gunship to fly cover, and the Apaches are in high-demand recently). Finally, word arrives that the UH-60 is 15 minutes out. We transfer Naziah from the ventilator to the ambu bag and make sure she is stable. Her oxygen saturation remains 100 percent.

We load Naziah onto the back of a Ford Ranger (diesel version here in Afghanistan – no emissions rules), and we pull out for the helipad. The Afghan driver thinks he is Jimmie Johnson in the Chase for the Cup (I’ll have to remember to kindly explain to him later how fast speeds and speed bumps don’t combine well in a safe patient transfer). We pull up exactly as the Blackhawk lands. It is a seamless transfer of the patient to the Blackhawk, and I have a brief flashback from Iraq. I’ve been here before.

It is a brief helicopter ride to … wait for it … Forward Operating Base (FOB) S. “What?” you say… “Didn’t you say that the patient was headed for Air Base B?” Yep. A colonel in a location remote from all of this decided at the last minute to change our destination, without telling us. There are no ENT surgeons at FOB S.

Oh well, I watched the child most of that night, until she flew out to Air Base B early the next morning. I’m currently sitting at an Army 1st Sgt’s desk, using his computer to type this letter. Fortunately, I know several of the medical personnel here, from various points in my military career, and they’re taking good care of me. It’s a very small world.

I’ll follow up on how the child’s doing in a few days when we call Air Base B.

I don’t think the Taliban have much of a chance of recruiting this little girl’s father to their cause … nor any of his family … nor anyone he speaks to about Americans.

This concludes the letter I wrote many months ago. I have other stories, but this article has gone on long enough. As it turns out, I saw Naziah several months later at Air Base B during her recovery. She had undergone multiple trips to the O.R. for tracheal reconstruction and treatment of a T-E fistula. She was breathing room air via a tracheostomy and was standing up in a pediatric ICU crib. She appeared slightly Cushingoid from the corticosteroids she was taking. What I remember most was that Naziah had the biggest smile on her face I had ever seen. The ICU nurses who had been caring for her all these months said she was one of the happiest children they had ever known – always with a smile on her face.
The combined SAUSHEC anesthesiology program was started in the same year as the initiation of SAUSHEC itself and was fully accredited by the Accreditation Council for Graduate Medical Education in 2000. Although we initially started with 31 residents, it has since grown to a total of 42. Since the SAUSHEC program is the sole military training program for the Air Force (the Army has a second program at Walter Reed Army Medical Center in Washington, D.C.), the class makeup is weighted toward the Air Force (eight Air Force and six Army residents per class). The principle goal of our program is to create highly skilled military anesthesiologists who support the needs of the active-duty members and their dependents and retirees at bases around the world.

**Current Program Overview**

Because of the need for its graduates to be able to deploy worldwide to conflict zones, the program has emphasized certain areas, in particular: trauma, burn and regional anesthesia. For the most part, residents follow a traditional set of annual rotations based upon 13 blocks of four-week duration. After their clinical base year, the clinical anesthesia years expose the residents to patients with increasing levels of severity of illness, complexity of surgery and risk. The CA-1 year is an overview of anesthetic practice. In this year, basic knowledge and anesthetic skills are learned on lower-risk patients (many ambulatory) undergoing relatively simple procedures. General
O.R. is the dominant rotation of the year (a minimum of eight rotations) with complementary experience being gained in the ICU, the pain clinic, obstetrics, the postanesthesia care unit, the preoperative evaluation clinic and the burn unit.

Like that of most anesthesia residencies, the CA-2 year provides residents with the cases to hone their skills in subspecialty areas of anesthesia, particularly in cardiothoracic, critical care, neurosurgical, vascular, pediatric, obstetric and regional. In order to provide our residents with a comprehensive experience, away rotations at leading hospitals throughout Texas are offered in some of these subspecialty areas. This exposes residents to different practice patterns and gives them experience in quickly adapting to varying work environments – an invaluable skill that will serve them well throughout their military (and civilian) careers.

In the CA-3 year, our program offers flexibility regarding the resident’s career goals, with either an advanced clinical track or a clinical scientist/research track. During this final year, residents are exposed to seriously ill patients undergoing complex procedures requiring advanced anesthesia skills. Additionally, the CA-3 curriculum includes one month of advanced regional and acute pain management, one month of TEE training in conjunction with cardiothoracic anesthesia, advanced neuroanesthesia, vascular anesthesia, and dedicated time for research, if desired. As the capstone of their anesthesia training, residents must complete an approved academic or research assignment during the CA-3 year.

Although the program’s overall curriculum is traditional in its components, residents are also exposed throughout their training to an ongoing military-unique training curriculum that familiarizes them with the equipment and medicine they will practice in deployed settings. Additionally, many of the residents participate in humanitarian missions in a variety of austere environments in countries such as Honduras, Guatemala, Chile, El Salvador, Ecuador and Paraguay. These missions are invaluable in giving our residents experience in facing the challenges imposed by these environments and in preparing them for their future as military anesthesiologists.

Challenges and Initiatives

In preparing our future military consultants, our program has faced challenges that are common to military training programs in general as well as those specific to anesthesia. These tests have been the driving forces in the development of several unique approaches and strategies. As an example, at the forefront of our latest group of initiatives has been the implementation of education days – an entire day every two weeks devoted to resident didactics.

As we move toward full integration of Wilford Hall Medical Center and Brooke Army Medical Center, the initiation of construction at both facilities has created logistical impediments that make traditional morning conferences difficult within the constraints of resident work-hour limits. Furthermore, as the curriculum between both parent institutions has become unified over the past few years, we noticed obvious redundancies and have taken strides to improve efficiency. Additionally, our residents who are not on away rotations are split between the two institutions and therefore rarely interact with one another within a particular month. To address these concerns, we developed the education day. Although the intent is to have all residents at BAMC and WHMC participate, we permit residents in their advanced clinical blocks the latitude to manage index cases in lieu of their education day.
Each education day starts with a morbidity and mortality conference or a traditional case presentation with the faculty. We then break up into four groups and rotate through faculty-led interactive sessions (either problem-based learning, mock oral boards, simulation scenarios, or hands-on equipment and procedure laboratories). After a short lunch break, there is another lecture, followed by a chief resident conference and feedback session. Each day is centered on one of about 20 thematic areas that compose the foundation of our curriculum.

One of the many advantages of this system has been the ability to objectively and uniformly assess each resident within peer-groups, particularly within the CA-2 and CA-3 year groups, as they are often selected at random to assist the faculty in leading the small groups. Thankfully, faculty and staff support has been tremendous at both institutions.

The Future of the Program

As we look to the future, we are planning to expand upon the unique military aspects of our curriculum by establishing an elective rotation at Landstuhl, Germany, where our residents will experience the early management of casualties evacuated from Iraq or Afghanistan. In addition, although simulation is already a strong part of our curriculum, we are looking at innovative ways to use this extremely valuable resource and expand its role in our program. Finally, as we continue to increase our level of integration, which will culminate in the full realization of the San Antonio Military Medical Center (SAMMC), our program is at an advantage in that we have already been combined for more than a decade. According to current plans, our physical location will eventually be centered at BAMC, which will be known as SAMMC North. However, the spirit and heart of our program exist independently of our physical location – the dedicated faculty that take it upon themselves to educate our future military anesthesiologists. We are extremely grateful to them for all that they do.
This is my story – a story rather than an article, because I have foregone the strictly academic or educational. There are many vital issues relating to military medical missions: the diplomatic importance of humanitarian aid to politically volatile countries; the necessity of careful patient selection given our limited resources, time and follow-up capability; and the value of medical success in positively impacting host nation public opinion. Undoubtedly, these crucial themes color my narrative. In particular, it is worth noting that successful surgical outcomes are instrumental to the Navy’s mission and that anesthesiologists play an integral role in achieving that success.

As background, the U.S. Naval Ship (USNS) Comfort is a floating hospital that has been in operation since 1987. She has capacity to accommodate more than 900 staff and 1,000 hospital beds and has been called to duty many times over the years for missions ranging from the Middle East to Hurricane Katrina relief efforts. From June through October 2007, the Comfort circumnavigated Central and South America as part of President Bush’s “Partnership for the Americas” initiative, aiming to promote “democracy and social justice” in the Western Hemisphere. I was one of the anesthesiologists assigned to this recent endeavor, in which we brought free medical care to underserved populations throughout Central and South America and the Caribbean, including Belize, Guatemala, Panama, Nicaragua, El Salvador, Peru, Ecuador, Colombia, Haiti, Trinidad, Guyana and Suriname. The mission not only provided valuable training to our military personnel, but promoted U.S. good will throughout the region in the form of roughly 98,000 patients treated and 1,100 surgeries performed.

This is the tale of my experiences during four months aboard the USNS Comfort. It is largely adapted from journals I kept to record my adventures as a relatively junior Navy medical officer on her first deployment.

June 16th – Atlantic Ocean

We have been at sea for several days now. As we departed Portsmouth, Virginia, we manned the rails in our summer whites, and the Navy band played “Anchors Away,” which created, I imagine, quite an impressive sight. A Russian carrier arrived as we were leaving so we looked across to their sailors with curiosity. Some of us waved, and eventually they waved back.

As this is my first deployment aboard ship, I noted several differences from conventional cruise ships, my only at-sea experience to this point. To begin with, the Comfort rolls considerably, as it was converted from an oil tanker and has no stabilizers. I am used to the constant motion now and have not been sea sick. Late last night, our two HC-60 helicopters arrived, practically filling the flight deck, even with their tails
and wings folded down. Walking on the flight deck at night can be daunting because there are no guard rails – just a small net around the edge. Really, the most remarkable feature when stepping outside is how incredibly dark it is. Unlike a passenger ship, we are not illuminated on the exterior when we are underway; however, the sky was illuminated magnificently with stars and planets, as there was almost no ambient light to obscure the view. The spiral arc of the Milky Way folded from one edge of the horizon to the other like an evening rainbow. Walking the weather decks was somewhat intimidating until my eyes adjusted to the conditions. There would be slim chance of being seen or heard if one fell overboard, especially at night. The few lights visible included a number of portholes and, surprisingly, glow sticks attached to the security vests of force protection personnel manning machine guns around the perimeter of the ship.

I made my way to the stern, watching the wake flow out behind us, and tried to identify familiar constellations. It was so peaceful, with a slight breeze and relative silence, as the only noise comes from the ship’s engines far below deck. It was a welcome break from the crowded conditions inside, where 900 people are preparing for our mission. I could see shipmates sitting on the decks in singles, twos and threes, talking quietly or smoking cigarettes.

Of course, another notable feature of life aboard the Comfort is adjusting to the living quarters. My own consists of a small room with four sets of bunk beds, a double sink, a small table and walls lined with lockers. There are about 30 such rooms, some with only three people, others packed with eight (like us). Luckily, no one in our room snores. Down the hall are toilets and showers, all of which make up Female Officer Berthing. I accidentally went to the enlisted quarters once, and though I thought the officers’ berthing was crowded, I saw that the enlisted sailors are really packed in. The crew aboard includes members of the U.S. Navy, Air Force, Public Health Service and Air National Guard as well as Canadian forces and civilians from non-governmental organizations such as Operation Smile and Project Hope.

We are well prepared to start work in our first country, Belize. All the O.R.s, equipment, supplies and pharmaceuticals have been checked over and appropriately stocked. Security briefed us regarding safety in-country, and we were issued MREs, water, ponchos, insect repellant and anti-malarial tablets. The helicopters brought in the last of the supplies during their evening maneuvers. The weather is hot, and it seems that everything is permeated with humidity and expectation at the moment. I think we are restless to begin.

June 30th – Guatemala

The weather has been stormy, limiting boat runs significantly. It must be hard for our patients to endure an hour-long boat ride back through rough seas after having surgery one to two days beforehand. The patients arrive by boat or helicopter, depending on the prevailing weather. So far, I have cared for children needing skin grafts for burns, or repairs of strabismus, inguinal hernias, cleft palates and club foot. All of these families come from sugar cane farmlands about two hours into the interior of the country. They seem overwhelmed but fascinated and evince curiosity, appreciation and obvious awe to be aboard the ship. I think they are so brave and trusting to travel the white-capped waves to this unknown ship in the hope of medical care. One patient with strabismus came from a local orphanage and his escort told me that as they arrived pre-dawn through the choppy

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waters, our enormous white vessel materialized through the fog like a beacon, which thrilled the boy to no end (although the escort admitted she felt extremely sea sick).

Overall, the children I meet are clean and well fed, with proper-fitting clothes and shoes. They are noticeably stoic and often thankful for the care they are receiving. I really enjoy spending time with these children and their families, especially when feeling homesick myself, but it breaks my heart to witness the poverty in which they live. The children especially love the toys we hand out – donations from our own families and friends back home. There was a fascinating group of mountain inhabitants here recently who learned of our visit on the radio and traveled for several days to reach the on-shore clinic. Most of them only spoke the Mayan dialect, Quichean. These Mayan descendents are unfamiliar with such concepts as water fountains, medications or door handles, but are gracious and inquisitive about our American medical ideas.

**July 4th – Panama**

It was swelteringly hot today as we set up dockside clinics in Colon. It is a nice change from being anchored off the coast. One of the local ladies laughed at our discomfort, saying, “It is winter here – you must be from the North.” I tried to explain in faltering Spanish that it was the humidity that was so bothersome, but she remained amused by our admittedly ill-suited long sleeve khakis and steel-toed boots.

Many of the supplies we desperately needed arrived, as did the mail. It is hard to capture in words the importance of mail call on a ship where telephone and Internet connections can be unreliable. The galley served steak and lobster, in recognition of Independence Day, and later someone figured out how to order Pizza Hut, so 30 boxes arrived for a late night snack. I hope no one gets sick! We are at 100-percent capacity in the operating room, and apparently equally busy ashore, judging from the weary and dusty-looking doctors, dentists and nurses who return to the ship every evening. After completing this mission, we will transit the Panama Canal toward our Western ports of call.

**July 22nd – Nicaragua**

I had the best case today! My patient was a gorgeous 9-month-old Nicaraguan boy with club feet. His mother was young, sweet and really smart, asking very astute questions about the procedure. The case went smoothly, and when I brought his mother to see him in recovery, she was crying with relief. She gave me a big hug and said how grateful she was for her son’s care. It was a moving scene, and I was happy to be part of it.

**August 6th – Pacific Ocean**

We left El Salvador and crossed the equator on our way to Peru. In keeping with Navy tradition, the entire crew participated in a “Crossing the Line” ceremony, wherein novice “pollywogs” that have never crossed the equator are initiated into the “Kingdom of Neptune” as “shellbacks.” It was a freezing ordeal of cold water and slime, but good fun all the same, and capped off with a hot shower and warm meal.
The weather has changed considerably since crossing the equator. It is actually quite cool with a hazy, lingering fog. We go ashore tomorrow, but the waves look pretty uncooperative at the moment, which may necessitate a chaotic undertaking of multiple helicopter runs in bad weather. Walking the decks last night, I saw the lights of Salaverry, Peru, glittering through the fog. The wind had died down, leaving the security forces only mildly chilled. The coastline is approximately three miles away and looks extremely eerie. Desert flatlands portray a sandy lunar landscape, and a few scattered structures form what appears to be an alien settlement on a hostile planet. On one grey hill is an enormous cemetery marked with giant steel crosses, a testament to generations of hard living, I suspect. Spreading out from land is a similarly grey ocean. Not too enticing so far!

I can’t believe how much the dismal weather affects my mood. Into the uniform again: khakis, boots, hair pinned up. I am starting to really miss looking like a girl. At the moment there is little do and even less external stimulation as we sail to the next stop. I am starting to grow weary of everything about the ship on general principle – perhaps the novelty is wearing off. These must be the doldrums that Coleridge wrote about. In boredom, I noted that, yes, the toilets do flush in the opposite direction.

**September 5th – Colombia**

Colombia is a dangerous and compelling country. We came ashore via a long helicopter ride across dense green jungles flocked with white herons and winding streams. It was beautiful, yet somehow reminiscent of “Apocalypse Now.” When we arrived at the HLZ (Helicopter Landing Zone) we were greeted with guarded looks and heavily armed soldiers – quite different from the usual smiling, welcoming throngs. We rode to the health center in darkened vans under armed escort, stopping at sentry checkpoints every 50 feet along the way. However, we were warmly greeted by the town’s mayor when we arrived, and caution slowly gave way to camaraderie as we mingled with the local personnel. The outlying hills are infested by guerrillas and drug runners, and I learned that Colombia has extensive international forces stationed in-country to help fight drug trafficking. At the nearby submarine base, thousands of outboard engines litter the water, confiscated from drug-running fast boats. We have treated numerous patients and completed 40 surgical cases to date, yet I doubt we saw even a fraction of those who waited in line, resilient against the rain and lightning.

**October 6th – Suriname**

We moved on to Guyana, to our furthest anchorage yet, 13 miles from shore. Georgetown, Guyana, is a lovely place, tropical as you might imagine from a Garcia Marquez novel. It sits slightly below sea level, with canal-lined streets that channel water to crop fields. Homes are built on stilts some few feet above ground, and amidst all the water grow ridiculously large water lilies and hibiscus, fed on – in turn – by ridiculously brilliant exotic birds. The children walk along the banks in brightly colored European-style school uniforms, and herds of cattle roam the drier fields, fat on the abundant greenery. We completed 26 surgical cases over the past four days, ranging from orthopedic corrections of syndactyly and contractures, to hernias, cholecystectomies, and a posterior chest wall mass resection in a 1-month old.

Now we are in Suriname, the last country of this deployment. It is strange to be able to say that – looking at our itinerary some months ago, Suriname seemed a distant port indeed – and yet we are here and finished. We completed the last O.R. day today and are closing up shop with thoughts of steaming home. Or perhaps I should say limping home, as the cafeteria is running out of food, the washers are mostly broken and the shop has no more shampoo. No matter – we will be back home in 10 days, and I am content after an amazing four-month journey.
Saildier isn’t a real word (it’s the combination of the Navy’s “sailor” and the Army’s “soldier”), but it’s one I’ve heard a lot lately; it strikes a familiar chord and even starts to sound correct with each passing day. As a graduate of the Anesthesiology Residency Program of the National Capital Consortium (NCC), a combined Army/Navy program with core training at Walter Reed Army Medical Center and National Naval Medical Center, Bethesda, I’m familiar with both military cultures.

I first heard the term “saildier” in October 2008 when I returned to the United States from Okinawa, Japan, where I’m currently stationed at the Naval Hospital as a staff anesthesiologist and director of the Interventional Pain Clinic. I came back for training in preparation for my current deployment in Djibouti, a small country at the “Horn” of Africa on its central east coast just north of Somalia and east of Ethiopia. Other neighbors include Eritrea, Yemen, Saudi Arabia and, further afield, Kuwait, Iraq and Afghanistan. Djibouti is touted as one of the hottest continuously inhabited places on earth. Fortunately, I’m here in the “winter.” I’m deployed as an anesthesiologist with a general surgeon, a CRNA, an E.R. physician, a pulmonologist/critical care specialist, an internist, a PA, and several nurses and corpsmen as the rest of my Navy team. Our primary mission is the successful execution of resuscitation and stabilization in a mass casualty situation; several secondary missions include routine daily sick call and preventive medicine for the active-duty service members on our camp, instructing camp members in basic life support, and providing medical coverage for weapons ranges and missions outside the camp. All four services are represented here, and I work and live side by side with predominantly non-medical counterparts from other uniformed services from the U.S. and coalition forces.

Though I’ve been an active-duty sailor since 1998, I became a saildier in October during the third phase of pre-deployment training. The first phase started roughly six weeks earlier in Okinawa and consisted predominantly of ensuring my own medical and dental readiness, as well as online courses and certificates in topics such as personnel recovery, hot and cold weather injury prevention, operational security and antiterrorism force protection. The second phase took place in San Diego, the location of one of several Naval Mobilization Processing Stations for desert camouflage uniform and some field gear distribution and further medical screening (I received smallpox and anthrax vaccinations). The third and final part occurred on Camp McCrady at Fort Jackson, South Carolina, the U.S. Army’s largest and most active Initial Entry Training Center for Army recruits, and for the past several years, the site for NIACT – Navy Individual Augmentee Combat Training. More than 11,000 sailors have graduated this training at Fort McCrady since its inception.
Jackson. Approximately 60 percent of those Navy members with “boots on the ground” in support of the war on terrorism are Individual Augmentees (IA), meaning we come to the theater of operations as individuals pulled from several commands rather than entire units deploying together. Many of the estimated 15,000 sailors currently in theater serve with Army units “downrange,” and the premise is that standardized training, instructions and gear issue are beneficial for the ultimate mission success. In essence, NIACIT is training for Navy sailors by Army drill instructors on an Army fort. The Navy pays the Army to train its sailors, and we become (somewhat tongue in cheek) “saildiers.” At least that’s the theory behind the T-shirts sold at the shoppette at McCrady.

In nearly three weeks, our medical platoon was trained by the Cadre of the U.S. Army 1/518th. This was the first time the group of people intended for deployment at the Expeditionary Medical Facility Djibouti trained together and began integration at this phase of the deployment process. We trained in Weapons Topics (M16 service rifle, M9 service pistol and heavy machine guns), Land Navigation, Communications, Basic Combat Skills (including detainee search and handling; identification of, reaction to and reporting of Improvised Explosive Devices and unexploded ordinance; and Highly Mobile Multi-Wheeled Vehicle driver and rollover egress training), General Military Training (including combat operational stress control, rules of engagement, Geneva Conventions and cultural awareness) and even some basic first-aid topics. Much of the time we trained wearing the full battle load, weighing nearly 65 pounds and consisting of helmet, flak jacket with armor plates and various accoutrements. We were also responsible for our issued M16 service rifle at all times. Although I had worn older flak and Kevlar on prior deployments and field training exercises, I am amazed by the newer gear today’s war fighters use. I see first-hand how the body armor protects the vital organs and appreciate the role it plays in the higher survival rates of the wounded service member in this war compared to previous conflicts. I’m also quite thankful that in Djibouti’s heat, I don’t wear that extra 65 pounds to work every day in the operating room! We trained side by side with Navy personnel assigned to other platoons destined for missions in Iraq, Afghanistan and Kuwait, and in many instances they are wearing the body armor on a daily basis.

As mentioned previously, my primary role as an anesthesiologist on this deployment is for contingencies. In order to keep my skills current, I’m volunteering at the French Army Hospital and the Djiboutian hospital, both out in town. I’ve been asked to develop and present a series of six lectures for the Djiboutian hospital team of visceral Continued on page 26

O.R. #3 at General Peltier Hospital in Djibouti City. An Italian-made Siare Alpha Delta Lung Ventilator with halothane vaporizer. The anesthesia provider brings a bottle of halothane to work, fills the vaporizer with enough for the case and drains any remaining back into their bottle at the end of the day. Photo by Tammy J. Penhollow, D.O.
(general) surgeon, anesthesiologist and “nurse anesthesia/technicians” with special emphasis on regional and neuraxial techniques. The surgeon specifically asked for a lecture and demonstration in caudal anesthesia because he would like the anesthesia providers to be able to place a caudal in the not-so-uncommon situations where a circumcision has been done at home and the boy presents to the emergency room with complications. In this very poor country, general anesthesia is reserved for trauma and certain intra-abdominal surgeries where it’s preferable to a regional or neuraxial technique. In a hospital with four operating rooms and one anesthesiologist who also covers the critical care ward, the anesthesiologist will often either place or supervise the placement of a peripheral block or spinal and allow a nurse/technician to remain in the room with the patient. By teaching the Djiboutian providers, we are building international relations and helping Africans help themselves.

I also have the privilege of working with the Army Civil Affairs Team as a physician provider in a series of Medical Civil Action Programs (MEDCAPs) in rural villages in Djibouti’s Ali Sabieh and Dikhil districts. The “village” may be a school building or merely a water collection point for the nomadic and pastoralist people. Our role during the MEDCAP is to promote diplomacy and foster relationships between the U.S. and Djiboutian governments as well as to support the mission of the Djiboutian Ministry of Health in its efforts to provide medical care to those who might not otherwise receive it. Most of the patient complaints are primary care or dental related. You may wonder how an anesthesiologist can play a role in a primary care setting, but it’s really quite simple: The Navy has a unique approach to training and utilizing its physicians. After internship, many Navy physicians spend between two and four years as a General Medical Officer (GMO), Flight Surgeon or Diving Medical Officer, providing primary care services before becoming specialized. As a former GMO with the Seabees (Naval Mobile Construction Battalion), I provided care on six MEDCAPs in

Many Djiboutians are nomadic/pastoralist. These villagers stopped at the watering point but did not seek medical care at our MEDCAP. Photo by Tammy J. Penhollow, D.O.

U.S. Air Force photos by Senior Airman Kimberly Moore Limrick.
Serbian and Albanian villages in Kosovo while deployed in support of Operation Joint Guardian and Task Force Falcon, and I worked in an urgent care clinic during my second tour as a GMO while teaching Independent Duty Corpsman (IDC) School at the Naval School of Health Sciences, San Diego.

Advances in technology allow me to correspond with my family and friends (including others who are deployed) while I’m here in Africa. I’m the only one of my residency classmates and friends to date who had the opportunity to train at Fort Jackson, and I’m able to make comparisons and come to the conclusion that my NIAC experience is valuable and enviable. I’ve received different training than my NCC residency classmates who are serving with the Army or Marines in Iraq and Afghanistan; it’s O.K. because it’s a different mission. I’m thankful for the continued training with and by the Army, and I apply that training in my daily interaction with soldier patients as well as the Army’s MEDCAP mission commanders and planners.

This deployment is still young, but I intend to participate in several more MEDCAP missions and to spend two days per week working and teaching at the hospitals out in town as well as volunteering at the local baby orphanage and the cheetah refuge. It’s a nontraditional role in any circumstance outside this unique military setting, but a role that this sailor enjoys developing and exploring!

A mother explains to a Navy provider what is medically wrong with her children. We prepare supplies and manning for each MEDCAP to care for up to 500 patients. Photo by Tammy J. Penhollow, D.O.

Dr. Penhollow excising a thorn from the plantar surface of this village elder’s foot. Photo by Petty Officer First Class Jeffrey Geiser.

U.S. Air Force photo by Senior Airman Kimberly Moore Limrick.
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Living the Adventure: A Navy Doctor’s Experience, From Hospital Corpsman to Anesthesiologist

Arvin W. Trippensee, D.O., LCDR, MC, USN

Career

It was May 1987. I was in my senior year of high school, contemplating how I was going to pay for college, when a Naval Reserve recruiter contacted me. He told me about a program that would send me to recruit training (a.k.a. “Boot Camp”) that summer, followed by Hospital Corpsman “A” School the following summer. I would perform active-duty service for one weekend per month and two weeks every year. In return, I would earn active-duty pay for recruit training, “A” School, and the weekend of duty every month, and would also be eligible for the Montgomery G.I. Bill while going to college. After thinking about it for several days, I signed the enlistment paperwork and embarked upon an adventure that continues today.

In August 1987, I left for recruit training at the Naval Training Center in Great Lakes, Illinois. This was a big experience for someone who had never done anything away from home. Over the following eight weeks, I was transformed into a motivated junior sailor. As a recruit, I learned to “pay attention to detail” and “follow instructions.” Of course, learning strict order and discipline was paramount. There was a quote on the wall of Drill Hall 1200 that read, “The true meaning of discipline is not punishment, but that development of self control and teamwork which enables a man to strive for perfection and accomplish greatness.” That phrase has remained in my mind for the last 21 years.

After returning from recruit training, I attended my local community college to pursue an associate of arts degree. In July 1988, I took a semester off to go to Hospital Corpsman “A” School at the Naval School of Health Sciences in San Diego. As my first introduction to patient care, it was a very intense 12-week course of instruction, combining basic hospital clinical education and emergency medical training. Hospital corpsmen have a long and proud history of providing outstanding frontline care to the U.S. Navy and U.S. Marine Corps.

After earning my associate of arts degree in 1990, I transferred to the University of Florida to work toward a bachelor’s degree. That August, Iraqi soldiers invaded Kuwait, ushering in the beginning of Operation Desert Shield/Desert Storm. I was recalled to active duty and deployed to Saudi Arabia in February 1991, where I served as an anesthesia technician for a 500-bed tent hospital. Thus, my interest in anesthesia was piqued, to be further fueled by one of the anesthesiologists and two CRNAs who took the time to explain to me what it was that they did every day in the operating room. They would allow me to stay with them during the cases and taught me about the different medications and techniques that they were using.

After Desert Storm, I returned to finish my studies at the University of Florida. In my senior year, I applied to several different medical schools as well as to the Navy’s Armed Forces Health Professions Scholarship Program (AFHPSP). This program covered the cost of tuition, books and supplies for medical school and also granted a small stipend for living expenses.

Following medical school, I was commissioned as a lieutenant in the U.S. Navy and entered internship at the Naval
Medical Center, Portsmouth, Virginia. Afterward, I reported to Pensacola, Florida, for the six-month Naval Flight Surgeon Course. Earning my “wings” in February 1999, I received orders to the 1st Marine Aircraft Wing, Marine Aircraft Group Twelve in Iwakuni, Japan. For the next two years, I would live, eat and sleep U.S. Marine Corps aviation. I flew in the back of F/A-18s, E-6Bs and C-130s. Flying in tactical jet aircraft was an exhilarating experience. Flying faster than the speed of sound, pulling six “Gs,” and speeding at 500 knots just 500 feet above Australian mountain ranges was better than any roller coaster around. I was also given the opportunity to lead a small medical department. While my deployments sent me to Thailand, Korea, Australia and Mt. Fuji, my wife and I were able to explore Thailand, China and Singapore on our own. Overall, this was a fast-paced two-year tour with the U.S. Marines that has provided me with enough memories to last a lifetime.

In 2001, I returned to Naval Medical Center Portsmouth to begin my residency in anesthesiology. During three years of residency training, I worked with several great attendings and was allowed to rotate to the University of Virginia, Washington Hospital Center, and Johns Hopkins. I learned that every institution has its own particular way of doing anesthesia, but the more differences I learned, the more similar they all became.

My next tour took me to the Naval Hospital in Jacksonville, Florida. During my time there, I had the opportunity to spend a month at sea on the USS John F. Kennedy prior to its decommissioning. The Kennedy was one of the last oil-burning aircraft carriers in the Navy. Because my tour as a flight surgeon had been with the Marines, I had never deployed on an aircraft carrier. Wow! The aircraft carrier is an extremely organized floating city with continuous activity. Watching the jets take off and land during the day was exciting, but to see it happening at night was truly amazing. I also had the chance to provide anesthesia coverage for two weeks at a small and remote naval hospital in Iceland. While there, I was able to explore the island and learn more about its unique history and culture. My next deployment was in support of Operation Iraqi Freedom at the Expeditionary Medical Facility in Kuwait.

Currently, I am assigned to the Naval Health Clinic in Hawaii, but I practice out of Tripler Army Medical Center. Tripler is the largest military medical center in the Pacific. Once again, I am stationed somewhere that has an awesome climate with many warm-weather activities. I feel very lucky every day that I wake up in Hawaii.

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Mentorship

In over 21 years in the Navy, I have worked my way from the most junior enlisted ranks to a mid-grade commissioned officer. While I was a junior enlisted person, I was inspired and assisted by many of the more senior enlisted personnel and a few officers. I had the chance to work under a variety of different leadership styles. Some have been positive, and I have tried to implement those styles into my own, while a few have been negative. I value these experiences equally, insofar as I can use the bad examples to stave off the negative whenever I am in a leadership position.

In medicine, as in the military, mentors have a lasting and direct impact on the development of their juniors. By setting the example for others to follow, they are also leaders. Having the courage to do the right thing is admirable but is frequently not the easiest course to follow. We must understand our roles and how we impact those around us. If we want to attract and retain the best and brightest physicians to our hospital, to our specialty or to our service, then we have to integrate, support and develop mentorship programs into our daily practice of medicine.

I am very thankful to all of the mentors who have influenced my growth and development as a leader, physician and anesthesiologist over the last 21 years. Many people have taken extra time to explain concepts and theories to me. They provided me with encouragement and support to assist me through some difficult experiences, and their belief in me strengthened my resolve when it was weak. It was a combination of their example and my dedication that has resulted in my success. I understand the immense impact that mentors have had on my career, and, therefore, I believe that it is my duty to become a mentor for others.

Service

There is innate value in service. Albert Schweitzer said, “I don’t know what your destiny will be, but one thing I do know: the only ones among you who will be really happy are those who have sought and found how to serve.” From President Kennedy’s 1961 inaugural address, we gained the now-famous phrase, “…ask not what your country can do for you – ask what you can do for your country.” And Albert Einstein added, “Only a life lived for others is a life worthwhile.”

The practice of medicine is rooted in our desire to serve others. We take pride in our abilities to diagnose and treat the sick and injured. It is very common to hear medical school applicants say that they want to become physicians so that they can help other people. We must embrace the act of service as something very important to our survival as a specialty, as a nation and as humanity. It is through service that we find value in what we do. Being a physician in the military has doubled my ability to serve something larger than myself: my patients and my country.

One of the current Navy recruiting ads goes, “If you want to do some great things in your world ... spend some time in ours.” The men and women of the U.S. military are true heroes. They volunteer their service and are prepared to go into harm’s way if asked to do so. Over the years, many have sacrificed their quality of life. They have suffered through the hottest and coldest climes, wet and dry. They have gone days, weeks, months and years without seeing their families. They have missed birthdays, anniversaries, holidays and special occasions. They have gone without hot food or warm showers. They have
pioneered science, aviation and space exploration. And in medicine, like many other fields, many excellent physicians may trace their roots to military medicine.

It is not about the money ... Although many may feel that money is the key to happiness, it is probably not true. If money is your main focus, then you will never have enough whether you’re in the military or not. My military experience has not made me wealthy; however, I have been able to travel, live in different parts of the world, fly in jet aircraft, go to sea on an aircraft carrier and enjoy truly unique experiences. My service granted me education, residency training, and now, board certification. As I get older, if I am asked, “Did you make a difference?” then I will surely be able to say, “yes.” I am honored to provide care to the heroes of our country and to their family members. It continues to be a humbling experience that I will value forever.

The views expressed in this article are those of the author and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, nor the U.S. Government.

I am a military service member. This work was prepared as part of my official duties. Title 17, USC, §105 provides that “Copyright protection under this title is not available for any work of the United States Government.” Title 17, USC §101 defines a U.S. Government work as a work prepared by a military service member or employee of the U.S. Government as part of that person’s official duties.
As experts in resuscitation, anesthesiologists are in the front lines of trauma care, as reported in the March 2006 issue of the NEWSLETTER, which described the amazing work being done by anesthesiologists in uniform (www.asahq.org/Newsletters/2006/03-06/TOC03_06.html). But we are also experts in being prepared. From the first day of residency, we are taught the importance of preparation for the unexpected – and as we all know, surgeons and patients always have new ways of surprising us.

The Board of Directors created an ad hoc committee and later the Committee on Trauma and Emergency Preparedness, or COTEP, as a response to the events and awareness that followed 9/11. While it was not surprising that preparation for bombings and bioterrorism dominated early committee work, Hurricane Katrina and other natural disasters seemed to follow quickly enough, causing us to address natural disasters and accidents. However, while we all need to be prepared for the unexpected emergency that might occur only once in our careers, many more members will be actively involved in managing patients with trauma on a daily, weekly or annual basis.

Both emergency preparedness and trauma anesthesiology are part of our responsibility as a specialty, but they require a different focus and skill set; therefore, the committee is organized into two task forces, Trauma Anesthesiology and Emergency Preparedness.

Trauma Anesthesiology

Trauma anesthesiology is not a recognized subspecialty, but we know that at our major trauma centers there are anesthesiologists who treat trauma patients 90 percent of the time (and these doctors may never see cardiac surgery done by others except “street surgeons”). There are also trauma fellowships offered at some of the major trauma centers. Notwithstanding the centers of excellence, almost any hospital anywhere will have to deal with both major and minor trauma care at some time. Our committee is tasked by the board with serving the needs of the members who are interested in trauma anesthesiology either from an academic, operational or political perspective. At the ASA 2009 Annual Meeting, we hope there will be refresher course lectures on adult and pediatric trauma in addition to panels and workshops. Politically, we are starting to encounter emergency room doctors who are confused as to the role of anesthesiology in the E.R., not to mention which specialty is an expert in airway management. Inside our hospitals, we have to decide on issues such as sedation in the emergency room and EMT training. The board has charged the committee with addressing all these issues, and we are interested in receiving input from any member who has expertise to share.

Emergency Preparedness

Anesthesiology is a technology-rich specialty. We spend our days using electronic devices to monitor our patients’ physiology and preserve their vital functions. Computers and computerized devices such as PDAs and cell phones have become vital to our ability to practice. Imagine if one day they all stopped working simultaneously.

One of the reasons this committee exists is to educate the general membership about how to be prepared for disruptions in service, whether by natural disasters, terrorism or any other situation in which our normally high-technology specialty operates. Jay H. McIsaac, M.D., is leading the creation of a new chapter in the Manual on Departmental Operation and Management www.asahq.org/clinical/toolkit/madom.htm. The chapter will provide guidance and, most importantly, links to documents that will help us manage our personal and departmental preparedness. In addition, the chapter will explain the expected roles of the hospital and the anesthesiology department on a major emergency. Outside of the hospital, emergencies are handled by the police, fire EMS, National Guard, Coast Guard, FEMA, state, city and county public health departments, and other agencies. With all of these different players, communication breakdown is frequently one of the most difficult aspects of an emergency. We would like to provide our members with as much information as they need to be prepared and to be able to help out in difficult situations. Further complicating preparation for the unexpected is the all-too-human tendency to avoid thinking about the situations that are unlikely to occur; thus, COTEP has surveyed ASA membership, and far too few of us are personally prepared.
for or have an understanding of the emergency response plans in our workplaces.

Large-scale infrastructure issues are outside the realm of anesthesiology, but we can be advocates for change. It is critical that anesthesiologists become aware of hospital, local and state plans for responding to these threats and all disasters in their work places. We understand infrastructure. We spend our days looking for vulnerabilities and devising plans to protect and mitigate. We need to advocate, educate and be the protagonists for constructive change. Vigilance and preparation are what anesthesiologists do best, and we should be leaders among the surgical specialties for disaster preparedness.

Joseph H. McIsaac, M.D., contributed to the writing of this article.

There have been two NEWSLETTER articles by Jill Antoine, M.D., when she chaired the COTEP, and I would recommend that you review them as I have tried not to duplicate her work here. See www.asahq.org/Newsletters/2006/08-06/antoine08_06.html and www.asahq.org/Newsletters/2006/11-06/whatsNew11_06.html.

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Friends, Colleagues, Lifesavers: One Doctor’s Experience in the Reserves

Continued from page 7

Sciences (USUHS) F. Edward Hébert School of Medicine in Bethesda, Maryland. The late Congressman Hébert (pronounced “A-Bear”) served the 1st District of Louisiana, around my home town of New Orleans. His dream was to create a “West Point” for physicians and other medical personnel. In USUHS, he has succeeded, and his dream is doing very well. This was just after Hurricane Katrina struck the Southeast, and I volunteered to help out with critical care transport as well. On a personal note, I had just become engaged to Heidi Chua, M.D., a consultant colorectal surgeon here at Mayo Clinic.

For the past five years, I had been exercising regularly. On Wednesday, March 13, 2006, I went to the gym and starting running on a treadmill. Sixteen minutes into the exercise, I sustained a “sudden death” cardiac arrest and collapsed off the treadmill. Fortunately, right next to me was an Army dermatology resident who immediately started CPR, applied an AED, and returned my heart back to normal sinus rhythm within three minutes. I woke up eight hours later in the ICU at Bethesda Naval Hospital (fortunately, I had all of my neurological faculties about me). Now it was the ICU physician who was the patient. In the next two hours, I saw two familiar faces, my wife and my dear colleague, Roy F. Cucchiara, M.D. Subsequently, I went to the cath lab and had a drug-eluting stent placed in my LAD. Surprisingly, I had not sustained an MI, and there is not a day that goes by that I do not thank God and my country for my life. As I had noticed with my first experience with the military, it truly is a brotherhood and a family that takes care of its own.

Since then, I have returned to Bethesda for more active duty service, only on a medical waiver. Dr. Chua and I are married and are the proud parents of our wonderful 8-month-old girl, Brooke. We have changed Mayo Clinic sites and now live in Rochester. It has been a fantastic journey. The United States Air Force has played a vital role in it, and I owe it my life. May God bless our armed forces as well as the great country and people that they protect!
OAPRS: Fledgling Society Focuses on Optimizing Care for Orthopedic Patients

Jacques E. Chelly, M.D., Ph.D., M.B.A., President-Elect
Orthopedic Anesthesia, Pain and Rehabilitation Society

Orthopedic surgery represents one of the most innovative perioperative environments. Specific anesthesia and acute perioperative pain management protocols have played a critical role in rendering as feasible new orthopedic surgical techniques, improved outcomes, increased patient satisfaction and reduced hospital length of stay. In this regard, more orthopedic surgeons have acknowledged that optimizing orthopedic patient outcomes while minimizing costs of evolving procedures depends on a multidisciplinary approach, including specific anesthesia and perioperative pain management protocols. This environment has led to the recognition that orthopedic anesthesia and pain management have evolved into a most relevant subspecialty of anesthesiology.

The Orthopedic Anesthesia, Pain and Rehabilitation Society (OAPRS) is a new organization dedicated to developing multidisciplinary approaches to the perioperative management of patients undergoing orthopedic surgery. The Society’s Board of Directors is composed of 13 members from the United States, Canada and Europe. Board members include Alain Borgeat, M.D., Ph.D., Professor, Head of the Department of Anesthesiology, Orthopedic University Hospital Balgrist, Zurich, Switzerland; Bruce Ben-David, M.D., Clinical Associate-Professor of Anesthesiology, University of Pittsburgh Medical Center; Chester C. Buckenmaier III, M.D., Chief, Anesthesia and Operative Service, Walter Reed Army Medical Center, Washington, D.C.; Asokumar Buvanendran, M.D., Director of Orthopedic Anesthesia, Rush University Medical Center, Chicago; Jacques E. Chelly, M.D., Ph.D., M.B.A., Professor of Anesthesiology and Orthopedic Surgery, University of Pittsburgh Medical Center; Laura L. Clark, M.D., Professor of Anesthesiology and Perioperative Medicine, University of Louisville, Kentucky; Sugantha Ganapathy, M.D., Professor of Anesthesiology, University of Western Ontario, Canada; Jennifer R. Greger, M.D., Tomball Anesthesia, Tomball, Texas; David A. Nelson, M.D., Director of Regional Anesthesia Services, Capitol Anesthesiology Association, Austin, Texas; Andrew D. Rosenberg, M.D., Professor of Anesthesiology and Chief, Department of Anesthesiology, New York University Hospital for Joint Disease; Eugene R. Viscusi, M.D., Director of the Acute Pain Service, Associate Professor, Department of Anesthesiology, Thomas Jefferson University, Philadelphia; and Brian A. Williams, M.D., M.B.A., Associate Professor, Department of Anesthesiology, University of Pittsburgh Medical Center.

The OAPRS Board has declared that its mission would be best served through collegial education, including the development of orthopedic anesthesia fellowships, research initiatives and consensus-based clinical practice guidelines.

Since its incorporation in September 2005, OAPRS membership has been open to all anesthesiologists, orthopedic surgeons, physiatrists, and corresponding residents and fellows involved in and/or interested in the perioperative management of orthopedic patients. More than 200 physicians, mostly anesthesiologists, have joined the Society since its creation.

Planned initiatives related to the OAPRS mission are as follows:

• Support a multidisciplinary approach, including orthopedic surgeons, anesthesiologists, pain specialists and physical medicine physicians involved in the perioperative care of orthopedic surgical patients.

• Develop and promote orthopedic anesthesia fellowship programs.
• Educate and support a multidisciplinary approach to the orthopedic surgical patient.

• Develop educational programs and workshops.

• Develop educational guidelines for subspecialty training in orthopedic anesthesia, pain management and rehabilitation.

• Underwrite orthopedic anesthesia, pain and rehabilitation research via the evolving OAPRS Research Foundation.

• Promote communication, interaction and the development of multidisciplinary task forces to develop clinical practice guidelines.

• Promote the publication of orthopedic-relevant articles and reviews in anesthesiology, orthopedic, pain and rehabilitation journals.

• Develop a society Web site www.OAPRS.org with specific emphasis on the education of its members and interested patients.

• Develop formal relationships with other anesthesia subspecialty societies sharing common goals and interests, such as ASRA www.asra.com, SAGA www.sagahq.org and SAMBA www.sambahq.org.

• Develop a formal relationship with interested orthopedic societies and organizations.

• Seek representation in the ASA House of Delegates and the editorial boards of relevant orthopedic, anesthesiology, pain and rehabilitation journals.

The areas of interest of OAPRS include all aspects of orthopedic surgery, including joint replacement, orthopedic trauma, orthopedic oncology, spine surgery, sports medicine and pediatric orthopedics. OAPRS directs attention to anesthetic and perioperative issues such as pharmacology, blood transfusion and anticoagulation as relevant to orthopedic anesthesia.

At present, all activities are funded via annual membership fees of $125 as well as via corporate sponsorship. Each OAPRS member also benefits from a discounted subscription fee for the Journal of Clinical Anesthesia, the official journal of the Society. Members also receive a registration fee discount to attend the annual OAPRS meeting. This meeting is scheduled on the Friday prior to the beginning of the ASA Annual Meeting. This day-long meeting includes state-of-the-art lectures by expert orthopedic surgeons and anesthesiologists, pro/con presentations, debates and a regional anesthesia/ultrasound workshop. The program of the last pre-ASA OAPRS meeting in Orlando can be viewed at www.oaprs.org. Since 2005, in addition to the scientific program, the OAPRS meeting has included an address by the ASA President-Elect. The 2009 pre-ASA meeting is scheduled as a joint meeting between SAGA and OAPRS in New Orleans. Both societies hope that many of you will join us for this important event.

OAPRS embraces the new clinical challenges that are posed by evolving surgical techniques and patient needs in orthopedic contexts. This new Society aims to provide its membership with a current didactic basis for evidence-based clinical practice in an effort to improve patient outcome.
Nominations Sought for Award for Excellence in Research

James C. Eisenach, M.D., Chair
Committee on Excellence in Research

The annual ASA Award for Excellence in Research recognizes an individual for outstanding achievement in research that has or is likely to have an important impact on the practice of anesthesiology.

The individual’s work must represent a body of original, mature and sustained contribution to the advancement of the science of anesthesiology. The nominee need not be a physician, an anesthesiologist or a member of ASA, but must be presently engaged in research related to anesthesiology, academically accomplished with peer-reviewed publications and funded research, and nominated in response to a call for nominations. The completed application must include the nominee’s current curriculum vitae, a letter of nomination, and a seconding letter from two individuals with an understanding of the research contributions of the individual.

The 2008 Award for Excellence in Research was presented to Zeljko J. Bosnjak, Ph.D., at the ASA Annual Meeting in Orlando, Florida, on Monday, October 20, 2008. Dr. Zeljko is Professor and Vice Chairman of Research, Department of Anesthesiology, and Professor of Physiology, Medical College of Wisconsin, Milwaukee.

The deadline for nominations for the 2009 Excellence in Research Award is March 31, 2009. Anesthesiologists who are within seven years of their first appointment to a department of anesthesiology, who are Board-certified, ASA members, and who spend at least two days per week in clinical practice are eligible for the award. Nominees must be academically accomplished with peer-reviewed publications and funded research. Candidates should be nominated by their department chair or by the Committee on Research after review of the current year’s grant applicants of the Foundation for Anesthesia Education and Research. The nominee’s department chair should submit a letter of support and the nominee’s current curriculum vitae as well as a seconding letter from a senior faculty member. Only one nominee per department will be accepted.

Please submit nominations or any questions regarding this award to George H. Kendall, Managing Editor, Anesthesiology, Department of Anesthesiology, Wake Forest University School of Medicine, Medical Center Boulevard, Winston-Salem, NC, 27157; e-mail: managing-editor@anesthesiology.org.

Nominations Sought for Presidential Scholar Award

The ASA Presidential Scholar Award recognizes colleagues who dedicate their formative careers to research.

The deadline for nominations for the 2009 Presidential Scholar Award is March 31, 2009. Anesthesiologists who are within seven years of their first appointment to a department of anesthesiology, who are Board-certified, ASA members, and who spend at least two days per week in clinical practice are eligible for the award. Nominees must be academically accomplished with peer-reviewed publications and funded research. Candidates should be nominated by their department chair or by the Committee on Research after review of the current year’s grant applicants of the Foundation for Anesthesia Education and Research. The nominee’s department chair should submit a letter of support and the nominee’s current curriculum vitae as well as a seconding letter from a senior faculty member. Only one nominee per department will be accepted.

Please submit nominations or any questions regarding this award to George H. Kendall, Managing Editor, Anesthesiology, Department of Anesthesiology, Wake Forest University School of Medicine, Medical Center Boulevard, Winston-Salem, NC, 27157; e-mail: managing-editor@anesthesiology.org.

Announcement and Call for Abstracts: Annual Anesthesiology/FAER Joint Session

Anesthesiology, in conjunction with the Foundation for Anesthesia Education and Research (FAER), is pleased to announce the 2nd annual joint session to be held at the ASA Annual Meeting on October 20, 2009, in New Orleans, Louisiana. The 2nd annual session is titled “Simulation in Anesthesia Practice.”

Simulation plays a key role in patient safety programs, human factors research and as a method to assess performance. Over the last decade, simulation-based training has stimulated and fostered a number of inter-related initiatives aimed at improving clinical practice. In this symposium, a combination of invited speakers and selected abstracts and posters will include sessions that describe performance assessment, simulation training for Maintenance of Certification in Anesthesiology (MOCA®) as well as a novel application of simulation to improve the safety of clinical research.
The advent of simulation-based training has stimulated a more thorough appraisal of the breadth of skills required in patient care settings. Practice skills that were often considered difficult, if not impossible, to acquire in settings other than clinical care are included in simulation-based training and assessment programs. For this reason, simulation has stimulated a renewed interest in learning strategies that ensure physicians more effectively acquire and retain the knowledge, skills and attitudes essential to practice. Three invited speakers will describe a) the application of simulation-based training as a method to measure performance, b) the implementation of the MOCA simulation training for maintenance of anesthesia certification and c) an innovative training approach using simulation to prepare for a clinical research protocol.

These lectures will be accompanied by the presentation of eight posters selected for their relevance to the symposium topic. The joint session date, time and location will be announced at a later date.

Abstracts should be submitted via the usual online process (which can be accessed via the Web sites www.ASAhq.org and www.anesthesiology.org). Interested individuals should be sure to check the Anesthesiology/ FAER Joint Session box on the abstract submission form to be considered for inclusion in this special session. The deadline for abstract submission is March 31, 2009.

Announcement and Call for Abstracts: Annual Journal Symposium

ASA and its journal Anesthesiology announce the 18th annual Journal Symposium to be held at the ASA Annual Meeting on October 20, 2009, in New Orleans, Louisiana. The 2009 Journal Symposium will highlight up-and-coming and noteworthy concepts in anesthesia research and clinical practice.

The 2009 Journal Symposium is titled “Biomarkers and Perioperative Outcomes.”

Just as anesthesiologists have been affected by the recent imaging revolution, so are we now by a revolution in novel biomarkers for disease. Assessing the value of proposed biomarkers is complex, but validated biomarkers of disease could improve diagnosis, guide therapy, and presage outcome in perioperative and critical care medicine. In this symposium, lectures by internationally recognized experts will describe the history of an established and validated biomarker (troponin for cardiac injury) and the evolution of novel biomarkers for acute renal injury in perioperative and critical care medicine. Although considerable progress has been made in the methodology and report of randomized trials, anesthesiology lags behind some areas of medicine regarding development, validation, and interpretation of diagnostic and prognostic biomarkers. The third lecture, by the statistical editor of Anesthesiology, will discuss approaches for clinical investigators and readers of scientific literature to make sense of this important emerging literature.

Investigators from around the world with an interest in this subject are requested to submit their work to ASA for the Annual Meeting. Abstracts from both basic and clinical sciences are welcome. Studies examining or evaluating key biomarkers in perioperative and critical care medicine are encouraged. Abstracts should be submitted via the usual online process (which can be accessed through the Web sites www.asahq.org and www.anesthesiology.org). Interested individuals should be sure to check the “Journal Symposium” box on the abstract submission form to be considered for inclusion in this special session. The deadline for abstract submission is March 31, 2009. Abstract selections will be made by the symposium organizers, Anesthesiology editors Bruno Riou, M.D., of University Pierre and Marie Curie, Paris, France, and Evan D. Kharasch, M.D., Ph.D., of Washington University, St. Louis.

The authors of abstracts selected for the symposium will be offered an opportunity to submit their work to Anesthesiology for inclusion in a special symposium issue to be published in the spring of 2010.
Our Mission: CSPS Promotes Excellence in Patient Safety in Surgical and Perioperative Environment

Mark J. Lema, M.D., Ph.D.
Committee on Surgical Anesthesia

The Council on Surgical & Perioperative Safety (CSPS) and Joint Commission Resources, Inc. (JCR) will co-convene the Second National Conference on Perioperative Care and Safety. CSPS and JCR are cosponsoring a symposium titled “Improving, Enhancing and Sustaining Positive Patient Outcomes,” to be held May 8-9, 2009, at the Sheraton Chicago Hotel and Towers. The target audience is intended to engage all those who provide care and services within the surgical area, including surgeons, anesthesiologists, nurse anesthetists, perianesthesia and perioperative nurses, surgical physician assistants, surgical technologists, and pharmacists. The conference goals of increased teamwork and improved communication translate to better patient outcomes and topics of interest to leadership (CEO, CFO) and risk management professionals. At the end of the conference, participants will be able to: describe the current state of perioperative safety and prioritize strategies for improvement within their home organization; analyze methods shared to select those that work best for their setting in order to enhance the interdisciplinary care model; evaluate and apply interdisciplinary approaches designed for specialty patients/situations; examine tenets of and advocate for medication safety in the perioperative area; and investigate causes of surgical/anesthesia misadventures as a means to develop preventive processes. To register, and for more information, please go to www.jcrinc.com/Conferences-and-Seminars/Perioperative-Safety-Symposium/1512/.

CSPS is a unique multidisciplinary collaboration of seven professional organizations whose members (more than 250,000 members representing more than 2 million health care practitioners) are involved in the care of surgical patients. It is made up of the following organizations representing the perioperative team: the American Association of Nurse Anesthetists; the American Association of Surgical Physician Assistants; the Association of periOperative Registered Nurses; the American Society of Anesthesiologists; the American Society of PeriAnesthesia Nurses; and the Association of Surgical Technologists. Mark J. Lema, M.D., Ph.D., and Alexander A. Hannenberg, M.D., serve on their Board of Directors. For more information on the CSPS, please go to www.cspsteam.org, or contact Ms. Denise Goode at dgoode@facs.org.

JCR, Inc., is a not-for-profit affiliate of The Joint Commission, providing quality and safety innovations to health care organizations worldwide. Its sustainable solutions foster a culture of continuous improvement and the latest in patient safety and quality.

Mark J. Lema, M.D., Ph.D., was ASA President in 2007 and ASA NEWSLETTER Editor from 1997-2003.
Anesthesiologists are the lifeline of modern medicine, but that lifeline’s reserve strength is steadily diminishing. According to a new RAND survey, presented during the January 2009 ASA Conference on Practice Management, the United States is currently experiencing a shortage of anesthesiologists, which, if current trends continue, will worsen by 2020. On the other hand, if current trends continue, a surplus of CRNAs will exist. The timing of the successful passage of the anesthesiology teaching rule fix could not have come at a more crucial time to ensure a future where patients will have access to safe, high-quality care from an anesthesiologist.

The survey, funded by Ethicon Endo-Surgery, Inc., a Johnson & Johnson company, sought to assess the following areas:

- Characteristics of the anesthesiologist and CRNA labor markets (demographics, employment arrangements, compensation, time usage),
- Differences in characteristics by geography and facility,
- Perceptions of and preferences for anesthesia technologies,
- Whether a shortage or surplus labor market existed for anesthesiologists and CRNAs.

Due to time constraints, the presentation focused on the assessment of the shortage or surplus in the labor market. Many of you may recall a prior workforce study conducted by Abt Associates, Inc., the conclusions of which led to some fears of a potential surplus of anesthesiologists in the country. The Abt study relied upon a demand-based analysis to derive its conclusions.

To provide a more comprehensive assessment of the current anesthesia labor market, RAND used multiple methodologies in the analysis. First, RAND analyzed the labor markets jointly, which differed from prior studies that assessed the markets separately. The RAND study also examined whether a shortage or surplus existed on a state-by-state basis, rather than providing only national figures.

One of the methodologies used by RAND, a survey-based analysis, used survey response data on employment-related information, such as open positions, need for extra professionals to handle the case load, and postponed procedures. The caveat with this approach is that individual survey responses supply only a limited amount of information on the aggregate nature or multiple dimensions of the labor markets.

A second methodology, a demand-based analysis that is not economic-based, calculates the total supply of and demand for full-time equivalent (FTE) workers using time taken per unit of service. This analysis calculated the supply and demand assuming both a 40- and 49-hour week as the basis for an FTE.

Krishna Kumar, Ph.D., Senior Economist with RAND, commented on such an approach, “A demand-based analysis, which is traditionally used for a workforce analysis, is sensitive to the definition of a ‘full-time equivalent’ workweek. Moreover, this method does not make full use of data, most notably wages, that affect supply of and demand for anesthesia services. It is the interplay of supply and demand that ultimately determines whether there is a shortage or a surplus in a labor market. For these reasons, in addition to conducting a demand-based analysis, the

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the RAND study also conducts an economic analysis that uses data on wages and institutional differences across states. Results from the economic analysis and demand-based analysis differ in important ways.”

Finally, an economic analysis was used by RAND as a complementary methodology approach that makes the most complete use of all information available on wages, regulations and other factors. This analysis estimates a demand and supply relationship, accounts for responses of professionals and hospitals to changing conditions such as wages, and adjusts for assumptions made on the institutional aspects of the labor market.

RAND based its analyses on survey responses obtained from anesthesiologists, CRNAs and anesthesiology department directors. While ASA and AANA did not have control over the content of the survey, RAND did seek input from both organizations prior to administering the survey. The surveys distributed to anesthesiologists and CRNAs gathered demographic, employment, time usage and technology preference information, while the anesthesiology department directors’ surveys gathered information on overall labor market conditions. Here is the survey response rate breakdown:

<table>
<thead>
<tr>
<th>Surveyed Group</th>
<th>Contact Details</th>
<th>Sampling Frame</th>
<th>Responses</th>
<th>Response Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiologists</td>
<td>Direct e-mail</td>
<td>19,941</td>
<td>4,259</td>
<td>21.4%</td>
</tr>
<tr>
<td>CRNAs</td>
<td>E-mailed by AANA</td>
<td>22,791</td>
<td>4,543</td>
<td>20.0%</td>
</tr>
<tr>
<td>AN Directors</td>
<td>Regular mail</td>
<td>1,200</td>
<td>679</td>
<td>56.6%</td>
</tr>
</tbody>
</table>

The surveys received from the respondents paint the following summarized picture:

- The Northeast currently has the most acute shortage of anesthesiologists and CRNAs.
- The West currently has more of a surplus of both anesthesiologists and CRNAs.
- Labor shortages are more likely in urban areas and with larger employers.
- Most employers reported at least one open position for either an anesthesiologist or CRNA.

The demand-based analysis demonstrated that the average anesthesiologist has a clinical work week of 49 hours, compared to the CRNA’s average clinical work week of 37 hours. Assuming a 40-hour FTE for both groups, the demand-based analysis showed the following:

- A current shortage of 8,406 FTE anesthesiologists.
- A current surplus of 2,832 FTE CRNAs.

RAND’s economic analysis of the survey data led to a number of interesting conclusions, some of which differ moderately but in similar directions when compared to those of the demand-based analysis.

- **54.1 percent of the states in the U.S. currently have a shortage of anesthesiologists.**
- The average state experiencing a shortage needs 10 percent additional anesthesiologists to achieve equilibrium.
- The required change in wage to restore equilibrium is nearly 20 percent.
- **The estimated current national shortage of anesthesiologists is 4,655.**
- The estimated current national shortage of CRNAs is 1,186.

RAND found that the survey-based analysis methodology correlated well with the economic approach, but less so with the demand-based approach. Both the demand-based and economic analysis methodologies were more likely to classify a state as having a shortage of providers if the wages in that state are much higher than comparison states.

Using the demand-based analysis, RAND projected how the two provider labor markets will look through the year 2020. For the projections, RAND calculated demand by converting time per procedure for all procedures based on initial (2007) values obtained from the surveys (1,534,773 procedures that averaged 1.08 hours per procedure). The average annual growth rate of total surgeries (1.61 percent) was calculated from Area Resource File (ARF) data from 1985-2004. A high demand growth rate of 3 percent was also considered. The analysis examined the demand based on assumptions of both a 40- and 49-hour FTE. For the supply side, an entry rate of 1.82 percent was calculated from National Resident Match Program data (2000-2006), and an exit rate of 1.15 percent was calculated from ASA data. The analysis assumes the trends continue each year and no actions

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The Louisiana First Circuit Court of Appeal affirmed the lower court’s declaratory judgment that the Louisiana State Board of Nursing’s 2005 statement expanded the scope of practice of nurse anesthetists into an area where they have not traditionally practiced and that the practice of interventional pain management is not within their scope of practice, but rather is solely the practice of medicine. Additionally, the court affirmed the permanent and mandatory injunction against the nursing board and nurse anesthetist who sought the statement.

The statement issued by the nursing board authorizes nurse anesthetists “to perform procedures under the direction and supervision of the physician involving the injection of local anesthetics, steroids and analgesics for pain management purposes, peripheral nerve blocks, epidural injections, and spinal facet joint injections when the CRNA can document education, training and experience in performing such procedures and has the knowledge, skills, and abilities to safely perform the procedures based on an order from the physician ...” The statement was issued in response to a petition filed by a nurse anesthetist for clarification on nurse anesthetist scope of practice in Louisiana. The statement was published on the nursing board’s Web site and in its quarterly publication.

In response, Spine Diagnostics of Baton Rouge, Inc. (Spine Diagnostics) filed a lawsuit against the nursing board, contending the board was attempting to promulgate a “rule” within the meaning of the Louisiana Administrative Procedure Act (LAPA) and therefore should be declared invalid because it had not been properly adopted. Additionally, the plaintiffs sought to prevent the nurse anesthetist who sought the opinion from performing interventional pain management procedures and sought a declaratory judgment that the practice of “pain management” constitutes the practice of medicine.

Subsequently, Spine Diagnostics sought an advisory opinion from the Louisiana State Board of Medical Examiners to clarify that the procedures described above constitute the practice of medicine. The opinion states that while a “nurse anesthetist may utilize these procedures on the prescription of and under physician direction and supervision for surgical cases and acute pain associated with surgery ... it is beyond the scope of practice of CRNAs to employ them to diagnose, manage or treat chronic pain patients. To do so would permit the CRNA to exercise independent medical judgment, perform diagnostic testing, render diagnoses, and provide treatment or recommendations for treatment of patients suffering with chronic pain.”

The opinion further states that such determinations are reserved solely to physicians and are not “delegable to a non-physician by physician prescription, direction or supervision.”

The Court of Appeal held in December 2006 that Spine Diagnostics made a prima facie showing that the nursing board substantively expanded the scope of practice of a nurse anesthetist into an area where they have not traditionally practiced. Such substantive expansion constitutes a rule within the meaning of LAPA. Additionally, the language of the statement is not limited in application to the nurse anesthetist who petitioned the nursing board and is capable of being applied to every nurse anesthetist who has the requisite knowledge, skills and abilities to perform the procedure at issue. Nurse anesthetists can freely access the statement on the board’s Web site and via the quarterly publication. Finally, the court issued a preliminary injunction enjoining enforcement of the statement and enjoined the nurse anesthetist who sought the opinion from practicing chronic or interventional pain management procedures pursuant to the statement. At this juncture, the Court of Appeal did not address the declaratory judgment, which was to be addressed by the trial court.

In 2007, legislation was introduced that mirrored the nursing board’s statement. Spine Diagnostics amended its petition and alleged that the nursing board attempted to circumvent the court’s December 2006 ruling by urging the legislation, which ultimately died in committee.

At trial on the plaintiff’s request for declaratory judgment, permanent injunction and contempt was held in November 2007. On January 10, 2008, the trial court rendered a judgment in favor of Spine Diagnostics, which included:

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• The practice of interventional pain management is not within the scope of practice of a nurse anesthetist.
• The practice of interventional pain management is solely the practice of medicine.
• The advisory opinion issued by the nursing board is an effort to substantively expand nurse anesthetist scope of practice and is an improper attempt at rule making.
• A permanent injunction issue prohibiting the nursing board from enforcing the statement.

The central issue before the Court of Appeal is whether the scope of practice of nurse anesthetists includes the procedures described above for pain management purposes or whether these procedures constitute the practice of medicine and can only be performed by a physician. The nurses contend that interventional pain management is not solely the practice of medicine and that had the Louisiana Legislature intended to exclude nurse anesthetists from performing interventional pain management procedures; language restricting such procedures from their scope would have been added to the statute governing their scope of practice.

However, Spine Diagnostics argues that the evidence presented at trial supports the lower court’s ruling that the statement expands nurse anesthetist scope of practice into an area not traditionally practiced. They contend that 1) nurse anesthetists do not have an established history of performing the procedures at issue; 2) nurse anesthetists lack the education, training or accreditation to safely and effectively perform the procedures; 3) studies demonstrate decreased safety, competency and efficacy when the procedures are performed by nurse anesthetists; 4) nurse anesthetists lack any regulatory mechanism or process to assess their competency, training or education; 5) no verifiable need exists for nurse anesthetists in this area of practice; and 6) nurse anesthetist practice will negatively impact public health and safety.

Using the “abuse of discretion standard,” the Court of Appeal reviewed the trial court’s decision and testimony presented at trial from experts for both parties. Among the experts for the nurses is a nurse anesthetist who stated that he “knows of no regulations or guidelines of any sort that apply nationally to institutions to assess the competency, ability, credentials or skill sets for nurse anesthetists with respect to interventional pain management procedures.” An instructor who trains nurse anesthetists testified that she does not teach a section called “interventional pain management,” but rather the majority of instruction focuses on training for the hospital setting. Additionally, the instructor was not “aware of any post-certification competency benchmarks related to interventional pain management procedures.” The Executive Director of the Louisiana State Board of Nursing acknowledged that the nursing board does not have any mechanism to verify or assess whether a nurse anesthetist has the documented education, training, experience and skills to safely perform interventional pain management procedures. A representative of the American Association of Nurse Anesthetists acknowledged that “there are no guidelines for assessing the competency, skill set, abilities, or training needed for CRNAs to begin performing interventional pain management procedures” and opined that a “CRNA should be allowed to perform these procedures once the CRNA has had the ‘necessary education, training, and feels like they have the necessary skills.’”

A physician expert in the field of orthopedics testified that for five years he referred patients to a nurse anesthetist who performed interventional pain management procedures after he has seen and diagnosed the patient. However, he is not in the operating suite when the nurse performs the procedures, and there could be times when he is not in the facility when the procedures are performed.

In reviewing the testimony above, the Louisiana Court of Appeal held that the trial court did not abuse its discretion in issuing its declaratory judgment and that Spine Diagnostics met its burden of proof on the permanent and mandatory injunctions. Therefore, the Court of Appeal affirmed those portions of the trial court’s ruling.

With respect to the nurses’ argument on appeal that the statement was not a rule and therefore did not violate LAPA, the Court of Appeal held that law of the case doctrine precluded it from reviewing this issue. The arguments and issues raised by the nurses appeared to be indistinguishable from those presented to the trial court. Additionally, the Court of Appeal previously considered the nursing board’s authority to issue declaratory orders and advisory opinions and concluded that the statement was a rule that required compliance with LAPA.
The Committee on Standards and Practice Parameters produced several new documents in 2008. New practice parameters approved by the House of Delegates included a “Practice Advisory on Anesthetic Care for Magnetic Resonance Imaging,” a “Practice Alert for the Perioperative Management of Patients with Coronary Artery Stents,” and an updated report of the “Practice Guidelines for Neuraxial Opioids Associated with Respiratory Depression.” These practice parameters are published or are scheduled for publication in the January, February and March issues of Anesthesiology.

Also in 2008, the following ASA statements were amended and approved by the House of Delegates: “Policy Statement on Practice Parameters,” “Statement on Nonoperating Room Anesthetizing Locations” and “Statement on Routine Preoperative Laboratory and Diagnostic Screening.”

Presently, two new practice parameters are in progress: “Practice Advisory for the Prevention, Diagnosis and Management of Infectious Complications Associated with Neuraxial Techniques,” chaired by Terese T. Horlocker, M.D.; and “Chronic Pain Management, an Updated Report,” chaired by Richard W. Rosenquist, M.D. Both of these practice parameters are scheduled for completion this year. The “Practice Guidelines for Perioperative Transesophageal Echocardiography: An Updated Report,” chaired by Daniel M. Thys, M.D., is being revised and will be resubmitted to the House of Delegates in October.

The committee elected to proceed with two new practice parameters – “Central Venous Catheter Insertion” and “Monitoring of Oxygenation and Ventilation for Patients Receiving Postoperative PCA and PCEA Opioids” – and to update the “Practice Guidelines for Preoperative Fasting.” These practice parameters are scheduled for completion in 2010.

Twenty evidence-based practice parameters and seven updates have been approved and published in Anesthesiology since 1992. Thirteen have been reviewed and approved by the National Guideline Clearinghouse (NGC), and nine are currently listed on its Web site www.guideline.gov.

In the December 2008 ASA NEWSLETTER, an ASA member raised a number of concerns about the ASA guideline process. I have carefully considered these concerns and would like to share my thoughts with ASA members.

The first criticism was that the Practice Guidelines for Chronic Pain Management were not updated in a timely process. This is a valid criticism since our current process for guideline development typically generates a nine- or 10-year interval between an initial practice parameter and its associated update. Why? In addition to updates, there is always a need for new practice parameters. ASA has limited resources and a finite budget, so the process of creating and updating practice parameters results in a “queue,” or waiting list. Our committee prioritizes the work on this waiting list by seeking the advice of committee members, the Board of Directors and the ASA membership. We strive for updates on a five-year schedule, but it is not always possible. We are committed to finding new ways to make the update process speedier.

A second criticism was that two task forces – not one – are needed to do the work on chronic pain. If the current task force considers this to be valid, such a recommendation will come forward and it will be carefully considered by the Committee on Standards and Practice Parameters. To date, no such recommendation has been made. When we find that the scope of an originally planned parameter is too large, we usually ask the task force to split the work into smaller segments and to do the work in series rather than in parallel. This allows us to keep the overall process moving forward while meeting our budgetary constraints.

The third criticism was that ASA has a practice parameter process that is bureaucratic, expensive and outdated. Yes, it is bureaucratic. But the bureaucracy serves an important purpose. We could use other processes, such as those employed by the Centers for Medicare & Medicaid Services or The Joint Commission, but these would not serve our members or our patients. The “bureaucratic” aspects of our process are actually safeguards – they ensure that voices are heard, controversies are aired and evidence is properly considered. This requires face-to-face meetings to uncover areas of consensus and discord. It requires membership surveys and open forums that give us new ideas.

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James F. Arens, M.D., is now retired. He was ASA President in 1989.
are taken to alter the supply. Given these parameters and caveats, RAND found the following:

- Assuming a 40-hour anesthesiologist FTE, 2020 will see a shortage of 14,000 anesthesiologists.
- Assuming a 49-hour anesthesiologist FTE, 2020 will see a shortage of 4,500 anesthesiologists.
- Assuming a 40-hour CRNA FTE, 2020 will see a surplus of 10,866 CRNAs.
- Assuming a 37-hour CRNA FTE, 2020 will see a surplus of 8,000 CRNAs.

Thus, as many of you have asserted for some time, the current labor market for anesthesiologists appears to have a substantial shortage and one that will continue unless action is taken. The teaching rule fix, which will be implemented in 2010, will restore Medicare payment equity to academic anesthesiologists who supervise two residents on overlapping cases. It is an enormous legislative victory and will assist academic anesthesiology departments in expanding their capacity to train residents and fellows.

While some continue to suggest there is a national shortage of nurses, the RAND study demonstrates that the shortage of CRNAs may be minimal, and it may, in fact, transition to a surplus in the near future. In its January 2008 AANA News Bulletin, the American Association of Nurse Anesthetists (AANA) describes efforts to increase student enrollment 122 percent over the last 10 years. The implications of the RAND study findings will be pertinent to these additional and future nurse anesthetist students.

RAND expects to complete its quality assurance review of the full report in the spring and will release it soon thereafter. ASA will share the full report via our Web site once it is available.

The RAND results summarized in this article are preliminary and subject to change as a result of RAND’s quality assurance review. Members are encouraged to review the final report, which ASA will post on its Web site once it is made available.

References:
We’ve probably all watched the same videos – the ones chronicling a resident whose life was destroyed by drug addiction while other residents and attending anesthesiologists comment on how that resident was the last person in the whole program that they would have suspected of abusing drugs, and how easily they dismissed warning signs that only have context in retrospect.

The first week of residency, I watched these videos with my class and felt a newfound fear and respect for the syringes I casually and routinely draw up before each case and carry in my scrub pocket.

There is no pharmacy policy, no drug dispensing system, and no computerized record that can stop someone from abusing controlled substances, but such safeguards can serve a role in limiting the duration of the substance abuse before the abuser is discovered, potentially limiting the incidence of overdose. I believe everyone will eventually be caught, a victim of his or her own dependence. The only questions that remain are when will they be discovered, and will they recover.

- 19 percent of residency programs from 1991-2001 had at least one resident die from overdose or suicide; and

- 80 percent of residency programs from 1991-2001 had experience with trainee impairment, primarily opioid abuse.

Recently, residency programs have revealed resident drug abuse through analysis of drug-dispensing records, discovery of an acutely impaired resident, and discovery of a deceased resident. When I hear these stories recounted, someone always comments on how no one suspected that particular resident of abusing drugs.

This is not to say that we should suspect everybody. But, ultimately, residents are the first and last hope to protect each other, and it doesn’t matter who you do or don’t suspect. I care about my friends and am conscientious and thorough when witnessing the wasting of their drugs. And I insist on the same standard when I waste drugs.

During residency, a majority of our waking hours are spent in the hospital with each other. Residency can be stressful – we make sacrifices and work long hours, assume vast responsibility, often for critically ill patients, and receive less than ideal compensation. As always, we are our own best advocates. An addict is likely the last person to acknowledge that he or she has a problem. In order to care for our patients, it is imperative that we care for ourselves, and for each other.

The ASA Task Force on Chemical Dependence of the ASA Committee on Occupational Health of Operating Room Personnel prepared a document that should be read by all residents and their families. It is titled Chemical Dependence in Anesthesiologists: What you need to know when you need to know it and can be downloaded at www.asahq.org/publicationsAndServices/chemical.pdf.
Present Your Medically Challenging Cases at the 2009 Annual Meeting

Please Note the New, Earlier Submission Deadline of June 1!

Four years ago, a new section was introduced at the ASA Annual Meeting that allowed physicians, both attendings and residents, to present medically challenging cases that they have managed. The section has been a resounding success, and each year the number of presentations has grown, with more than 550 cases presented at last year’s Annual Meeting. Discussion is very lively at the poster presentations. Why don’t you consider presenting at this year’s meeting in New Orleans? The section provides a dynamic and informative forum for physicians to share their experiences, teach others how they have handled a difficult situation, and receive feedback as to how others might have proceeded under the same circumstances.

If you have an interesting case that you think others would enjoy hearing about and discussing, please submit it for consideration. Medically challenging presentations are open to ASA members, attendings, and residents and must be submitted online at the Annual Meeting Web site at www2.asahq.org/web/index.asp. Please note that the deadline for submission has been changed and is now June 1, 2009.

Annual Meeting Highlights CME

Anesthesiologists unable to attend the ASA Annual Meeting can subscribe to the 2008 Annual Meeting Highlights online continuing medical education program. The 2008 Annual Meeting Highlights offers more than 25 courses. “Highlights” education sessions are selected by members of the Committee on Annual Meeting Oversight for relevancy to practice, timeliness of subject matter and suitability for electronic delivery. Jointly developed by the Committee on Outreach Education and the Committee on Annual Meeting Oversight, the Annual Meeting highlights programs are Internet-based, multimedia presentations.

Visit the 2008 Highlights Web site at 2008highlightscme.asahq.org for more information on courses and access to registration.

ABA: Overwhelming Response to Voluntary Anesthesiology Recertification Program

The American Board of Anesthesiology’s (ABA’s) voluntary Anesthesiology Recertification Program is being phased out in 2009. Several thousand ABA diplomates applied for voluntary anesthesiology recertification by the original December 31, 2008, deadline. Due to the overwhelming diplomate response to this final recertification opportunity and the fact that ABA has been unable to correspond with diplomates who have not maintained a current address, the ABA Board of Directors has decided to open one final application window to all anesthesiologists certified before 2000 (non-time-limited certificate holders).

Diplomates who want to take advantage of this final opportunity to recertify should submit an application between May 1 and June 15, 2009. Applications for admission to the voluntary Anesthesiology Recertification Program must be submitted via physicians’ portal accounts, which can be accessed from the ABA Web site at www.theABA.org. Applications must be submitted by 11:59 p.m. Eastern Standard Time (EST) on June 15, 2009. After June 15, 2009, Maintenance of Certification in Anesthesiology® will be the only voluntary recertification option for diplomates certified before 2000.

Individuals applying between May 1 and June 15 will have one opportunity to appear for the Anesthesiology Recertification examination, which will be administered through Pearson VUE test centers from December 5-19, 2009. Exam seats are extremely limited; therefore, this testing window is only available to diplomates who apply between May 1 and June 15, 2009.

The voluntary program for Anesthesiology Recertification has two major components: an evaluation of the quality of the applicant’s current practice conducted at the local level, and a secure examination.

ABA will not alter the status of non-time-limited certified diplomates if they do not recertify, and voluntary participation in the Anesthesiology Recertification program will not jeopardize the diplomate’s certification status.
January Cover Gets to Heart of Branding Message

I received the January ASA NEWSLETTER titled “Branded, Reshaping Our Image.” Something struck me immediately about the pictures used on the cover: They showed four men—two standing there doing nothing, one with his feet up, one drinking coffee, and one playing golf. The two women were the only ones doing any work. Is that the image you were trying to express? That men are lazy? Or were you thinking that men are not offended by this sort of thing?

We are, in fact, offended.

Colin Blake, M.D.
Gardner, Massachusetts

Editor’s Note: ASA commissioned opinion research which showed that these negative perceptions of anesthesiologists do exist. The ASA’s Lifeline Campaign is designed to help change these perceptions. Starting this month, make sure to visit www.lifelinecampaign.com. Together we can change our image.

Kudos to Editor’s Quinquagenarian Status

I note with great interest your attainment of quinquagenarian status. My heartiest congratulations on reaching this significant milestone! In May 2008, I had the pleasure of attending my 50th class reunion at Howard University College of Medicine. I was honored to give the class lecture titled, “Historical Vignettes in Anesthesiology.”

My wish for you is that you continue to have as much joy and satisfaction as I have had in my practice over the years. My advice to you is not to set any particular age for retirement, but as long as the passion, the ability and the desire last, to continue. Then, when you do retire, I am sure you will find other interests which will engage the same dedication and verve in you that have characterized your pursuits over the years.

Best personal regards to you and your family.

Clyde W. Jones, M.D.
San Diego, California

Residency Duty Hour Regulations Paying Off?

I read with interest the article by Armin Schubert, M.D., M.B.A., titled “2008 Anesthesiology Resident Class Size and Graduates” (December 2008). One of the observations he noted is “the greater stability in class size since about 2003 compared with higher losses from class cohorts in the years before.” Could we be seeing a beneficial effect of the residency duty hour regulations introduced in 2003 by the ACGME? It would be interesting to see if the trends are similar in other surgical subspecialties.

Robin B. Stedman, M.D., M.P.H.
New Orleans, Louisiana

Old-Fashioned

I appreciate Dr. Bacon’s note in the December “From the Crow’s Nest” letter to Santa about anesthesiologist attire requirements. Despite the few of our colleagues who may argue that the reason to dress in gym style is to lose the extra sweets we had for the holidays and that it makes it easier to camouflage the extra weight, it is a pity that we come to work in our scrubs, clogs and O.R. “hat” (I personally don’t, but I use “we” as esprit de corps).

As a medical student, after the white coat ceremony, I was required to dress in a shirt and tie, and I believe it is a privilege as a physician to maintain a professional décor. But that was the case in the early years of medical school, too, where eating during a lecture or wearing a baseball hat was considered extremely rude.

The personal trainer style is pervading academic and private practice, ala Beverly Hills 90210.

Davide Cattano, M.D., Ph.D.
Houston, Texas
FAER Takes Action to Weather Economic Storm, Preserving Grants and Programs and Protecting Donor Investments

Alan D. Sessler, M.D.  
FAER President

D. David Glass, M.D., Chair  
Board of Directors

At the Foundation for Anesthesia Education and Research, we are dedicated to advancing medicine through education and research in anesthesiology. We are vigilant about protecting our donors’ investments in the spectrum of education and research grants and programs FAER provides.

With the onset of current economic difficulties, we reduced spending to ensure that FAER can meet its $2.5 million in existing grant commitments and continue to offer new grants to our specialty's young investigators. Here are the specific measures we are taking to preserve your investment in anesthesiology's most promising cohort of human capital.

The first constraint introduced by the FAER Board was to reduce the number of grant funding cycles in 2009. Rather than funding grants in both spring and fall, FAER offered just one grant application deadline this year on February 15, 2009.

"In a tight economic environment, it’s important to protect current resources and to conservatively approach funding grant requests," says James R. Zaidan, M.D., Treasurer, FAER Board of Directors. “FAER’s decision to reduce the number of funding cycles in 2009 assures that, when the economy rebounds, we will have the resources to expand our funding cycles and possibly fund additional grants. We hope to return to two grant funding cycles in 2010.”

FAER also made a change to the funding format of our Mentored Research Training Grant (MRTG). Beginning with the February 15, 2009, application deadline, MRTGs no longer provide a $20,000 mentor stipend. MRTGs now provide $75,000 in year one and $100,000 in year two for a total of $175,000 — down from the previous $215,000 per-grant investment. This change reduces the cost of the grant by $40,000 while preserving its original intent — to provide research training for talented young investigators.

The FAER Board also voted to reduce the size, and therefore the cost, of our programs for medical students and residents. The Medical Student Anesthesia Research Fellowship Program, which offers scientifically talented medical students eight to 12-week fellowships in anesthesiology research, will be limited to 40 students in 2009 — down from 61 students in 2008. The Resident Scholar Program, which offers residents the opportunity to experience the ASA Annual Meeting early in their careers and to learn about the specialty's advances and educational opportunities, will also be limited to 40 residents in 2009 — down from 60 in 2008. These changes will ensure that these programs will continue and, hopefully, expand again in the future.

In addition to making changes in how we fund our grants and the size of our programs, FAER took a close look at administrative
expenses. To maintain the grant funds necessary to continue our mission, we reduced staffing as well as capital expenditures, travel costs and office expenses.

Despite funding challenges, with ASA’s support we launched a new program in 2009. The FAER Practice Management Resident Scholar Program is a collaboration with ASA that offers CA-2 anesthesia residents the opportunity to attend the ASA Conference on Practice Management. Twenty grants of $750 were provided to residents’ departments to help defray the cost of sending a resident to the 2009 conference, held January 23-25 in Phoenix. This program gives residents a valuable preview of the challenges and opportunities inherent in practice management, from basic billing and collections to hospital organization to Health Insurance Portability and Accountability Act (HIPAA) compliances and much more.

At the heart of our efforts to ensure that FAER’s work can continue is a deep respect for the specialty and the expression of trust represented by each gift contributed by our supporters, be it a gift of dollars or a gift of time.

“FAER is central to promoting education and research, a mission it shares with ASA,” says ASA President Roger A. Moore, M.D. “Without active research, which is translated into clinical applications, the profession of anesthesiology would stagnate. Support for FAER is support for our profession.”

With your help, FAER and the specialty will emerge from beneath this temporary storm cloud and continue to provide the research and career development opportunities essential to the preservation and growth of our profession.

Keep the Specialty Healthy: Donate to FAER Today!

FAER makes it easy for you to donate. Visit www.faer.org and click the Donate Now button to donate with your American Express, MasterCard or VISA. You can also make a credit card donation by calling FAER at (507) 266-6866, or donate the old-fashioned way by mailing a check to:
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Anesthesiologist in Birmingham, AL
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The University of Alabama at Birmingham invites applications for multiple faculty positions for clinical anesthesiologists in the Department of Anesthesiology. Applications from women and ethnic minorities are encouraged. For more info or to apply, go to http://careers.asahq.org/jobdetail.cfm?job=3066560.32

Anesthesiologist in Connecticut
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Anesthesiologist with interest in Liver Transplant in Atlanta, GA
Full Time – Experienced, Salary: Open
Seeking a faculty anesthesiologist for Emory University Hospital with an interest in liver transplant anesthesia. Will assist with relocation costs. For more info or to apply, go to http://careers.asahq.org/jobdetail.cfm?job=3063730.32

Cardiac Anesthesiologist in Atlanta, GA
Full Time – Experienced, Salary: Open
Board certification or eligibility. The Department of Anesthesiology at Emory University School of Medicine is currently seeking a Cardiac Anesthesiologist. 2 openings. Will assist with relocation costs. For more info or to apply, go to http://careers.asahq.org/jobdetail.cfm?job=3047347.32

Pain Management Faculty
Anesthesiologist in Atlanta, GA
Full Time - Experienced, Salary: Open
The Department of Anesthesiology at Emory University School of Medicine and The Emory Clinic is seeking a faculty anesthesiologist to work at the Grady Memorial Hospital. Will assist with relocation costs. For more info or to apply, go to http://careers.asahq.org/jobdetail.cfm?job=3050146.32

Obstetric Faculty Anesthesiologist at Grady in Atlanta, GA
Full Time – Experienced, Salary: Open
The Department of Anesthesiology at Emory University School of Medicine and The Emory Clinic is seeking a faculty anesthesiologist, with an interest in developing an academic career in obstetric anesthesia, position located at Grady Memorial Hospital. Will assist with relocation costs. For more info or to apply, go to http://careers.asahq.org/jobdetail.cfm?job=3067244.32

Chief, Pain Service & Director Pain Fellowship in Oklahoma City, OK
Full Time – Experienced, Salary: Open, Board Certified.
The Department of Anesthesiology at University of Oklahoma College of Medicine & Health Sciences Center is currently seeking a BC fellowship-trained physician to lead the Pain Service, as well as to oversee the Pain Fellowship Program. For more info or to apply, go to http://careers.asahq.org/jobdetail.cfm?job=3070373.32

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Neuroanesthesiologist in Danville, PA  
Full Time - Experienced, Salary: Open  
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Practice Parameters – 2009 Update

Continued from page 43

an opportunity to consider all opinions (not just those of experts or special interests). It requires pointed criticism at reference committees, debate at caucuses and – perhaps most important – the final and careful approval of the House of Delegates. I agree that there are many steps to follow, but we follow them because they produce a carefully considered and well-understood product.

All of this does come at a price. But ours is less expensive than other groups that develop practice parameters. Our members donate their time to practice parameter development. This is an enormous gift to the specialty, and we truly owe an enormous debt to all who have served on our task forces. We are especially indebted to our past task force chairs, whose leadership and guidance were critical to making our practice parameters among the best in the world.

As for the criticism about the “outdated” nature of our process, there are some important reasons to take exception. Our methods for creating parameters are constantly evolving. We have refined our use of search tools, statistical tests, survey instruments and evidence assessment. An important indicator of our up-to-date status is that our methods for synthesizing and classifying evidence are attracting more and more attention from health analysis in other health care areas.

I would like to add a few words about our Task Force on Chronic Pain guidelines. Its members are experienced, talented and dedicated. The former chair has been replaced by an energetic and insightful new chair, Richard W. Rosenquist, M.D., on whom the timeliness, quality and effectiveness of the guidelines will depend. I am confident that they will produce an excellent guideline in a timely fashion.

The ASA process for developing practice parameters is not perfect. Criticisms and suggestions are important. I welcome them on behalf of our oversight committee and each of our task forces. Our goal is to do the best job now… and a better job in the future.
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