

***THE GAS PIPELINE***  
**ANESTHESIA MONTHLY GAZETTE**  
Department of Anesthesia, Stanford, CA 94305



Patricia I. Rohrs for Audrey G. Pullens, Editor

Volume 11: (No. 11) July–August 2005

**CHAIRMAN'S UPDATE**



July is a time of transition, as our graduating residents complete their three years of anesthesia training and our incoming residents begin a new cycle. Several weeks ago we had our annual resident farewell dinner, which was again a great success. This year's graduating class did not make an audiovisual presentation but instead each resident gave a poignant, humorous, or combined perspective on events during their training. Many residents brought family and friends to celebrate the culmination of a quarter-century of training. Each year I give a nickname to the graduating class. Since this year's graduates applied for residency in 2000, they will be known as "The Class of the Millennium." This nickname also recognizes that this class represents a generational change, where family has an increasingly important value—this year's graduating class has as many children as it does residents.

During the last few weeks of residency, I meet with each graduating resident to get his or her

views on how we can improve the training program. Although each resident makes personal comments, there was a general consensus among the residents on many issues.

**Attendings**—Although specific residents had different favorite Attendings, included were more than half our faculty involved all three institutions. Most all residents stated that they had received superb clinical training and felt extremely confident in their knowledge and abilities. They noted that the workload during residency was high but consistent with their expectations. Residents had no negative comments about any Attending, and no current Attending had repeated negative comments.

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**STEVE SHAFER TO BECOME EDITOR IN CHIEF  
ANESTHESIA & ANALGESIA**

Steve Shafer, incoming Editor-in-Chief (EIC) of *Anesthesia & Analgesia* ([www.anesthesia-analgesia.org](http://www.anesthesia-analgesia.org)), offers his perspective on his forthcoming role as the journal's chief.



The Board of Trustees of the  
International Anesthesia Research Society,

On its behalf and that of the  
Society of Cardiovascular Anesthesiologists,  
the Society for Pediatric Anesthesia,  
the Society for Ambulatory Anesthesia,  
the International Society for Anesthetic  
Pharmacology, and the  
Society for Technology in Anesthesia,

Proudly announces that  
**Steven L. Shafer, MD,**  
Professor of Anesthesia, Stanford University,  
and Adjunct Professor of Biopharmaceutical  
Science at the University of California,  
San Francisco, has been named the next  
**Editor-in-Chief**  
of their illustrious medical and scientific Journal,  
***Anesthesia & Analgesia*,**  
effective April 1, 2006.

Instead of being concerned about professional pressures to “publish or perish” or to become “rich and famous,” (or, at least, famous) he connects his EIC role to his ongoing care for patients, who will benefit from this 83-year-old publication's mission to “foster progress and research in all phases of anesthesia.”

**Continued to right column, this page**

**EDITOR'S NOTE:**

I welcome your feedback on *The Gas Pipeline*. I apologize if items you submitted to Audrey Pullens did not get forwarded to me. If you would like to submit an article or news item for

consideration, please email Patricia Rohrs at [rohrrs@stanford.edu](mailto:rohrrs@stanford.edu)



In his own words, he puts it this way:

Veterans are the world's greatest patients. Many of them are in the VA system because of physical and psychological injuries sustained defending our country. It's an honor to care for them. In my 15 years at the Palo Alto VA, my life as a doctor became defined by the love and care I could bring to the veterans.

Stanford is different, yet the same. It is more impersonal. The patients are more varied. The interactions seem rushed and perhaps more technical. Did77 Lima (trauma name changed to mask confidential PHI), unconscious since falling from a telephone pole, sense how much I cared for him while pumping 30 units through his Level 1? Perhaps not. However, I struggled all night to keep him alive, because he was my patient. I cared a lot for him and did the best I could do.

Whether the task is pumping blood into a trauma patient, developing new drugs for unmet medical needs, or publishing manuscripts to document scientific advances and educate clinicians, the goal is serving patients.

“That's why we work all night, show up the next day to pursue research in the lab, stay up the next night to write review papers, and read journals during vacation. We want to do the best—the absolute best—that we can for our patients.

## STEVE SHAFER, INCOMING EIC (CONT'D FROM PAGE 2)

Medical journals, including *Anesthesia & Analgesia*, ultimately exist for patients. By vetting and documenting advances in medical science, they foster new discovery and innovation that will benefit patients. By bringing the latest research to clinicians, they turn scientific discoveries into advances in medical practice.

*Anesthesia & Analgesia* is not about the International Anesthesia Research Society, our affiliated societies, our editorial board, our authors, our readers, or me. It is about our patients. Most will never see the journal. All will benefit from it.

I owe a lot to the veterans at the Palo Alto VA, and to my patients at Stanford. I will continue to serve them by working as hard making *Anesthesia & Analgesia* the best journal possible as I did to get 77 Lima though a long night.

**Steven L. Shafer, M.D.**  
**Professor of Anesthesia**

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## NEW PUBLICATIONS



**Mariano ER, Chu LF,  
Albanese CT,  
Ramamoorthy C**

Anesthetic Management  
of Infants with Palliated  
Hypoplastic Left Heart  
Syndrome Undergoing  
Laparoscopic Nissen  
Fundoplication

*Anesthesia & Analgesia*, Volume 100, No.6: pp 1631-1633, 2005.

**van der Starre P, Guta C, Dake M, Ihnken K,  
Robbins R**

The Value of Transesophageal Echocardiography  
for Endovascular Graft Stenting of the Ascending  
Aorta. *Journal of Cardiothoracic and Vascular  
Anesthesia*, Volume 18, No.4: pp 466-468, 2005.

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## REPORT FROM INDIA

During monsoon-soaked July, Dr. Chandra Ramamoorthy, Dr. Mohan Reddy (pediatric cardiac surgeon), and other members of a Stanford medical team visited Jaslok Hospital in Mumbai, where their mission was to operate on children with heart disease. The one-week trip was organized by Children's HeartLink of Minneapolis ([www.childrensheartlink.org](http://www.childrensheartlink.org)). The team operated on 16 patients over six days.



One neonate weighing about 2.8 kgm had a successful arterial-switch operation and was released from the ICU in four days. Dr. Ramamoorthy reports “I was fortunate to have the help of Dr. Shanthala Keshavacharya, a trainee from the Stanford anesthesia program, who currently practices cardiac anesthesia (adults and children) in India. Without her help it would be hard to do as many cases as we did.”

Dr. Ramamoorthy also gave talks at the Jaslok Hospital and Research Center on “Advances in pediatric cardiac anesthesia” and “Anesthesia for children with heart disease undergoing non-cardiac surgery.”

Her next stop was beautiful Hyderabad, the Silicon Valley of India—a city filled with historic forts, parks, and the fabulous one-man collection of art housed in the Salar Jung Museum.

She was invited to give talks at the annual meeting of the Pediatric Cardiac Society of India, where she spoke on “Anesthesia for fetal cardiac surgery” and “Advances in pediatric cardiac anesthesia.”

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**CHAIRMAN'S UPDATE (CONT'D FROM PAGE 1)**

**Rotations**—Many rotations were named as being extremely positive experiences.

**Curriculum**—Overall, the residents' comments emphasized the accomplishments we have made over the past several years in improving our educational program.

**Improvements**—However, some comments demonstrated the need for further improvement: (1) We need to emphasize to all Attendings that residents' primary focus must be on educational objectives; clinical needs should not dominate the program. To help achieve educational goals, over the next few months we will significantly expand our original faculty size. (2) Residents noted specific rotations that can be improved. We will increase our efforts to identify the problems and develop solutions. (3) Although residents recognized the many ways the department provided financial and educational support throughout training, the available support needs to be more personally communicated. This year we have restarted our Big Sib program (so that each new resident is paired with a senior resident), and we are restructuring our advisor/mentor program. (4) Finally, we continue to improve our orientation program so that the new residents get off to the best possible start.

**In sum**—The incoming group of 20 residents represents the largest class in Stanford history. As I reviewed in a prior column, they are a truly superb group, possessing both academic excellence and extracurricular achievements. I believe we are offering the best group of residents in the country the best educational experience in the country. Please join me in welcoming the class of 2008 to Stanford.

**Ronald G. Pearl, M.D., Ph.D.**  
**Professor and Chairman**  
**Department of Anesthesia**

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**REPORT FROM INDIA (CONT'D FROM PAGE 3)**

Dr. Ramamoorthy also provided anesthesia care for two, complex operations Dr. Reddy performed at the Apollo Hospital. One of these cases was live-telecast to the audience at the society meeting.

Her subsequent "escape" from Mumbai was marked with the usual GI upsets and the huge floods that struck the area.

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**RESIDENT-OF-THE-MONTH, JULY 2005  
CONGRATULATIONS, DR. DAVID SORAN!**



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**AUD'S CORNER**

*Several years ago, Dr. Peter McDermott, sent me these lessons for life, which I recently rediscovered.*

**1. The cleaning lady.**

During my second month of college, our professor gave us a pop quiz. I was a conscientious student and breezed through the questions, until I read the last one:

“What is the first name of the woman who cleans the school?” Surely, this was some kind of joke. I had seen her several times—tall, dark-haired and in her fifties, but how would I know her name?

**Continued on page 5**

**ATTENDING-OF-THE-MONTH, JULY 2005  
CONGRATULATIONS, DR. DAVID DROVER!**



*Dr. Drover never steals your lines or procedures, no matter how hard you struggle. He would rather coach you through it, and he is so, so smart! He sets a great example and is one of the best Attendings we've got!*

*Dr. Drover deserves to be Attending-of-the-Month! He is an excellent clinician, a wonderful teacher, and all-around good guy to work with.*

*He is always helpful in the OR.... He makes every case a new learning opportunity.*

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**AUD'S CORNER (CONT'D FROM PAGE 4)**

I handed in my paper, leaving the last question blank. Just before class ended, one student asked if the last question would count toward our quiz grade. "Absolutely," said the professor. "In your careers, you will meet many people. All are significant. They deserve your attention and care, even if all you do is smile and say "Hello." I have never forgotten that lesson. I also learned that the cleaning lady's name was Dorothy.

**2. Pick up in the rain.**

One night, at 11:30 pm, an older African-American woman was standing on the side of an Alabama highway trying to endure a lashing rainstorm. Her car had broken down and she desperately needed a ride.

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**DEPUTY CHIEF'S COLUMN  
Rick Novak, M.D. [rjnov@yahoo.com](mailto:rjnov@yahoo.com)**



**Clinical Case of the Month**—A 44-year-old man is scheduled for a knee arthroscopy. He takes Prilosec for Gastro Esophageal Reflux Disease (GERD). He is six feet tall, weighs 70 kg, and refuses regional anesthesia. Regarding airway management for general anesthesia, you may choose a Laryngeal Mask Airway (LMA) or an endotracheal tube. **What do you do?**

**Discussion**—The symptoms of esophageal reflux and heartburn are exceedingly common in our society. For years the histamine-2 blockers, such as cimetidine and ranitidine, were among the top, money-making prescription drugs in America, before they became the over-the-counter bestsellers they are today. Open any weekly magazine today, such as *Newsweek* or *Sports Illustrated*, and you may find full-page ads for Nexium and Protonix. People hurt, and they want these pills.

This prevalence of GERD is relevant in an anesthesia practice because a large percentage of patients will answer "yes" to the question of heartburn or GERD in a pre-operative questionnaire. Thus GERD goes on their chart as a diagnosis. How important is this? Are they an ASA I or and ASA II based on GERD? Do they need endotracheal intubation for general anesthesia to prevent the dreaded complication of pulmonary aspiration of gastric contents?

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## DEPUTY CHIEF'S COLUMN (CONT'D FROM PAGE 5)

A leading textbook says “Because of the limited ability of the LMA to seal off the laryngeal inlet, the elective use of the device is contraindicated in any of the conditions associated with an increased risk for aspiration.

“In patients without these predisposing risks, the risk for pharyngeal regurgitation appears to be low.” (Miller: *Miller's Anesthesia*, 6<sup>th</sup> edition, 2005, pp 1626-7). “GERD has been increasingly appreciated as a risk factor for perioperative aspiration.

“These patients are presumed to chronically aspirate greater quantities of gastric contents during sleep than normal patients do. . . . Patients with GERD should receive preoperative non-particulate antacids (Bicitra) and gastropropulsive medications such as metoclopramide preoperatively, and cricoid pressure should be applied during induction of anesthesia.” (Miller: *Miller's Anesthesia*, 6<sup>th</sup> edition, 2005, p 1860).

I submitted the Clinical Case above to the twenty Attending anesthesiologists in private practice who are members of the Palo Alto Medical Foundation or the Associated Anesthesiologists Medical Group. What follows is a consensus of what the majority do, every day, in operating rooms in the heart of Silicon Valley:

If the patient had GERD well-treated on medication, and had no symptoms at present, my colleagues said they would use an LMA for airway management, rather than intubate the patient's trachea. If the patient had active symptoms of GE reflux that were not under control, then they would use an endotracheal tube following cricoid pressure.

### **Why the disconnect between what we do and what the textbook says? Are we negligent? Is the textbook (gasp) wrong?**

One could be dogmatic and say this: If a patient has GERD, then intubate the trachea with a rapid-sequence intubation each time, or you run the risk of aspiration pneumonitis. And if you do not use an endotracheal tube, and the patient aspirates, you will be practicing below the standard of care. You can be sued and lose

## RESIDENT OF THE MONTH, AUGUST, 2005 CONGRATULATIONS, DR. SHANNON MARTIN!



millions in a devastating malpractice settlement. Defensive medicine is common, right? So why not intubate them all?

A common theme in this column is the *standard of care* in medical practice, defined as “within a specialty field, the standard of care is that of the *reasonably competent specialist*, not that of the most experienced or the least qualified specialist . . . a physician who performs in accordance with the commonly accepted practice of other physicians in similar circumstances will not be held to have been negligent.” (Tsushima WT, *Effective Medical Testifying*, 1998, p 119.)

In a court of law, to prove that an anesthesiologist is negligent, an attorney would have to obtain an expert witness to testify that what the anesthesiologist did was below the standard of care and therefore negligent. Would it be possible to find a medical expert witness to state that the standard of care is to intubate the trachea on all patients with GERD when they have general anesthesia? As one of my partners often states, “For a fee, if the plaintiff attorney searches hard enough, he can find a medical expert witness to say just about anything is below the standard of care.” Furthermore, such an expert witness could validate his or her argument by quoting the references from Miller's textbook above.

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## DEPUTY CHIEF'S COLUMN (CONT'D FROM PAGE 6)

The ProSeal LMA has a larger cuff and a drain tube inside the cuff, which allows the insertion of a gastric tube to drain the stomach. There is a case report in which an anesthetized patient with a ProSeal regurgitated 25-ml of brown fluid into the drain tube. The conclusion was that the ProSeal protected the airway by allowing the regurgitated fluid to pass up the drainage tube without leaking into the glottis. (Evans NR, *Can J Anaesth.* 2002 Apr; 49(4); 413-6). The ProSeal may have a role in this patient population, but to date it occupies a trivial market share of the LMA usage in Palo Alto private practices.

No one would use an LMA to do an anesthetic on a patient who had a full stomach. But on an otherwise healthy NPO patient with treated GERD and no current symptoms, there are anesthesiologists—well trained graduates of the Stanford anesthesia residency program—who use an LMA.

What will you do? When you finish your training, you will decide what you are comfortable with in your practice. You will pay your own malpractice insurance and have to live with the consequences of your complications.

The good news is that the prevalence of clinically important aspiration in otherwise healthy NPO patients is negligible. I believe that is why most of my colleagues use the LMA in this case.

**Clinical case for next month**—The head of your anesthesia group tells you that both the surgeons and the fellow anesthesiologists in your group want you to work faster. If you do not, you will not make partner in that group. You are worried about succumbing to “production pressure.” You don’t want to work faster. **What do you do?**

### ADDENDUM TO DEPUTY CHIEF COLUMN

The election for the two-year term of Vice-President of the Medical Staff at Stanford is being held this month. Current Vice-President Kent Garman, M.D., an anesthesia faculty member, will be promoted to President of the Medical Staff. We have the rare opportunity to elect back-to-back anesthesia colleagues to the office of Vice-President. Bryan Bohman, M.D., a member of

the Associated Anesthesiologists Medical Group on Welch Road, is on the ballot to follow in Dr. Garman’s footsteps. Dr. Bohman, a physician of high integrity, has been in the Stanford community for twenty-five years. He is double-boarded in internal medicine and anesthesia, a past Chief Resident in anesthesia, a past Delegate to the California Society of Anesthesiologists from District 4, a current member of the Stanford Medical Board, and above all, an individual with an outstanding work ethic. I believe that hospital-based physicians such as these two anesthesiologists are uniquely qualified to understand the problems of our Medical Center, and I urge each Medical Staff member to cast a vote for Dr. Bohman, when the ballot arrives in your mailbox.

**Dr. Richard (Rick) Novak is a member of the Associated Anesthesiologists Medical Group.**



### LETTER TO THE CHAIRMAN

**Re: Chairman’s Update in *The Gas Pipeline*, May 2005**

Dear Dr. Pearl,

With sincere and all due respect, I'd like to differ in regards to your perspective on protocols (*The Gas Pipeline*, May, 2005). Protocols do have a role—to substitute for bedside clinical judgment when the latter is unavailable or to augment clinical judgment when uncertainty exists. The use of protocols to supersede clinical evaluation of the patient, when such is readily available, is truly a dubious, if not disgraceful practice. A study in the *NEJM* showed that pts with respiratory failure who were weaned via clinical judgment, were extubated hours to days earlier than those weaned via protocols(1). In an earlier editorial, John Marini, one of the foremost critical-care pulmonologists in the world, stated “At the bedside, the subjective assessment of the weaning trial by an experienced clinician remains the most reliable predictor of weaning success or failure” (2).

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LETTER TO THE CHAIRMAN (CONT'D FROM PAGE 7)

As an attending in cardiac anesthesia at the Cleveland Clinic (4000 hearts/year), protocols for extubation virtually forbade treating a pt based on clinical parameters and just looking at the patient from the foot of the bed, thereby delaying the extubation of post-op hearts for hours. Even the mother of a nationally prominent cardiac anesthesiologist was forced to endure hours extra on the ventilator because of the protocols, while her son sat at the bedside.

High-dose opioid anesthesia for cardiac surgery is itself a great example of protocolized practice that endured long after its time was gone.

With the almost primitive surgical and anesthetic techniques for heart surgery in the 60s and 70s that were employed in often desperately ill patients, there is no doubt that opioid anesthesia was a godsend during those early years (1).

Yet the practice continued into the 2000s, despite much improved anesthetic agents and adjuncts, monitoring modalities, and surgical and perfusion techniques—all this employed in *much* healthier patients than those who frequently underwent cardiovascular surgery as a last-ditch effort in the early days, and despite *multiple* reports in the literature that demonstrated equivalent or superior results using inhalation agents or intrathecal opioids (3-16).

*My* answer to routine and complex clinical problems is not development of a protocol, but the attention of an interested clinician, who is willing to devote the time, and is not afraid to think outside the box. Chalmers summarized this view as follows: “The practice of medicine is in effect the conduct of clinical research... Every practicing physician conducts clinical trials daily as he is seeing patients” (17). The development of protocols is simply an outgrowth of the increasing rarity of clinicians so inclined to put in the time and effort.

Sincerely,

Leo Stemp  
leos@cox.net

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## LETTER TO THE CHAIRMAN (CONT'D FROM PAGE 8)

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## THE CHAIRMAN'S RESPONSE

Dear Leo,

Thank you for the comments. Although your letter was written as an evidence-based argument against the use of protocols, in fact it has an abundance of evidence which argues in favor of the use of protocols. For example, the Ely study in *NEJM* which you quote demonstrated that the

use of a protocol to identify patients who were ready for extubation shortened the time to extubation by 1.5 days compared to using physician judgment alone in the absence of any protocol. This study has subsequently been replicated multiple times with similar results. The literature is replete with studies showing improved outcome in a wide range of patients with the use of best-practice protocols; in contrast, almost no studies suggest that physician judgment is better than protocol management. Similarly, multiple studies in cardiac anesthesia have demonstrated that fast-track protocols result in earlier extubation and fewer complications than physician judgment alone. I would argue that physicians did not adopt advances into their practice because they relied on "clinical judgment," rather than on new, best-practice protocols. There can be protocols that do not constitute best practice, and they can result in bad patient care. However, I continue to have difficulty understanding why an individual physician would believe that his or her approach to a standard patient would be better than a consensus approach developed by experts in the area. If you or your loved one were sick, would you not want expert opinion to guide your care?

I believe your discomfort with protocols is based on an assumption that patients are made to fit protocols, even when the patient does not. Protocols should never prevent physicians from being able to use clinical judgment, when the judgment is based on the specific characteristics of an individual patient. However, it is difficult to justify having multiple, different approaches simply because there are different physicians. Protocols that present an approach to the routine patient consistently improve outcomes and promote the interdisciplinary approach that is important in current clinical practice.

**Ronald G. Pearl, M.D., Ph.D.**



## THE PIPELINE

### INVITED TALKS

- ❖ John Brock-Utne spoke on “When clinical research goes wrong” at the University of Oslo, Norway on May 6 (Rikshospitalet) and May 26, 2005 (Ullevaal Hospital).
- ❖ Andrew J. Patterson, M.D., Ph.D. spoke on “Blood Pressure Management for the Critically Ill Neurology Patient” at the El Camino Hospital Stroke Seminar on June 14, 2005.
- ❖ Andrew J. Patterson, M.D., Ph.D. spoke on “Pharmacologic Control of Perioperative Cardiac Risk” at Grand Rounds, UCSF East Bay Surgery Program on August 18, 2005.
- ❖ Jim Wong, M.D. (presenting author) spoke on “The beta2 Adrenergic Receptor PDZ Binding Motif: Assessment of Its Role in Cardiac Protection” at the 9th Congress of the World Federation of Societies of Intensive and Critical Care Medicine in Buenos Aires, Argentina in August, 2005. Authors are Jim Wong, Craig Chen, Helen Hwang, Amy Romer, Meghaan Walsh, Monica Feliu-Mojer, Rani Agrawal, M.S., and Andrew J. Patterson, M.D., Ph.D.

### HONORS

Christina Mora Mangano, M.D. is president-elect of the Society of Cardiovascular Anesthesiologists (SCA). This six-year term includes two years as president-elect, two as president, and two as immediate-past-president. Dr. Mangano is the first woman to hold this position in the 28-year history of SCA, which now includes 6000 anesthesiologists interested in practicing cardiac, thoracic and vascular anesthesia.

### NEW FELLOWS

The CV Anesthesia Service welcomes two fellows: Daryl Oakes, M.D. and Charles Hill, M.D. Daryl returns to the Bay Area from Brigham and Women’s. Married to Dr. Benny Gavi, Daryl is the daughter of Dr. David Oakes and the mother of baby Ethan. Charles, from Vanderbilt University, is the husband of the new attending anesthesiologist, Jonay Hill, M.D.

## THE ALUMNI REUNION RECEPTION

The Department of Anesthesia at Stanford



cordially invites you to attend its alumni reunion

Date: Sunday, October 23, 2005

Place: New Orleans Hilton  
Riverside Hotel

Time: 6:00-8:00 pm. RSVP to Renee Grys,  
[grys@stanford.edu](mailto:grys@stanford.edu) 650.7223.5439.

### NEW RESIDENTS WELCOMED AT BRUNCH

Jill Wilson reports that July’s annual welcome brunch, hosted by the Anesthesia Department for new residents, was a smashing success. Twenty new residents (named below) were greeted with champagne and a delicious assortment of breakfast entrees plus desserts at the Palo Alto Hills Club, overlooking a beautiful golf course and vistas of the Bay and foothills. Ron Pearl welcomed each resident and asked for a few words of self-introduction. Renee Grys planned this outstanding event.

Scott Ahlbrand	Lindsey Atkinson
Albert Chiang	Joshua DuBois
Melissa Ennen	Ryan Green
Jiang-ti Kong	Thomas Kyler
Rachel Lecha	Rakesh Marwah
Samuel Mireles	Sheila Rajagopal
Nicolette Roemer	Echo Rowe
Vicki Ting	Van Tran
Glenn Valenzuela	Michael Wagner
Manik Wijesinghe	Jimmy Wong

### UPCOMING MEETINGS

- ✓ Sept 9–11: CSA, The Changing Practice of Anesthesia, San Francisco
- ✓ Oct 21: SPA, annual meeting, New Orleans
- ✓ Oct 21: SAMBA, Exciting Developments in Ambulatory Anesthesia, New Orleans
- ✓ Oct 21–22: ISAP, annual meeting, New Orleans
- ✓ Oct 22–26 ASA, annual meeting, New Orleans

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## THE PIPELINE (CONT'D FROM PAGE 10)

- ✓ Oct 23: STA, 2005 Dinner & Ty Smith Annual Lecture, New Orleans
- ✓ Oct 24: STA, Breakfast Panel *Wireless Technology in the Operating Room*, New Orleans
- ✓ Oct 31–Nov 4 CSA, Hawaiian seminar, Kauai

## GOODBYES

The CV Anesthesia Service bids farewell to Jens Looser, M.D., who completed a thoracic fellowship with Dr. Jay Brodsky. A welcome addition to the CV faculty, Jens returns home to a busy CVT practice in Vancouver, assured there is always a position for him here at Stanford. Good-luck, Jens! We will miss you!

## BIRTHS

CA-1 resident Ryan Green, his wife Marci, and their son Alex welcomed David Francisco Green (8lbs. 3 oz.) on July 22<sup>nd</sup>. Everyone is doing well.

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## MISSION TO HELP GUATEMALA'S RURAL POOR

Accompanied by twelve, armed soldiers to protect them from bandits and drug gangs, a volunteer, interdisciplinary medical team, led by obstetrician/gynecologist Dennis Siegler of the Palo Alto Medical Foundation, drove through steaming, dense, highland jungles of Guatemala to the remote village of Nuevo Progreso, near the border with Chiapas, Mexico.

Sponsored by Hospital de la Familia ([www.hospitaldelafamilia.com](http://www.hospitaldelafamilia.com)), a rural hospital run by nuns in Nuevo Progreso, the team's mission was to care for underprivileged children and adults. The team included general and plastic surgeons, ophthalmologists, gynecologists/obstetricians, anesthesiologists, pediatricians, nurses, optometrists, and technicians.

During their mission, the team performed surgeries ranging from cleft lip and palate repairs for children to thyroidectomies, cholecystectomies, and total abdominal hysterectomies for adults.



They also delivered babies and treated adult and pediatric emergencies that presented during their stay. Some patients walked for many miles and days to be treated.

Working conditions were austere but adequate in the make-shift hospital run. Frequent, tropical thunderstorms caused daily power outages, forcing surgeons to operate by flashlight.

The team was unified and strengthened by its common goal of helping those in need.

Volunteers for this important mission were:

- ❖ **Stanford Residents:** Amy Evers, M.D. (Anesthesia), Anjali Rao, M.D. (Gynecology), Musa Zamah, M.D., Ph.D. (Gynecology), Christine Ham, M.D. (Surgery), Steven Bates, M.D. (Plastic Surgery)
- ❖ **Stanford Faculty:** Andrew J. Patterson, M.D., Ph.D. (Anesthesia), Bert Johnson, M.D. (Obstetrics/Gynecology), Gerald Shafren, D. (Obstetrics/Gynecology), George Yang, M.D., Ph.D. (General Surgery), and Steve Sanislo, M.D. (Ophthalmology)
- ❖ **Stanford Optometrist:** Katherine Warner, O.D.
- ❖ **Stanford Nurse:** Betty Kolbeck, R.N.
- ❖ **Packard Nurse:** Carol Kibler, R.N.
- ❖ **Palo Alto Medical Foundation Physician:** Dennis Siegler, M.D. (Obstetrics/Gynecology)

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- ❖ **El Camino Hospital Physician:** Seth Strichartz, M.D. (General Surgery)
- ❖ **Private Practitioners:** Gary Donath, M.D. (Plastic Surgery, San Luis Obispo), William J. McClure, M.D. (Plastic Surgery, Napa), and Dana Duncan, M.D. (Pediatrics, San Jose).
- ❖ **Stanford Anesthesia Alumni:** Mike Champeau, M.D, Matt Oldroyd, M.D., and Eric Amador, M.D.
- ❖ **Stanford Affiliate:** Jeremy Pearl, who worked as translator, scrub tech, anesthesia assistant, instrument cleaner, carrier of small children, and human ventilator.

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AUD'S COLUMN (CONT'D FROM PAGE 5)

Soaking wet, she flagged down the next car. A young, white man stopped to help her, an act generally unheard of in those conflict-filled 1960s. He took her to safety, helped her get assistance, and put her into a taxicab. She seemed to be in a big hurry, but wrote down his address and thanked him.

Seven days passed, and a knock came on the man's door. To his surprise, a giant, console color television set was delivered to his home with special note attached:

*"Thank you so much for assisting me on the highway the other night. The rain drenched not only my clothes, but also my spirits. Then you came along. Because of you, I was able to make it to my dying husband's bedside, just before he passed away.*

*Sincerely,  
Mrs. Nat King Cole*

### 3. Always remember those who serve.

In the days when an ice cream sundae cost much less, a 10-year-old boy entered a hotel coffee shop and sat at a table. A waitress put a glass of water in front of him. "How much is an ice cream sundae?" he asked. "Fifty cents," replied the waitress. The little boy pulled his hand out of his pocket and studied the coins in it. "Well, how much is a plain dish of ice cream?" he inquired.

By now more people were waiting for a table, and the waitress was growing impatient. "Thirty-five cents," she brusquely replied. The little boy again counted his coins. "I'll have the plain ice cream," he said. The waitress brought the ice cream, put the bill on the table, and walked away. The boy finished the ice cream, paid the cashier, and left. When the waitress came back, she began to cry as she wiped down the table. There, placed neatly beside the empty dish, were two nickels and five pennies. You see, the boy couldn't have the sundae, because he had to have enough left to leave her a tip.

### 4. Giving when it counts.

Many years ago, I got to know a little girl named Liz, suffering from a rare and serious disease. Her only chance of recovery was a blood transfusion from her five-year-old brother, who had miraculously survived the same disease and had developed antibodies to combat the illness. The doctor explained the situation to Liz's little brother, and asked him if he would be willing to give his blood to his sister. I saw him hesitate for only a moment before taking a deep breath and saying, "Yes, I'll do it, if it will save her." As the transfusion progressed, he lay in bed next to his sister and smiled, seeing the color return to her cheeks. Then, his face grew pale, and his smile faded. Trembling, he looked up at the doctor, "Will I die right away?" The little boy had misunderstood the doctor; he thought he was going to give his sister *all* of his blood to save her.

So you see, after all, understanding and attitude are everything!

