

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



Patricia I. Rohrs, Editor

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CHAIRMAN'S UPDATE



The future looks bright.

A specialty's future depends upon the quality of the people who enter it. In anesthesia, the caliber of both our starting and graduating residents continues to dramatically increase, at Stanford and elsewhere. One measure is U.S. medical school graduates' performance on the written board examination. Whereas the pass rate was 71% in 2000, it has steadily increased: to 77% in 2001 and an average of 84% in 2002–2004. Although the 2005 data are not yet available, at the oral examinations several weeks ago, we learned that the number of candidates passing the written examination increased by 300 this year (approximately a 20% increase).

The annual, in-training examination (ITE) for anesthesia residents provides another measure of quality (ITE significantly overlaps with the written boards). National data indicate that on average residents in all three classes perform at a

significantly higher knowledge level (equivalent to one-half year of training) than in prior years. We have seen similar performance increases among students in our residency classes at Stanford; in fact, 16 of the 22 residents who will take the examination next year already possess this year's passing scores. I expect this trend to continue because the number of medical students applying to anesthesia is unprecedented.

We celebrate milestones

This fall, we celebrate two departmental milestones: First, Mike Rosenthal will complete 30 years as our division chief for critical-care medicine, and second, Aud Pullens, the spirit of the department for over two decades and founder and editor of *The Gas Pipeline*, is retiring.

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Recruited to Stanford in 1975 as Medical Director of the Intensive Care Units, Mike Rosenthal has remained a leader in critical care and anesthesia throughout his three decades at Stanford. During these years Mike oversaw tremendous expansion of critical-care services at Stanford and developed a primary, interdisciplinary, critical-care system that has been adopted worldwide as a model. He trained over 100 critical-care fellows, more than half of whom have entered academic medicine, where they now run critical-care units and anesthesia departments throughout the U. S. and Canada. Mike's responsibilities have encompassed the growth of our critical-care division's faculty—from three to the current eleven; oversight of three critical-care services (medical-surgical, surgical-trauma, and cardiothoracic) and development of the single, integrated service at the VA.

During his tenure, Mike has also served as president of the American Board of Anesthesiology and president of the Foundation for Anesthesia Education and Research. His awards include the Lifetime Achievement Award from the American Society of Critical Care Anesthesiologists, the Ellis N. Cohen Achievement Award (Mike was the original recipient of our department's highest honor), and multiple Bloomfield and Kaiser medical student teaching awards. To honor Mike's contributions to critical care, anesthesia, and Stanford, the department created the annual Myer H. Rosenthal Lectureship in Critical Care. Tom Feeley, who worked for 21 years with Mike as a faculty member in critical care at Stanford, gave the inaugural lecture Saturday, October 15, 2005 at 3 p.m. in Packard Auditorium. Tom is now Professor and Head of the Division of Anesthesiology and Critical Care at the University of Texas M.D. Anderson Cancer Center. Appropriately, Tom's topic is "The Evolution of Critical Care Medicine in Healthcare: Reflections on Thirty Years of Supporting Life." After the lecture the critical-care faculty and fellows held a special celebration honoring Mike's contributions.

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Katrina's destructive rampage awakened awe, fear, despair, and compassion. It spurred the medical community's desire to serve the victims. This devastation also presaged what is likely to happen here—a major, devastating earthquake. None of us likes to imagine such dreadful scenarios. However, in August 2001, FEMA predicted three U.S. catastrophes: a terrorist attack in New York City, a full-strength hurricane that would wipe out New Orleans, and a major earthquake along California's San Andreas Fault. Two of the predicted disasters have occurred in just four years.

Stanford physicians' response to Katrina was amazing. Eighty-five doctors, including me, were willing to be deployed on short notice for a two-to three-week tour of duty. So far, however, neither FEMA nor the Red Cross has yet asked for our assistance, but they may need to send in volunteer teams until at least December.

Many of my friends from elsewhere were deployed within two days of the disaster and served under harrowing, dangerous conditions. Frustrated by my inability to be among them, I researched exactly how the Federal government and the Red Cross organize and execute such deployments, so that I could satisfy my desire to know and also pass along that knowledge to you.

Do not just show up

The Policy on Unsolicited Medical Volunteers (published by The American College of Emergency Physicians and the National Association of EMS Physicians) specifies an organized, sponsored approach in a disaster. Emergency agencies will likely turn away healthcare professionals who simply appear, unsolicited, for work, because they will not be covered under a Federal program and they may not be credentialed to practice medicine in the affected state. If they do actually work, healthcare professionals subject themselves to liability, because they are not sponsored by a Federal program. They may also be violating state law against practicing without a license.

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FAREWELL, AUDREY (AUD) PULLENS

With Aud Pullens' retirement from Stanford's Department of Anesthesia after two decades, serving in many different roles, an era has ended.

Aud is one-of-a-kind, and she accomplished much. Residents will remember her as "mother Aud." Like a mother, older sister, or friend, she was always there to listen and nurture. She initiated the Resident-of-the-Month program to help recognize the special accomplishments of her wards. Aud launched and edited *The Gas Pipeline*, the newsletter you are now reading. She was in constant touch with faculty, residents, fellows, staff, and alumni—all of whom provided grist for her editorial mill. She wrote *Aud's Corner*, a monthly column that added her special touch to the publication.

What could be more appropriate than to publish in the next edition of *The Gas Pipeline* a special *Aud's Corner* that contains your reminiscences about her? I am asking former residents, faculty, staff members, and other readers (even surgeons) to please send your anecdotes to me at Jbrodsky@stanford.edu or to rohrrs@stanford.edu

Jay B. Brodsky, M.D. Professor of Anesthesia

RESIDENT-OF-THE-MONTH, SEPTEMBER 2005 CONGRATULATIONS, DR. AMY EVERS!



CHAIRMAN'S UPDATE cont'd from page 2

We celebrate milestones

The other major departmental milestone is Audrey (Aud) Pullens' retirement after over two decades of service. Aud established and edited *The Gas Pipeline*, which this year celebrated its 100th edition. Aud helped more than 300 residents survive Stanford and continue their association as active alumni. She created the prizes for Resident-of-the-Month and featured the honored resident in *The Gas Pipeline* (see photo to left). Most important, during her years with Stanford, Aud was a steadfast friend to uncountable numbers of departmental faculty, fellows, residents, and staff. In her typical fashion, she did not want a retirement celebration. Instead, we will celebrate her accomplishments and contributions by collecting your stories for a special *Aud's Corner*.

ASA in Atlanta

Finally, in recognition of the tragedies resulting from Hurricane Katrina, this year we will not have an alumni reception at the ASA. However, I hope to see many of our faculty and alumni in Atlanta this year and look forward to a larger celebration next year in Chicago.

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

CARDIOVASCULAR ANESTHESIOLOGY FELLOWSHIPS

The CV faculty is pleased to announce that outstanding residents Matt Kolz and David Soran, have been accepted at Stanford for one-year fellowships in Cardiovascular Anesthesiology. Matt's PhD. work is in engineering and ultrasound. David is a Board-certified internist. Welcome to both!

**DAVID GABA TO BECOME EDITOR-IN-CHIEF
*SIMULATION IN HEALTHCARE***

David Gaba, Associate Dean for Immersive and Simulation-based Learning (ISL), has been appointed editor-in-chief of a new journal, *Simulation in Healthcare*. Daniel Raemer, Ph.D., president of the Society for Medical Simulation (<http://www.socmedsim.org>), which sponsors the new journal, announced this appointment:



It is a great honor to announce that David M. Gaba, M.D. has been named as Editor-in-Chief of *Simulation in Healthcare*, the official journal of the Society for Medical Simulation. Dr. Gaba is currently the Associate Dean for Immersive and Simulation-based Learning at Stanford University School of Medicine, where he is a Professor of Anesthesia. His accomplishments in the field date back to the mid-80s where he pioneered simulation as a technique to teach crisis management in Anesthesiology and later in a number of other specialties. A prolific writer, Dr. Gaba produced many landmark papers in the application of simulation, as well as a classic textbook, numerous editorials, book chapters, and other important writings. Anyone who has heard him speak cannot help but appreciate his thoughtful and seasoned reasoning, deep understanding of research methodology, and clear, powerful expression. Only those who know him best truly understand the tremendous dedication to patient safety and learning that has embodied Dr. Gaba throughout his career in healthcare.

The Society and the Journal could not be endowed with a more worthy Editor-in-Chief....

According to *Stanford Anesthesia News* (2005-2006) Dr. Gaba "...defines how the School should use immersive and simulation-based technologies to support Stanford's clinical, research, and educational missions [and]...integrate the efforts of the VA Palo Alto Health Care Systems Simulation Center with the Center for Advanced Pediatric Education (CAPE), Stanford University Medical Media and Instructional Technology (SUMMIT), and the Department of Surgery's Center for Simulation in Medicine."

Dr. Gaba himself states "This appointment is another sign of Stanford's strength in Immersive & Simulation-based Learning." Look for *Simulation in Healthcare* in 2006.

NEW PUBLICATIONS



**Carvalho B, Cohen SE,
Giarrusso K, Durbin M,
Riley ET, Lipman S.**

"Ultra-light" patient-controlled epidural analgesia during labor: effects of varying regimens

on analgesia and physician workload.

Int J Obstet Anesth. 2005 Jul; 14 (3):223-9.

**Fuller A, Rivera L, Schmiesing C, and
Angelotti T.**

Perioperative management of previously undiagnosed hypertrophic cardiomyopathy in the older patient: Is there cause for concern?

J Clin Anesth (2005) 17:478-81.

DISASTERS cont'd from page 2

Thus medical personnel should respond to an emergency only if requested by the jurisdiction's EMS agency, unless they are already part of a federally credentialed group.

Instead, go through channels

You can join an organized team of healthcare professionals via one of these channels:

- Respond to a request from Health and Human Services (HHS) or FEMA.
- Volunteer online with HHS.
- Join a Disaster Medical-Assistance Team (DMAT).
- Join a Medical Reserve Corps (MRC).

Respond to an HHS/FEMA request to hospitals— Secretary Leavitt from HHS asked our regional Hospital Council, who asked Stanford Hospital to compile a list of credentialed, healthcare volunteers. If asked by FEMA, Stanford will send credentialed physicians, nurses, and others—all presumed to be a cohesive unit. In actuality, the group will not have been trained in disaster and field-medicine subjects and techniques.

Volunteer online with HHS—As an individual you can volunteer online via the HHS offices of The Surgeon General and Public Health Emergency Preparedness, both of which are identifying and mobilizing healthcare professionals and relief personnel to assist in Hurricane Katrina relief efforts (See <https://volunteer.ccrf.hhs.gov/>). The Office of the Surgeon General will contact only those who meet the field's requirements and needs. A caveat here is that as an individual, your lack of disaster training may result in not being able to contribute much. (Note: Two weeks after the disaster, HHS stopped accepting online applications, after having received 33,000 of them. It is doubtful any of these volunteers will be deployed.)

Join a Disaster Medical-Assistance Team (DMAT)— Within 8 hours of the Katrina disaster, FEMA deployed rapid-response, field-trained DMATs to Gulf state locations—to

supplement local medical care at fixed or temporary sites, until other resources could be mobilized. These 35-person volunteer teams consist of medical professionals, medical para-professionals, and logistical and administrative staff. Each team carries sufficient supplies and equipment to sustain itself for 72 hours. Once on site, tasks include patient triage, austere medical care, primary care, and patient evacuation. Tasks may also include receiving and disposition of patients to hospitals.

Highly specialized DMATs also exist. Some specialize in medical conditions like crush injury, burn, and mental-health emergencies. Others specialize in mortuary services (Disaster Mortuary Operational Response Teams or DMORTs), veterinary services (Veterinary Medical Assistance)

Teams or VMATs), and medical care for victims of weapons of mass destruction (National Medical Response Teams or NMRTs). Each DMAT team is sponsored by an entity—major medical center, public health or safety agency, non-profit, public or private organization—but a team can be activated by Emergency Medical Services (EMS) agencies at the county, state, or federal level. The sponsor recruits, organizes, trains, and deploys the team. Team members must meet certain requirements: maintain appropriate certifications and licensure within their disciplines, be up-to-date with immunizations, receive training, and attend meetings. When DMAT teams are deployed as part-time, paid Federal employees, their licensure and certification is recognized by all states, and they are protected by the Federal Tort Claims Act, which mandates the Federal government as the defendant in a malpractice claim.

Nationally, more than 29 teams exist, each with 50 to 150 civilian volunteers. California has five teams, which are part of California Emergency Medical Services Authority (www.emsa.ca.gov/dms2/dmats.asp). The nearest California team is the Menlo Park-based California Bay Area DMAT CA-6 (www.dmatca6.org), which meets every two months for overnight or multi-day field exercises.

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ATTENDING-OF-THE-MONTH, SEPT 2005
CONGRATULATIONS, DR. NATASHA FUNCK!



Residents say this about Dr. Funck: "Anybody who has worked at the VA knows how incredibly kind, patient, interested, and supportive she is. She's available to help with regional blocks with all patients, changing her schedule, double covering, being the extra attending, staying late to teach... and because she does this, the VA is one of our best opportunities to learn regional.

She's interested in all the cases, not just the ones to which she's assigned, and she's always someone you can turn to for additional teaching, advice, insight into a particular procedure or patient.

... she surely deserves it. She is ... always willing to explain things...she is a strong advocate and excellent teacher of regional anesthesia."

ABSTRACTS

The following abstracts were presented at the International Association for the Study of Pain Meeting in Sydney, Australia in August 2005:

- ❖ Ueno T, Soneji D, Ludlow D, Kaplan K, Glover G, Mackey SC *Reorganization of the Somatosensory Cortex in Complex Regional Pain Syndrome*
- ❖ Soneji D, Maeda F, deCharms C, Lutomski K, MacLeod S, Gabrieli J, Glover G, Pauly J, Kaplan K, Mackey *Real Time fMRI Augmented Learned Control of Brain Activation and Pain in Chronic Pain Patients: Preliminary Results*

ABSTRACTS continued

- ❖ Ludlow D, Soneji D, Ueno T, Kaplan K, Palma C, Patil E, Glover G, Sawyer-Glover A, Mackey SC *Intensity Encoding of Noxious Thermal Pain in the Human Cervical Spinal Cord*
- ❖ Nemenov, Michael I., Greenspan, Joel D., Crottaz-Herbette, Sonia, Cuellar, Jason M., Yeomans, David C. *Pricking Pain vs. Burning Pain Selectively Evoked by Infrared Diode Laser Stimulation*
- ❖ Crottaz-Herbette, Sonia, Nemenov, Michael I., Angst, Martin S., Klyukin, Mikhail, Cuellar, Jason M., Yeomans, David C. *Selective Activation Of C vs. A Nociceptors by Infrared Diode Laser Stimuli in Humans: an Evoked Potential Study*
- ❖ Yeomans, David C., Levinson, S. Rock, Tzabazis, Alexander, Gilly, William F., Wilson, Steven P. *Antihyperalgesic Effect of Herpes Vector Mediated Knock-Down of NAV1.7 Sodium Channels in a Rodent Inflammatory Model*
- ❖ Tzabazis, Alexander, Yeomans, David C., Nemenov, Michael I., Klyukin, Mikhail, Manering, Neil *C vs. A Selective Stimulation of Nociceptors in Rats by Infrared Diode Laser: Behavioral Evidence*
- ❖ Sluka KA, Radhakrishnan R, Audette K, Price MP, Yeomans DC, Wilson S, Welsh MJ. *ASIC3 Mediates Mechanical but not Heat Hyperalgesia after Muscle Inflammation*

FDA CONNECTION

Steve Shafer has been reappointed chair of the FDA's Anesthesia and Life Support Drugs Advisory Committee.

New email address? Send it to roh@stanford.edu

I myself am joining DMAT CA-6, having completed the extensive Federal application forms (over 30 pages). I would be happy to talk to anyone about my pending experience. Eric A. Weiss is also a member of DMAT CA-6, and he can give you his insights. Be sure to ask your hospital administrators to answer these questions. Moreover, if you are not already involved in your hospital's emergency-preparedness committees, volunteer immediately.

Join a Medical Reserve Corps (MRC)—From the Medical Reserve Corps website (www.medicalreservecorps.gov) you can locate and join the nearest MRC (29 exist in California). MRCs train community volunteers according to local needs and vulnerabilities, but they can also be deployed in state or national emergencies. Their focus is public health during such disasters as major communicable disease outbreak, earthquake, flood, or act of terrorism. However, in addition to such volunteers as current or retired health professionals (such as physicians, nurses, mental health professionals, dentists, dental assistants, pharmacists, veterinarians), an MRS may include professionals in communications/public relations, healthcare administration, and religious work. **See page 10**

READ *STANFORD ANESTHESIA NEWS*

The beautiful 2005-2006 edition of *Stanford Anesthesia News* features all facets of simulation-based training at Stanford. Learn about simulation's range of benefits for patients and physicians. Be sure to also read about spectacular research projects and spectacular increases in their funding, fascinating international medical missions, residency updates, and airway management training. There's also a newsmaker interview of Ron Pearl and a profile of Ellis Cohen, an emeritus pioneer. Get your copy from the front business office or visit <http://anes.stanford.edu/default.aspx>



Clinical Case of the 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, and 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?**

Discussion—At the end of your day in the operating room, the most important issue is the safe medical care of each patient you were asked to consult on. Patients don't care if you were a racehorse or a turtle; they care only about their results. Your malpractice insurance company doesn't care either if you were a racehorse or a turtle; they want you to practice at or above the standard of care and not get sued. Nevertheless, production pressures are a reality, especially in fee-for-service (FFS) practices.

In their article “*Production Pressure in the Work Environment, California Anesthesiologists' Attitudes and Experiences*,” David Gaba and Steve Howard of the Stanford faculty (*Anesth*, 1994 Aug; 81(2):488-500) discuss this pressure. The authors mailed a survey to California anesthesiologists, seeking their responses to questions pertaining to production pressure. The author's noted, “Every

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DEPUTY CHIEF'S COLUMN cont'd from page 8

modern industrial activity involves a balance between production efficiency and safety.” They defined production pressure as “overt or covert pressures and incentives on personnel to place production, not safety, as their primary priority.”

Fifty-four per-cent of respondents agreed they had made an error attributable to fatigue, and 63% suggested that they had made errors because of the work load within a case. Most respondents believed they had a duty to cancel cases if necessary, but 35% indicated that it was possible they would lose their job if they canceled too many cases.

Pressure was divided into two categories: internal pressures (pressures anesthesiologists put on themselves), and external pressures (pressures from surgeons, family, colleagues, or administrators). The greatest internal pressures were: a) to avoid delaying surgery, b) to get along with surgeons, and c) to avoid litigation. The greatest external pressures were: a) from the surgeon, to proceed with a case instead of canceling, b) from the surgeon, to hasten anesthesia procedures, and c) from administrators, to reduce turnover time. FFS respondents reported more internal pressure than did salaried practitioners to: maximize cases (P=0.0007), accrue income from high paying cases (P=0.0001), and avoid litigation (P=0.0002).

I worked a short stint in a salaried anesthesia job with Kaiser in 1986, before I began working in my current FFS practice. Production pressure most certainly exists, and I can attest that it is more apparent in FFS practice, where you have incentives to proceed with cases rather than cancel them, to turn over rooms quickly rather than take a 30-minute lunch break, and to keep your surgeon-customers happy rather than fight with them over cancellations.

I discussed today's question with other anesthesiologists in top Bay Area FFS practices. Among their expectations for new hires is that the individuals will possess The Three A's: Ability,

Availability, and Amiability. Part of the Ability ingredient is the talent to multi-task, that is, works with your hands, do paperwork, think, plan anesthetics, and monitor your patient simultaneously.

Some anesthesiologists are racehorses, and some are turtles. Consider this: All else being equal, the turtles will not last in FFS.

Surgeons in private practice in are faster than surgeons in residency. When you graduate and enter the private practice of anesthesia, you, too, will have to speed up to succeed. The message here is a wake-up call: Don't stand in the middle of the operating room and complain about production pressure. Work as efficiently as you can. Do not take short-cuts that endanger your patient, but get the job done.

If it sounds like I am applying production pressure with my comments, you may be right. Safety is the number one goal, but high production is an expectation, and not an unreasonable one.

The years of residency and fellowship are the time to hone your skills. Attempting to work at an efficient pace during the first weeks of your first FFS job will be impossible if you haven't valued efficiency in your training. If you are a turtle, will you lose your job? I have heard anecdotes about private FFS anesthesia groups washing out promising candidates because they were too slow for the private world. The candidates spent too much time starting IV's and other lines, getting their patients to sleep, placing regional anesthetics, waking their patients up, taking longer-than-expected breaks between cases, and arguing with surgeons instead of getting patients anesthetized.

Some surgeons are better than others. Anesthesiologists, nurses, and OR techs all know which ones possess excellent judgment and skill with their hands. In the same light, surgeons, nurses, and OR techs all know which anesthesiologists possess excellent judgment and skill with their hands. You want to be one of the anesthesiologists they admire.

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If the pace of the FFS world feels unsafe to you, I would advise you to find a different job model, perhaps a salaried job at a more languid tempo. In a FFS practice, you need to be both safe and efficient.

Clinical case for next month—A 76-year-old, 65 kg, 4-foot 11-inch tall friend of your family has elective CABG surgery at an outside hospital. Twenty-four hours after the surgery, she is still asleep and on the ventilator. You inspect the anesthetic record, and discover that the anesthesiologist used 20000 micrograms of fentanyl and 10 mg of midazolam for a four-hour anesthetic. The patient received no additional sedation in the ICU. **What do you do?**

ADDENDUM TO DEPUTY CHIEF'S COLUMN

Anesthesiologist Bryan Bohman, M.D. was elected to a two-year term as Medical Staff Vice-President of the Stanford Hospital, and Kent Garman, M.D. was promoted to a two-year term as President of the Medical Staff. Dr. Bohman will follow Dr. Garman in this office beginning in 2007. Congratulations to both men. Stanford's Department of Anesthesia should be proud of continuing to produce leaders.

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

BEST DOCTORS

Dr. Lawrence Siegel, Clinical Associate Professor of Anesthesia, was selected for inclusion in the Best Doctors in America 2005-2006 database. Dr. Siegel was first cited by Best Doctors in America in 1996.

REMEMBER

By November 10 send your stories and memories about Aud to rohrr@stanford.edu or Jbrodsky@stanford.edu

The following is adapted, with permission, from a letter Dr. Barrie Fairley, former Chairman of our Department, recently sent to Steve Shafer on the



announcement of his appointment as Editor-in-Chief of *Anesthesia & Analgesia*.

“The North American Anesthesia community of specialists was small

in the early part of the last century and there was a sense of need to communicate among each other. As you surely know, the so-called International Anesthesia Society and its publication *Anesthesia and Analgesia* had its beginnings in 1922 as a vehicle for this group on the two sides of the US-Canadian border, hence its name. Suffice it to say that the international flavor was about the same as that of the World Series of baseball. Long before the days of commercial exhibits at meetings, anesthesiologists used to visit each other's hospitals to see their equipment, watch techniques and to observe the many gadgets that anesthesiologists of that era used to invent. This was formalized in the “Anesthetists' Travel Club” which was formed in 1929 (its name changed to “The Academy of Anesthesiology” in 1952)... and the group met annually at a member's base. Of course, this evolved to meetings on neutral territory, usually at a resort. The group was small and membership was by invitation only, so I was very pleased when I was invited to join in 1964 while I was still in Toronto. ... it was a wonderful group of people among whom there was a real bond. I first met Bill Pender, who for many years was the Chief of the Palo Alto Clinic group, at an Academy meeting.

My own membership terminated when I joined the AUA and the problem that initiated the Travel Club/Academy had reversed itself. Now there was a plethora of meetings!

Each of us was issued a leather-bound book of members' photographs and CVs and a leather-bound “register” signed by attendees at each meeting....

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Prepare your hospital—Observing how rapidly hospitals' provision of basic patient care, security, evacuation, and even care of the dead deteriorated shocked us all and prompted a hard look at our own state of disaster-preparedness. We should be stirred into making concrete plans for a major earthquake here at home.

I am sure the hurricane crisis brought these questions and more to your mind:

- Are our emergency generators protected from falling debris and water?
- How much diesel fuel do we have for our generators?
- How much drinking water have we stored?
- How much emergency food have we stored?
- Will our buildings stay functional in a major earthquake?
- Will we have any communications when the cell, pager, and land lines go down?
- How much security do we have available to protect us?

J. Kent Garman, M.D., M.S.
Associate Professor of Anesthesia

Note: Disaster-Response-Readiness at Stanford and Packard hospitals will be discussed by the departmental governance committee and a summary will be presented to the faculty.

READ *STANFORD MEDICINE*

Look for the fall 2005 edition of the medical center's publication, *Stanford Medicine*. Focused on neuroscience, the issue features "Pain's stronghold: It's all in your head" with extensive coverage of Martin Angst's and Sean Mackey's work and quotations from Elliot Krane and Ray Gaeta

These books contain an extraordinary record of pioneers in our field. Founder members were Lundy (Rochester), Waters (Madison), Brown, Shields and Robson (all Toronto), Stewart (Montreal), Tovell (Hartford), Sword (Newhaven), Sise (Boston), Hammond (White Plains), Ruth (Philadelphia), Gaine (Atlanta). People like Griffiths and Bourne (Montreal), Tuohy (Rochester), Rovenstine (New York) and Knight (Minneapolis) followed soon after. The names go on and on down the years, but it is interesting to recall that these were all "household names" in the field in their day. What they have left behind is in some cases their name associated with a gadget, a method or a subspecialty. In all cases they have left us their passion for the specialty and their dedication to its future."

H. Barrie. Fairley, M.B., B.S.
Chairman 1985–1992

FUNDS-FLOW MODEL CREATES EQUITABLE, PREDICTABLE ENVIRONMENT

As you pursue your daily work and contemplate your long-range career plans, do you wonder how well-funded the Department of Anesthesia really is? Does it make money? Lose money? Will the money situation get better or worse? Will physicians in the department ever receive compensation comparable to that of our colleagues in private practice?

You can put these questions to rest, due to the efforts of innovators Dean Phil Pizzo and Department Chairman Ron Pearl. Beginning fiscal year 2006 (which started September 1st) a new funds-flow model, the *RVU Benchmark Model*, has been agreed upon by the Stanford Hospital and Clinics (SHC) and the School of Medicine (SOM). This new model will result in more predictable funds across the years and better parity between academic physicians' salaries and those of physicians in private practice.

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What is unique about the benchmark model?

Several factors render this model unique among academic medical centers within the U.S.:

- The model specifies fair-market value for service provided, using as benchmarks national average physician-units of work (ASA units for Anesthesia) and national average physician compensation.
- For every ASA unit of work you perform, its dollar value will be transferred to the department.
- Thus if your ASA units match the benchmark average, your compensation will closely match the national average, after department academic expenses have been considered.
- The model is indexed to inflation that occurs to physician compensation in private practice.
- Instead of depending on a variable, negotiated amount every year, a predictable funding level will exist from year to year.

How can you contribute to the success of this model?

If you generate better-than-average ASA units of work and/or reduce costs, the extra discretionary funds will be available for department projects. We will then be positioned, as a department, to determine how to best allocate a known and possibly growing pot of money for the projects we deem most critical.

If you generate better-than-average ASA units of work and/or reduce costs, the extra discretionary funds will be available for department projects. We will then be positioned, as a department, to determine how to best allocate a known and possibly growing pot of money for the projects we deem most critical.

Patricia Rohrs, Editorial Manager

INVITED TALKS & INTERVIEWS

- ❖ Gregory B. Hammer, M.D. spoke August 28–30, 2005 at Crianca 2005 (a large, multi-specialty pediatric meeting): in Curitiba, Brazil on the following topics:
 - Management of Low Cardiac Output in Infants and Children
 - Post-operative Pain Management in the Pediatric Intensive Care Unit
 - Sedation Management for Infants and Children after Cardiac Surgery
 - Perioperative Management of Infants and Children Undergoing Liver Transplantation
 - Pharmacology for the Pediatric Anesthesiologist and Intensivist
- ❖ Gregory B. Hammer, M.D. was visiting professor at the Kobe University School of Medicine on Sept.6, 2005, where he lectured on “Postoperative Sedation and Analgesia in Infants and Children.”
- ❖ Andrew J. Patterson, M.D., Ph.D. spoke September 9, 2005 at Grand Rounds on “Vasoactive Therapy in the Critically Ill Patient”, Mt. Diablo Medical Center, Concord, California.
- ❖ Chandra Ramamoorthy spoke September 9, 2005 at the North of England Pediatric Cardiac Surgical Meeting, Freeman Hospital, Newcastle UK on “Anesthetic Challenges in managing extremely low birth weight infants for heart surgery” and “Neurological Monitoring during and After Heart Surgery in Children.”
- ❖ Gregory B. Hammer, M.D. spoke to the Japanese Society for Pediatric Anesthesia (JSPA) in Shizuoka, Japan (near Mt. Fuji) on September 9–10 on “Total Intravenous Anesthesia” and “Dexmedetomidine.”

INVITED TALKS & INTERVIEWS continued from page 11

- ❖ Andrew J. Patterson, M.D., Ph.D. spoke September 14, 2005 at Grand Rounds on “Vasoactive Therapy in Critically Ill Patients” at the Division of Emergency Medicine, Stanford University.
- ❖ Steven Shafer, M.D. and Dennis Fisher, M.D. presented their Intermediate Workshop in Pharmacokinetic and Pharmacodynamic Modeling with NONMEM in Newark, New Jersey September 15–18. See www.nonmemcourse.com.
- ❖ Steven Shafer, M.D. was visiting professor at The Hebrew University of Jerusalem Sept. 26–27, where he lectured to the School of Pharmacy on “The role of clinical pharmacology in the development of anesthetics.” On Sept. 29 he lectured in Tel Aviv to the 20th Congress of the Israeli Society of Anesthesiologists on “Target-controlled infusions and total intravenous anesthesia.”
- ❖ Sean Mackey, M.D., Ph.D. was interviewed by National Public Radio (NPR) about the department’s clinical work in Pain Medicine and about his research. See <http://www.npr.org/templates/story/story.php?storyId=4731172>
- ❖ Tim Angelotti was invited to give two lectures October 5-8, 2005 at the XXVIII Latin American Congress of Anesthesiology in Tegucigalpa, Honduras. His topics were “Introduction to Intraoperative Neurophysiological Monitoring” and “Anesthesia and the Head Elevated Position.”

EDITOR’S NOTE

If you would like to submit an article or news item for consideration, email rohrrs@stanford.edu Contributors to this issue include J. Brodsky, J. Duperrault, B. Fairley, D. Gaba, K. Garman, S. Lim, R. Novak, and R. Pearl.

UPCOMING EVENTS

- ✓ Oct 20-21: ISAP annual meeting, Atlanta
- ✓ Oct 22–26: ASA, annual meeting, Atlanta
- ✓ Oct 31–Nov 4: CSA, Hawaiian seminar, Kauai
- ✓ Dec 5: Department of Anesthesia, Holiday Party

BIRTHS



- ❖ Ethan Scott was born to Scott Rudy and his wife Jennifer on July 31st.
- ❖ Elena Ryan was born to Inger Aliason and her husband Jeremy on Aug. 16th.
- ❖ Alexandra Lillian was born to Ian Carroll and his wife Bonnie on Sept. 3rd.
- ❖ Margaret Ainsley was born to David Soran and his wife Robin on October 13.

MARRIAGES

Former resident Elizabeth Steele was married to Ross Downey in August in Virginia.

REMEMBER: By November 10 send your stories and memories about Aud to rohrrs@stanford.edu or Jbrodsky@stanford.edu
