For the alumni and friends of the Department of Anesthesia
STANFORD UNIVERSITY

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I’m delighted to present the 18th edition of Stanford Anesthesia News to you. It goes out to a variety of people including alumni, medical students interviewing for anesthesia residency, potential donors, and other visitors and friends of the department. Overall, we focus on sampling department activities in research, education, and patient care. Too much is happening in the department to document everything, as one might in an annual report.

The theme of this issue is creative people, specifically some of the faculty who built the department over the years. We began to make this history available to you by digitizing all previous issues of Stanford Anesthesia News (available on our department website). Below are some highlights taken directly from the first newsletter (September 1988):

• “Fourteen residents will graduate from the Stanford Anesthesiology residency this year, the first cohort to complete the new mandatory three-year clinical anesthesia program.”

• “After many years of creating daily a surgical ‘blivit,’ that is cramming fourteen hours of surgery into a ten hour plus working day, Stanford University Hospital is finally going to have a surgical facility which has adequate space for its current case load and is well suited for attracting new programs. That surgical facility is part of the Hospital Modernization Project, a new building annexed to the present hospital….The 153 million dollar project, which was begun in the early eighties…will allow one OR to stand unused and ever-ready for trauma cases, making it no longer necessary to evoke the painful procedure of delaying rooms sequentially throughout the day to ensure an empty room at all times.”

• “New clinical activities (in the department) include the ‘Same Day Surgery’ unit, through which our increasing number of day of operation arrivals are processed …The new Acute Pain Service is largely devoted to the management of patients with post-operative pain, and an interdepartmental Pain Management Center is planned.”

The articles that follow give us further historical perspective on the department and insight into some of the personalities that have shaped it. I am sure you’ll enjoy spending a day with Ron Pearl, walking through a brief history of the department, listening to an interview with Steve Shafer, and reading the biographies of John Ahlering, Stanley Samuels, and Richard Mazze.

This concludes my 7th year as Editor. As much as I have enjoyed doing this job, especially getting to know all the neat things going on in the department, I will be assuming the Residency Director position, now that John Brock-Utne is retiring. Therefore, I am pleased to announce that Dr. Cliff Schmiesing will become the Editor in 2007. Cliff will bring new ideas and leadership to Stanford Anesthesia News.

As always I thank the staff for working hard to deliver the solid content that follows. Please let Cliff know if you have requests for future topics.

Best wishes for the remainder of 2006!

Alex Macario, MD, MBA
Editor, Stanford Anesthesia News
A Brief History of the Academic Department of Anesthesia at Stanford University
by Frank Sarnquist, MD

Anesthesia services have been provided at Stanford University's hospital since it opened its doors in 1905 in San Francisco. However, it was not until 1959, when the University moved the hospital to the campus on the Peninsula, that an independent, academically-oriented department was formed. Since moving to Stanford, the Department of Anesthesia has become one of the outstanding academic anesthesiology programs in the United States. During this time, the Department has had five Chairmen and several interim Chairmen.

1937—1955 Dr. William Neff

The leader of the Division of Anesthesia in the Department of Surgery at the School in San Francisco from 1937 to 1955 was Dr. William Neff, a Canadian who did his anesthesia training at the University of Wisconsin. When he joined the group, there were five other physicians on the staff—all women. In the 1990s, Neff pointed out that the Stanford and Wisconsin Departments of Anesthesia were the only two academic departments in the country to maintain all-physician anesthesia groups since their inceptions. Under Neff's leadership, a strong clinical program was developed, and an active research program was started, often including medical students in the projects.

1955—1959 Dr. Philip C. Bailey

When Neff resigned in 1955, the leadership was taken over by Dr. Philip C. Bailey. Bailey was another Canadian, from McGill University. He came to the group after a stint with the Anesthesia Department at UCSF. When the University decided to move the Medical School to Palo Alto in the late fifties, Bailey chose to remain in the city. Whether he stayed by choice or because he was not invited to head the new program is not clear.

1960—1972 Dr. John Bunker

In spring of 1960, John Bunker, MD, who was a visiting Professor from Harvard at UCSF, became the leading candidate for the Stanford position. He demanded a separate Department of Anesthesia, and at this point, Bunker speculates, the School realized it was not going to be able to recruit a national class researcher and clinical chief without establishing an independent department. Thus, in the fall of 1960, the Department of Anesthesia at Stanford University came into being, with Bunker as its first Chair. Bunker faced a hospital situation that was (and is) unique in the United States. As part of the agreement to create a University Medical Center in Palo Alto, the University had entered into an agreement with the City of Palo Alto to own the hospital jointly and to grant the established, local, private medical groups and practitioners full access to the hospital. The University subsequently purchased the city's share of the hospital and is now the sole owner.

A Brief History of the Academic Department of Anesthesia (continued)

During his tenure, C. Philip Larson, Jr., MD, greatly enlarged and strengthened the Department and recruited many capable clinical faculty. It was a well-funded decade in medicine, with rapid growth in the clinical activities at Stanford. With the improved clinical program came stronger residents and, over time, Larson felt he had fulfilled his charge to build an outstanding clinical program. He turned a research-oriented program with a limited interest in the clinical mission into a first class clinical operation.
A Brief History of the Academic Department of Anesthesia (continued)

However, a group of tenured faculty felt he had done so by shortchanging the scientific side of the department. The Dean, Dominick Purpura, relieved Larson of his administrative duties on December 1st, 1982 and began a search for a new Chairman. In the interim, an Emeritus Professor commanding great respect in the Department, Ellis Cohen, MD, was appointed the acting Chair. Cohen took over the running of the Department but shortly thereafter his health forced him to relinquish that role.

1985—1992 Dr. H. Barrie Fairley

H. Barrie Fairley’s, MB, ChB, term as Chair coincided with the major change in the compensation for medical care. He accurately predicted the increasing difficulty in keeping the Department solvent with the existing taxation scheme in the Medical School. He was sixty years old at the time of appointment and agreed to serve for five years. When he retired, he did so before the completion of the search for a successor. For several months Frank H. Sarnquist served as Acting Chair.

1992—1997 Dr. Donald R. Stanski

Donald R. Stanski, MD, who had made his research reputation as a clinical pharmacologist and pharmacokineticist, moved from his position at the Palo Alto Veteran’s Administration Medical Center to Stanford to take over running the Department. Stanski grew the research and clinical enterprise for five years. This time period was an eventful one for the Medical School and for the Department. In a period of increasing hospital financial shortfalls, a strategy of merging medical centers was seen as at least a partial solution. Although merger attempts elsewhere had met with limited success (and some with catastrophic failure) the local administrators at UCSF and Stanford decided that the Bay Area could not support two competing academic medical centers. Accepting this analysis, Stanford’s then President Gerhardt Casper and UCSF’s then Chancellor Joseph Martin agreed to merge their hospitals (but not the medical schools).

UCSF Stanford Health Care (USHC) began operation in 1997. What followed was an expensive and protracted (legal and administrative) unsuccessful attempt to combine and rationalize tertiary and quaternary medical care in the Bay Area. The failure to convince the respective faculties and workers at these two very different institutions (one public, the other private) that the merger would be good for them doomed the effort.

For the Department of Anesthesia the merger appeared to offer some advantages, as in some of the areas where Stanford’s department was weak (pediatric cardiac surgery at that time) UCSF’s department was strong. And in some areas (adult cardiac surgery) the Stanford Department could offer the UCSF residents a superior educational experience than was available in San Francisco. However, the geographic distance between the two hospitals and the lack of a medical school merger precluded the realization of any of the potential advantages.

Affecting the Department far more profoundly during these years was the collapse of medical student interest in anesthesiology as a career. This disinterest reached its nadir in 1996 when only 169 United States medical school graduates applied for the over one thousand anesthesia residency positions in this country. Many excellent programs failed to fill their available slots and some attracted no residents at all in the match. The reason for the collapse of interest in the field is difficult to understand, especially viewed in hindsight. At the time medical students were told that there would be few jobs for specialists, as general practice was the preferred mode of medical care for most Americans. Surgery, especially, would be less frequent, they were told, as medical solutions were discovered for surgical diseases (medical treatment of H. pylori caused gastric ulcers was the example cited). Also, the new “managed care” paradigm with general practitioner gatekeepers would eliminate much “unnecessary surgery.” Finally, an amazingly shortsighted front-page article in The Wall Street Journal (17 March, 1995) convinced many students that the future was not in anesthesia. This was an unpleasant time of secret deals, signing bonuses, elaborate recruiting dinners and entertainment, as Anesthesia Department Chairs around the country competed fiercely to fill their programs with the inexpensive labor, interesting company, and prestige that good residents provide.

Stanford’s program was aided in attracting good candidates by its excellent reputation, the attractive campus, the good weather, but, most of all, by the booming economy in the surrounding Silicon Valley. The influx of many professional and business people during this period brought with them a small but vital group of spouses and partners who were anesthesiologists, anesthesia residents, or resident candidates. These physicians had strong personal reasons for wanting to live in the mid-peninsula area and enabled the program to have enough residents to run at full strength during the nationwide resident shortage.

Frank H. Sarnquist, MD, once again assumed the role of interim Chair while a national search was conducted. Sarnquist remained in this role for 28 months.

1999—Current Dr. Ronald G. Pearl

Although there was considerable interest in the position, Dean Bauer eventually chose the superbly qualified and interested internal candidate, Ronald G. Pearl MD, PhD. He took over on the first of September 1999. During the subsequent seven years, the department has successfully expanded the faculty and residency numbers, has increased clinical activity, has markedly increased research funding, and has benefited from a new financial system that has made the department profitable each year.
A Day with Ron Pearl, Chairman

Anesthesia Chair “Walks the Talk” of Care, Teaching, and Research

by Patricia Rohrs

Editor’s Note: Patricia Rohrs spent several hours one-on-one with Dr. Pearl, shadowing him, to catalog some of the activities of a Department Chair and to get a glimpse of the person and the issues facing the Department.

When asked what moment in history he would most like to have witnessed, Dr. Ron Pearl’s eyes light up: “The Declaration of Independence. I am fascinated by group dynamics—how a group can surpass the individuals in it. How did the American revolutionaries collaborate and reach consensus on this far-reaching document?”

A hallmark of Pearl’s leadership since becoming Chair of the Department of Anesthesia in 1999 is his conviction that, “The whole is greater than the sum of its parts.” He believes his role is to collaborate with talented faculty, residents, and staff to help them achieve their personal goals, while melding them with the Medical School’s consensus goals of clinical care, education, and research.

During his seven years as an optimistic, forward-looking Chair, Pearl has overseen numerous initiatives that create the desired synergy: improved residency matches and education, improved research funding, and new translational research programs in neuroscience, pain, and molecular cardiovascular physiology.

As Chair, Pearl fulfills his diverse roles as clinician, researcher, teacher, mentor, and administrator largely by being hands-on, setting an example, listening, and mentoring. The seriousness with which he takes his work has doubtless influenced both mature and budding careers, including those of his two sons, Jeremy and Nathan. Both will be joining Stanford this year—Jeremy in the Medical School and Nathan in the undergraduate program.

Let’s spend the day with Ron Pearl, a native New Yorker who keeps that city’s storied energetic pace—emanating competence, inquisitiveness, sparkling wit, and graciousness—as he “walks his talk.”

Profile: Ronald G. Pearl, MD, PhD
Birthplace: New York, New York
Education:
- Yale University, BA, 1971
- University of Chicago, PhD, in Pharmacological and Physiological Sciences 1975
- University of Chicago, MD, 1977
Professional Training and Experience:
- Stanford University Medical Center
  - Intern, 1977-78; Internal Medicine Resident, 1978-80;
  - Fellow, Critical Care Medicine, 1980-81;
- Stanford University School of Medicine
  - Assistant Professor, Department of Anesthesia 1985-92
  - Associate Professor, Department of Anesthesia, 1992-99
  - Associate Chair for Clinical Affairs and Finance, Department of Anesthesia, 1997-99
  - Chairman, Department of Anesthesia, 1999-
  - Professor, Department of Anesthesia, 2000-
Family: Wife: Mary  Children: Jeremy, Nathan

Delivering Anesthesia in the OR
6:45–9:45 am—Dressed in scrubs, a relaxed Pearl strides into North ICU, to learn that today’s first case has been bumped by a “take-back” patient. This woman is bleeding after yesterday’s coronary artery bypass surgery. Clots are compressing her heart compromising proper filling of the cardiac chambers. Snagging anesthesia fellow Daryl Oakes, they’re off to the patient’s bedside. There, they meet and consult with six others, studying the echocardiography monitor, IV lines, and the patient’s record.

In the OR minutes later, Pearl crisply and quietly directs his anesthesia team: “Reprogram the patient’s IV pumps, turn on the (anesthetic) gas, roll the perfusion monitor close to the patient, get two units of …” A hands-on guy, Pearl expertly guides the transesophageal echocardiogram’s thin, black tube. The surgical team begins its work and discovers a hole in the aorta, to be repaired after they remove coagulated blood blanketing the exposed, beating heart.

As the two teams work quietly and efficiently, Pearl is completely engaged—he watches the echocardiogram display; he monitors vital signs and displays; he administers anesthesia products including albumin, blood, and nitroglycerin; he changes IV bags. He consults the protocol for continuous insulin infusion and injects a bolus of insulin. Pearl also takes time to teach, firing “if-then” questions to his medical student.

As surgery winds down, Pearl tells a story about visiting his son’s sixth grade class and being asked, “What happens if you make a mistake?” All the while, Pearl keeps his watchful, expert eye on the monitors, bags, lines, etc.

Conducting an Annual Review of Faculty Member
11:00 am—“Welcome! Please come in,” Pearl says warmly to a junior faculty member, arriving at his office for her annual review: “Let’s look over the residents’ evaluations of you and your previous year’s annual review. Then, I’d like to hear about your accomplishments in these areas: clinical, research, teaching, administration, and program. After that, let’s discuss your status in the promotion/reappointment process.” The meeting underway, Pearl clearly enjoys the exchange. The faculty member gets to

A Day with Ron Pearl, Chairman

(continued)
shine while discussing her achievements and goals with a seasoned pro. He gets to learn, mentor, and influence her career. Noticing that her interests overlap with another faculty member’s, Pearl suggests they collaborate. As the meeting winds down, he advises, “Be sure to talk to Nancy Federspiel, Director of Strategic Research Development, about research funding opportunities.”

**Attending an Executive Committee Meeting**

1:00 pm—Next up: Pearl the administrator joins the long, oval table in the hospital’s board room to meet with other medical school chairs, Dean Pizzo, senior associate deans, and leaders from both Stanford and Packard Children’s hospitals. Today’s topic is building a new hospital wing to replace outdated hospital areas. Sridhar Seshadri, Vice President for Process Excellence, fires up his PowerPoint on trends in hospital and surgical volume over the next decade. Members of the executive committee, including Pearl, compute on the fly. How do these trends translate into actual and projected numbers of beds and ORs? Always the critical thinker, Pearl examines each assumption and emphasizes the risks and benefits of having too few or too many operating rooms and hospital beds.

**Meeting with the Interdisciplinary Practice Committee**

3:00 pm—Pearl grabs bottled water and joins the Interdisciplinary Practice Committee meeting of physicians, nurses, nurse practitioners, and physician assistants for a discussion of proposed new positions for allied health personnel, who are increasingly used for patient care, so that residents can focus on educational activities and complex aspects of the patient’s care. The conversation revolves around a few key points: Will the new position enhance or detract from resident education—always a primary concern of the committee? Will the proposed position improve patient care and continuity?

**Directing a Lab Research Meeting**

4:00 pm—Donning his research hat, Pearl joins collaborators Peter Kao (Pulmonary and Critical Care Division) and his lab manager, Gail Benson, to discuss the latest rodent-model data obtained for one of their research questions: “What genes are activated during the development of pulmonary hypertension?” After they review physiology measurements (pulmonary artery pressure), histology (examining the lungs of the mice or rats with pulmonary hypertension), biochemistry (levels of different mediators related to pulmonary hypertension), and molecular biology (activity of different genes), they discuss how to interpret the data and what to do next: Gather more data? Plan future studies? Submit a grant?

**Emailing and paperwork**

6:30 pm—Shucking his jacket, Pearl winds down the day in his book-lined office by checking his email for the fourth time, knocking off responses to several of 80 or so emails per day. Loosening his tie, he examines his stack of files—faculty appointments, evaluations, proposals, financial reports, and memoranda—and selects a proposal that was prepared for his review. Absorbed, he lifts his pen to make notes.

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**THE NEXT DAY**

**Making Rounds in the Cardiothoracic Surgery ICU**

6:00 am—Appearing for rounds the next morning, Pearl greets the cardiothoracic surgery ICU team, “How did our patients do last night?” The team gathers around the monitor to discuss images of patients’ lungs, heart, endotracheal tube, and vascular catheters. Clearly in his element, Pearl relishes applying his expertise in cardiac anesthesia and critical care to this relatively new ICU service, spearheaded last year by Pieter van der Starre, one of the anesthesiology faculty.

Armed with printouts, the 8-person team briskly enters the first patient’s room. Pearl repeats, this time to the ICU nurse, “How did the night go?” Amidst the “trees” hung with IV bags and the sophisticated computer monitors that surround and attach to the patient, Pearl intently listens to a patient summary. He takes notes, reviews the monitors, gives directions, and asks questions: How high is the fever? How long has this headache been going on? Should we re-scan the patient? What nutrition is being given? Equally attentive, other team members read monitors, review and write into the patient’s red binder, and discuss what next steps to take, creating the overall effect of deep focus on the patient’s improvement and well-being. In short order, the group moves to the next patient. Pearl repeats, “How did she do last night?”

**Giving a Lecture**

8:00 am—After cardiothoracic ICU rounds, Pearl gathers residents into the service’s Call Room for his 30-minute lecture about ventricular-assist devices for the patient with acute heart failure. His aim is to foster understanding of the patients’ underlying physiology and the devices’ relevance to anesthesiologists. Talking while drawing pictures on a large...
sheet of paper, Pearl asks, “When we insert a left ventricular-assist device, what should we look for on the transesophageal echocardiography?” To help answer the question, the group migrates to a patient’s bedside to examine equipment and monitors. When a second year resident asks, “What is the best way to evaluate right ventricular function?” Pearl knows he has engaged his audience.

Holding “Office Hours”

8:45 am—Pearl holds office hours “on the fly,” wherever he may be. In the narrow Anesthesia break room with its tiny cul-de-sac kitchen, Pearl grabs a cup of tea, peels and ingests a whole egg, and munches on half a bagel. He talks with residents, also on break, about yesterday’s case. Then, he asks a resident, “What case are you doing today?”

“Large abdominal surgery for a patient with pulmonary hypertension,” replies the resident.

“Be sure to use a pulmonary artery catheter and be prepared to use inhaled nitric oxide for increased pulmonary hypertension.”

Then, turning to a resident preparing for his Boards, Pearl asks, “What are your plans? Cardiac anesthesia?”

While the conversation continues, a junior faculty member drops in for a peanut-butter-smeared English muffin. Pearl buttonholes him, “How is your research coming along?” Listening, Pearl recounts related research he recently read in a journal. “Check it out.”

Editor’s Note: We asked John Brock-Utne, Professor of Anesthesia, to comment on Dr. Pearl’s leadership.

“My dealings with Ron in the last 6 years have mainly been as the associate director of the residency program, chairman of the resident selection committee, and head of the department’s education committee. There is no doubt that Ron’s contribution to the department’s residency program has been enormous. He is always willing to hear “the other side” and can be relied upon to do what is best for the department and its staff. Some decisions I know have not been easy. But his explanations are always solid and convincing so people with opposing view see his point and accept that for the common good this is the best path. Ron’s educational policies have proved to make our residents among the very best in the country - something we all should be very proud of.”

Research Update

by Frances Davies

The Research Update this year takes on a different format, showcasing some of the many students (medical and undergraduate) who have worked in the Anesthesia Department and its laboratories. I know a large number of them have gone on to medical or graduate school as well as other great things. These students provide evidence that the Anesthesia Department contributes greatly to the quality of education at Stanford. We thought it might be nice to hear their success stories, and to bring out the research focus of their respective labs.

Amy Chow

If you think you recognize the name, it is because Amy competed in two Olympics, winning a Gold medal in 1996 and a Silver medal in 2000 in gymnastics. In 1996, Chow was a member of “The Magnificent Seven”, the first ever Gold Medal Olympic Gymnastics Team. She also earned the Silver medal on her favorite event, hurs. Amy Chow is now a fourth year Stanford medical student working with Brant Walton, an anesthesia resident, in Andrew Patterson’s lab. Amy began working with Dr. Patterson as an undergraduate. Together with Brant she is doing microsurgical insertions of pressure-volume catheters in genetically engineered mice that have either or both of the beta1 and beta-2 adrenergic receptors knocked out. They insert the catheter into the carotid and pass it down into the left ventricle, where they make the pressure-volume measurements. Steady hand-eye coordination is essential for this insertion, because the mouse’s carotid is small and delicate. In 2004 Amy published a paper with Dr. Patterson in Critical Care Medicine on the role of the beta-2 adrenergic receptor in the heart.

In her spare time, Amy makes personal appearances, gives motivational speeches, and coaches gymnastics. She plans to finish medical school next year and start a pediatrics residency.

Anesthesia Department Research Funding

Figure provided courtesy of Nancy Federspiel
Heath Lukatch worked in the lab of Dr. Bruce MacIver and graduated from Stanford with his PhD in Neuroscience in 1997. Heath’s thesis was titled “Synaptic Mechanisms of Synchronized Neocortical Micro-EEG Activity.” Heath elicited micro-electroencephalogram (micro-EEG) activity in neocortical brain slices by pharmacologically mimicking endogenous cholinergic and GABAergic neurotransmitter systems known to be active during wakefulness. Heath used this model system to elucidate the mechanisms of action underlying anesthetic effects on synchronized neuronal networks.

While still a student, Heath started his entrepreneurial ways in 1992, when he founded and became CEO of AutoMate Scientific, Inc., a biotechnology instrumentation company. After completing his PhD, Heath transitioned fully to the business world, joining McKinsey & Company in Los Angeles and San Francisco, where he focused on strategy consulting for biopharmaceutical companies. Following his time at McKinsey, Heath joined Piper Jaffray Ventures as a Managing Director (2001–2004). In 2004, he became a Managing Director and Founding Partner of Sightline Partners, an independent venture-capital firm investing in high-growth, private healthcare companies. He has been involved in the venture funding of several companies including Sanofi-Genzyme, OraCure, Ocular Therapeutix, and others.

Janet Tsui

After Janet was awarded a 2001 summer undergraduate research studentship from the Western States Division of the American Heart Association, she worked with David Clark, Frances Davies and Brian Hoffman of the VA Medical Service on a project to look at the fear-reducing properties of the alpha-2 adrenergic agonist dexmedetomidine. This work resulted in publications in Neuropsychopharmacology and Brain Research. Janet then returned to the University of Southern California to finish her Bachelors in Biomedical Engineering and then headed to UCSF Medical School.

During the first summer of medical school Janet created the Autonomic Nervous System modules for the Multimedia Learning Modules at UCSF. She enjoyed the challenge of making things clear. She quickly found that this section was very difficult for most medical students because of the receptor systems’ complexity. She devised graphics and interactive tasks to aid the students.

Janet has just taken a year off to do ophthalmology research on the effect of topotecan delivery via subconjunctival fibrin sealant injection on retinoblastoma. She also went to India to help repair easily correctable ophthalmic conditions, such as cataracts and infections. She strongly believes that this personal form of international aid promotes peace and understanding. Janet is hoping to do a residency in ophthalmology, once she finishes medical school, because she likes the prospect of combining neuroscience with surgery.

If that weren’t enough, Janet founded the UCSF Darfur Working Group, part of Student Health Professionals for Social Responsibility (SHPSR), which collected hundreds of UCSF signatures and presented them to US Representatives Tom Lantos and Nancy Pelosi to lobby for US and NATO financial support of African Union peacekeeping troops in the region.

Janet says that she had a great time and learned from her experience in the Anesthesia Department. She found that learning how to troubleshoot and to persevere in the face of adversity and blown experiments are valuable assets for a researcher. While basic research may not be in her future, she would like to be involved with transmitting the basic science information from the bench to the bedside.
of nine private biotech and medical device companies, and he is currently on the board of three companies. In April 2006, Heath joined Novo Ventures as a partner and opened Novo’s San Francisco office.

Heath is married to Carrie, has a pet dog Beau, and enjoys mountain biking, skiing, hiking, rock climbing, backpacking, fine food and wine.

Jason Cuellar
Jason Cuellar works with Dr. David Yeomans on electrophysiological models of trigeminal pain, in his “spare time” from second year of medical school at Stanford. He also works on aspects of disc herniation-induced radiculopathic pain in humans, in collaboration with Dr. Martin Angst. Jason plans to take the coming year off from medical school to devote more time to these projects.

While an undergraduate, Jason became fascinated with the pathophysiology mechanisms of pain, when he developed severe sciatica from a herniated disc in his lumbar spine, requiring microdiscectomy surgery in 2000. This interest motivated his doctorate work in Molecular, Cellular and Integrative Physiology at University of California, Davis with Drs. Earl Carstens and Joe Antognini.

At UC Davis he investigated the physiology of itch- and pain-processing sensory pathways by utilizing various behavioral testing and electrophysiology techniques to assess sensory abnormalities and/or pain sensation in an electrophysiological model of lumbar disc herniation in the rat. His continued interest in the role of inflammation and sensitization in various disease states causing pain motivated him to continue research in the Yeomans lab upon coming to Stanford for medical school in 2004. He was drawn to the Yeomans lab because of its activity in the field of gene therapy for pain and its track record of electrophysiological expertise.

His future plans are also influenced by his experience with sciatica. After medical school he hopes to enter an orthopedic surgical residency program with spine surgery as his ultimate goal.

Jason finds working in the Yeomans lab to be very rewarding due to the intellectually stimulating environment provided by his great coworkers and the collaborative environment of Stanford. He is looking forward to his upcoming year of research to pursue current projects full-time.

An Interview with Steven Shafer, MD, Editor-in-Chief,
Anesthesiology & Analgesia
by Patricia Rohrs

Why did you decide to take the Editor-in-Chief position for Anesthesiology & Analgesia?

Why do we stay in academia? At an institution like Stanford, we work long clinical days, spend our nights in the lab, and devote our weekends to reviewing grants and papers. Many of us work 80+ hours every week. We could earn higher salaries, have more time for our families, and not have the schizogenic expectation of being an outstanding clinician, scientist, and teacher if we left academia. So why do this?

We pursue academic careers because of a genuine devotion to making a difference in the world. We believe that through our work at an institution like Stanford, we can improve the care provided to patients everywhere. We believe our scholarly activities can advance our discipline. I’m always proud to say that I practice medicine, pursue research, and teach students, residents, and fellows at Stanford.

Accepting the Editor-in-Chief position for Anesthesiology & Analgesia position was a logical “next step” in my career. I still pursue research and write papers. However, I no longer run my own laboratory.

I’ve done a lot of review activity—four years on an NIH study section, six years with the VA Merit Review study section, two terms with the FDA advisory panel, and several terms as Associate Editor and Editor of Anesthesiology. Becoming Editor-in-Chief was the next logical step. However, being able to help patients and make a positive contribution to health care are the reasons I took this job.

What are the journal's greatest strengths and weaknesses?

Anesthesiology & Analgesia has numerous strengths. It is the oldest and largest journal in our specialty, with a long tradition upon which to build. Its large circulation and subscriber base is second only to that of Anesthesiology. The journal’s parent organization, International Anesthesia Research Society (IARS) and its affiliate societies are financially sound. The IARS is also apolitical, which may give us greater freedom to publish based strictly on merit (although I never saw the ASA interfere politically when I was with Anesthesiology). A & As outstanding, dedicated editorial board is truly international, as is its circulation.

As to weaknesses, we do not have an automatic subscriber base. Most anesthesiologists belong to the ASA, because it is our “trade organization.” As a result, Anesthesiology has a built-in subscription base nearly twice that of Anesthesiology & Analgesia. Since the IARS is not viewed as our “trade organization,” the only way to maintain A & As subscriber base is to offer a journal that anesthesiologists want to receive.

We have this constant vulnerability: be interesting, or vanish. I lose a lot of sleep over this.
What opportunities exist in the future for the journal?

We can develop academicians in foreign countries. We can be supportive, rather than dismissive, of junior authors’ efforts. We can become more valuable to the clinician-reader through several initiatives. However, the opportunity that interests me the most is to use Anesthesia & Analgesia to actively pursue evidence-based medicine, particularly in the area of health care policy. The journal, in partnership with IARS, is working with the academic community to evaluate the evidence, or lack of evidence, behind health care policy. So, the next time some accreditation body demands that you follow a certain practice, know that Anesthesia & Analgesia is examining accreditation bodies’ policies and will publicly hold them to the same evidentiary standards to which we hold authors of scientific manuscripts.

What changes do you plan for the journal?

Many changes are in progress, not all of which will succeed, so I am hesitant to raise expectations. However, these changes have occurred or have been planned:

- **Editorial Board**: The editorial board is larger and more diverse. By creating an Associate Editorial Board, the size of the full editorial board has doubled. We have improved gender, geographic, and intellectual diversity. We now have 7 women and 17 Editors or Associate Editors from non-US countries.

- **New Sections and Section Editors**
  - **Continuing Medical Education**: In October we will add a Continuing Medical Education section—free to IARS members and unavailable to non-IARS members. Journal reviewers will earn credits for their efforts—a modest but tangible way of expressing appreciation.
  - **Pain Mechanisms**: This new section will focus on the fundamental mechanisms of peripheral nociception, pain transmission, and pain perception. Its editor, Tony Yaksh, is one of the world’s foremost authorities in the area. Anesthesia Pain Mechanisms, Pain Medicine, and Regional Anesthesia will be grouped into a new mini-journal called Analgesia. This change reflects the fact that Anesthesia & Analgesia is the oldest journal with a specific focus in pain and highlights the importance of pain research and management to the discipline of anesthesiology.

- **Look and Feel**: The look and feel of both the printed and online journal changed with the July issue, the beginning of volume 103. The revamped layout reflects input from the affiliate societies. Our abstracts are structured. Letters to the Editor are now shorter and more focused.

- **Structure of Articles**: We are also changing the overall structure of articles to shorten them. If you pick up an issue of Science or Nature, you won’t find the extensive introductions and discussions that you find in most medical journals. Instead, articles in Science and Nature focus on just two main points: What did you do? What were the results? A modest discussion puts the results in context, but that’s all.

What might threaten the journal?

The Internet poses huge challenges for all journals and publishers. I read my journals electronically, and I believe most academicians do as well. However, because the print journal is more closely tied to revenue than the electronic journal, preserving the print journal will be a challenge. My incentive to change the physical journal is to give people a reason to maintain their IARS membership and subscription to the print journal.

What have you learned since becoming EIC?

The learning curve has been steep and intense. I know my own field of pharmacology well, but I’m learning other related disciplines that are quite foreign to me. I need to understand the basic science as well as the major players in these multiple disciplines. I’ve also learned a lot about publishing, including the mechanics of creating a printed journal.

As Editor in Chief, what takes up most of your time?

Poor English. I copy-edit about a third of the manuscripts submitted to Anesthesia & Analgesia, as well as every case report and Letter to the Editor. Unfortunately, this copy editing requires knowing the specialty, so it isn’t easily farmed out to non-clinicians. Another other huge time drain is academic misconduct—far more exists, of varying degrees of seriousness, than I ever suspected. I deal with a new case every week, and every one eats up many hours of time. Occasionally I look at the workload and wonder what I’ve signed up for. At steady state, just handling manuscripts and letters takes 6 hours per day, 7 days per week, and 365 days per year. It never stops.

Please give an example of academic misconduct.

Where to start? Last week a fellow in China translated his published manuscript from Mandarin to English and submitted it as a new paper to Anesthesia & Analgesia. Our reviewers picked up this fact, and I had to tell the author that his submission was considered a duplicate. He apologized and withdrew his submission. In another instance, I mediated a case-report controversy: one physician claimed that a case had been stolen from her by fellows at another hospital, and that the

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**Stanford Anesthesia News**

**Stanford Anesthesia News**
An Interview with Steven Shafer, MD

(continued)

case report was her patient, not their patient, and that the submission was bogus. Then
I’ve been working with another journal that received a paper rejected from A&A. That’s
fine, of course, but it is worrisome when a new experimental group, contemporaneously
randomized, unexpectedly shows up in the new paper.
Authors don’t realize that journals all tap the same expert reviewers. The week before I had
a reviewer allege duplicate submission, which I tracked down and found was not really
a duplicate at all. The reviewer hadn’t read the prior report carefully. A few months ago
a study was rejected because all the patients got enflurane. Two weeks ago the authors
resubmitted the manuscript, with identical results, except that all the patients got isoflurane.
Go figure. I deal with something like this every week.

What do you like best and least about being Editor?
What I like best is the science. I’m seeing wonderful, amazing, even thrilling science
submitted to Anesthesia & Analgesia. Our specialty is so diverse and our interests so
broad, that it is really exciting to see it unfold. What I like least are the cases of academic
misconduct. I want to be fair, kind, and, when possible, understanding and supportive.
Sometimes that just isn’t possible.

What lifetime belief have you changed your mind about?
I was a born-again Christian in college, but have lived most of my adult life as an atheist.
I’m continuously examining my religious beliefs, and always wonder when that will change
again.

What is your most embarrassing moment as a clinician?
I don’t like yelling at patients, particularly at the end of surgery. Rather than yell “Mr. Jones,
it’s time to wake up,” I prefer to calmly whisper in the patient’s ear. At the VA, I whispered
to the patient “Mr. Jones, it’s time to wake up.” He opened his eyes and said in a loud
voice, “Just don’t kiss me!”

What has been your proudest moment in life so far?
The births of Tom and Becca.

What would people be surprised to learn about you?
I love clinical anesthesia. I thoroughly enjoy providing anesthesia and teaching residents.
It’s the other demands that pull me out of the OR, but providing anesthesia is as much fun
as it was when I was a resident.

Who are your heroes in life?
Richard Feynman, Oscar Peterson, and Mahatma Gandhi. If I could come back and live
someone else’s life, it would be Richard Feynman’s. Feynman was probably the second
most brilliant physicist of the 20th century, second only to Einstein. However, what makes him
such a hero is all the fun he had with his gray matter. His life was one endless adventure of
curiosity, experimentation, and sheer joy at the wonder of it all. He saw patterns and logic
in the fabric of nature. He understood at a very fundamental level the nearly magical power
of mathematics to capture and describe physical reality. Understanding how something
worked, whether the universe, a photon, or a combination lock, was the ultimate pleasure
in life.
If I could switch places for a day with someone, it would be with Oscar Peterson. I think
he is the greatest jazz pianist of all time. I would love to know what it feels like to have that
kind of skill at the keyboard.

What’s been your toughest obstacle in life?
I set goals that I can’t attain, and I am forever disappointed.

What advice do you have for new residents?
Knowledge is power. Knowledge will empower you as a clinician, teacher, and if you
choose an academic career, as an investigator. Read voraciously. Read everything. The
more you know, the less grief you will get from everyone else.

When you were a kid, what did you want to be?
A cement truck driver. My parents remodeled their yard when I was five years old, and the
cement truck driver let me operate the controls that fed the cement into the wheelbarrows.
When I was eight, I decided to be a pediatrician, my goal up to first day of my pediatric
rotation in medical school.

What moment in history would you like to have seen?
Any of the miraculous demonstrations described in the Torah, Bible, or Koran. The
existence of God was historically “proven” by miraculous demonstration. While modern
life offers many miracles, often happening at Stanford, we have few miracles that require
supernatural causation. What would I have made of a burning bush, a holy chorus, or
Mohammed’s ascension to heaven? Do I see such miracles today and too readily dismiss
them?

How did you end up choosing medicine as a career and anesthesia as a specialty?
I was inspired by my pediatrician when I was eight. He knew everything. He was also a
kind, very highly respected man. Every year he spent four months on the ship “Hope”
working as a medical volunteer in Third World countries. I wanted to be like him. The
first day of my pediatric rotation changed that. I could not take the screaming children. I
decided that a career in anesthesia would better support family life.

What advice do you have for new residents?

Choose an academic career, as an investigator. Read voraciously. Read everything. The
knowledge will empower you as a clinician, teacher, and if you choose an academic
career, as an investigator. Read voraciously. Read everything. The
more you know, the less grief you will get from everyone else.

How many emails do you answer a day?
That’s easy. I’ve written 7545 e-mails since June 1, 2005, which works out to 21 per day. I
have 4446 unanswered e-mails in my Inbox since June 1, 2005.

What is your favorite vacation spot?
The most magical place I’ve ever been is the Otego Peninsula in New Zealand. I could go
back there in a heart beat. However, my favorite vacation spot these days is Pasadena, so I
can be with my Dad.
Residency Update
By John Brock-Utne

Another year has flown by. We are saying goodbye to a most wonderful group of residents. They are spreading their wings and going on to the next phase of their life.

Neetu Ahluwalia – Pain Fellow, Stanford
Inger Aliason – Pediatric Anesthesia Fellow, OHSU
Amy Evers – OB Fellow, Stanford
Shawn Hodge – Private Practice, Florida
James Janik – Pain Fellow, UC Davis
Michael Kim – Private Practice, Bay Area, CA
Karin Klika – Cardiac Fellowship, Stanford
Matthew Kolz – Cardiac Fellowship, SUH
Shannon Martin – Private Practice, Reno, NV
Joel Mata – Pain Fellow, SUH
Parag Mathur – Private Practice, Scottsdale, AZ
Shana McDaniel – Palliative Medicine Fellowship, VA Palo Alto, CA
Mauricio Michaels – Private Practice, Santa Rosa, CA
Lucia Povor – Kaiser Permanente, San Francisco, CA
Scott Rudy – PAMF, Palo Alto, CA
Jeannie Seybold – Pediatric Anesthesia Fellow, SUH
David Soran – Cardiac Fellow, SUH
Anthony Stanzi – Pediatric Anesthesia Fellow, SUH
Chris Stasny – Private Practice, Sequoia, Redwood City, CA
Vanessa Tang – Private Practice, Kaiser Permanente, Redwood City, CA
Heidi Witherell – CPMC, San Francisco, CA
Cynthia Weller – Private Practice, Sequoia, Redwood City, CA

As you can see 11 of 22 residents opted for private practice. This is different from last year when 15 of 15 residents went into private practice. The group last year was mostly married with children, and one can only speculate that important issues for this group in electing private practice were financial, family, and working conditions.

My job has been most enjoyable because of our eager and enthusiastic residents but also because of the unfailing support that I have in Janine Roberts and Nuvia Pacheco, our residency program coordinators. They have been outstanding in their support of the residents and me but also for their good humor to all they come into contact with.

The following twelve residents and faculty members went overseas this year:

Neetu Ahluwalia – Tanzania, Africa; Alice Edler, Peds, Stanford
Chris Arkind – Tanzania, Africa; Alice Edler, Peds, Stanford
Amy Evers – Guatemala; Drew Patterson, ICU, Stanford
Karen Klika – Quito, Ecuador; Nancy Marks, SC Valley
Matt Kolz – Quito, Ecuador; Gary Ruggera, Head, Medical Missions for Children
Joel Mata – Mante, Mexico; Geoff Lighthall, VA Palo Alto
Shana McDaniel – Quito, Ecuador; John Pooke, England
Cynthia Weller – Quito, Ecuador; Gary Ruggera, Head, Medical Missions for Children
Anthony Stanzi – Cusco, Peru; Ethan Jackson, Cardiac, Stanford
Damian Horstman – Leon, Nicaragua; Arne Brock-Utne, John Muir Hospital East Bay
Jung Hong – Maracaibo, Venezuela; Cosmin Guta, General OR, Stanford
Heidi Witherell – Ecuador; Fred Mihm, ICU Stanford

Dr. Cindy Weller is happy to graduate.
The Department has made going on missions a priority. We feel this is an important education for residents as physicians of the world. As you can see, the mission experience continues to be popular. My sincere thanks goes to Anthony Stanzi, Chief Resident, whose job it was to coordinate and organize these trips. He did a most spectacular job. Gary Ruggera, a past resident, has been very supportive of our residents going on trips with his organization, Medical Missions for Children. Thank you, Gary.

Although you may think that we have enough organizations to take our residents on missions, we are always looking for more groups to take our residents to faraway places. If you know of any groups/organizations that would be interested in having enthusiastic, well-trained residents participate, please let me know via e-mail at brockutn@stanford.edu.

Dr. Fred Mihm, with assistance of Geoff Lighthall, Michael Chen (you should see his nice ped's handout), and Larry Chu, has now produced the 8th edition of the very popular Stanford Anesthesiology Resident Guide. It was originally the joint brainchild of Drs. John Calabrese (resident) and Fred Mihm. The first edition came out in July 1999. For those of you who have not seen it, this pocket-sized handbook is updated every year and is a great benefit to the residents.

In February 2006, Neetu Ahluwalia organized the 2nd annual weekend ski trip for the residents. By all accounts it was a lovely party. The weather and skiing were fantastic. Thanks to Neetu for his flawless organization of this event for the second year in a row. He did a most wonderful job and made a lot of people happy. It is also important to remember and thank profusely the many faculty and fellows who looked after the “shop” while the residents played.

The 4th Annual Stanford Anesthesia Golf Tournament was held on the 30th of April under near ideal conditions. We had 20 players and it was a great success. The winning team consisted of Barry Waddell, Stephen King and his wife Diana, and Dr. Eng who got a score of 65. This was the Santa Clara Valley team, and they beat the 2nd place team (Scott Rudy [a previous two-time winner of this event], Michael Bigelow, Ivar Brock-Utne, and deputy greenkeeper (John Brock-Utne) by one stroke. The longest drive for the men was Scott Rudy, beating Michael Bigelow by less than a foot.

The longest drive for the women was Sherma Zacharia, and closest to pin was won by the deputy greenkeeper's wife, Sue Brock-Utne. Our sincere thanks go to ESP Pharma for partially sponsoring this venture. Drinks and a lot of different snacks (tacos) were enjoyed under the trees near the 18th green. We had a great time, and if you are interested in playing next year, please let me know.

We are still very fortunate that so many of our alumni participate as Adjunct Clinical Faculty (ACF) in the education of our residents, either in the form of working with them in the OR at Stanford, examining them in our mock orals, or taking them on missions to foreign lands. We acknowledge the following ACFs for their hard work and dedication to our department during the last academic year. (If I have left someone out of the lists below, I am very sorry and it won’t happen again. Please send me an e-mail and we’ll correct it in the next edition):


Mock Orals: (in brackets is the number of times they participated. The maximum per year is 4) Rhett Atkinson [4], Ed Baer [2], David Berger [3], Brian Bohman [2], Greg Botz (Houston, TX) [2], Arne Brock-Utne [2], Mike Champeau [3], Steve Fisk [2], Dan McFarland [4], David Newswanger [4], Bridget Philip [2], Charles Wang [4]

Overseas Missions: Arne Brock-Utne who took Damian Horstman to Nicaragua

Stanford Pain Clinic: Peter Abaci, William Brose, Steven Feinberg, Michael Leong, John Massey, Annu Navani, James Shaw

Should you wish to become an Adjunct Clinical Faculty, please contact Kim McMaster at mcmaster@stanford.edu. An ACF appointment requires 100 hours of teaching activity per year, which must directly benefit the Department of Anesthesia, Stanford School of Medicine or SUH/LPCH Hospitals. Teaching, mentoring, research or administrative service are acceptable. Clinical work where the Department bills and retains clinical earnings is also acceptable. Here is the link to the on-line Faculty Handbook that explains more about the ACF appointment: http://www.med.stanford.edu/academicaffairs/handbook/chapt6.html

Kent Garman is the Chairman of our Department's ACF Committee.
We are very proud of Damian Horstman, MD, PhD who got the SEA/HVO (Society for Education in Anesthesia and Health Volunteers Overseas) Traveling Fellowship Award for 2006-7. He will spend four weeks in the fall teaching anesthesia in Tanzania. This is the first time a Stanford resident has received this prestigious award. Well done, Damian. My thanks go to Alice Edler who suggested he apply.

Drew Patterson organized the 4th Annual Stanford Anesthesia Resident Refresher Course in June. As in the past, faculty covered resident clinical duties so that all the residents could attend. At the request of the residents, the number of Question/Answer Sessions was increased with the help of the REPLY audience participation system.

Always upbeat and happy, they managed to keep the “boat upright.” They also arranged many happy hours after work that were well attended by residents and faculty. The department generously supported this. Our new chiefs are Jennifer Marcus, Eric Smith, and Chris Tho. This is the first time the department has had three chiefs. This increase reflects the increased complexity of the job and the increased number of rotations and number of residents. They have settled in remarkably well and are doing a splendid job.

So this is the year that I am going to pastures. I am taking full retirement in September 2006 and coming back for half-time in January 2007. It will be a change, but I think I am ready. I am very confident that the day-to-day management of the residency will be in the best of hands.

In conclusion, I have a most wonderful job. Eager, enthusiastic, and happy residents surround me. They work and play hard. Did you know that Karin Kliska rides a 750cc motorbike? One of our new chief residents, Jennifer Marcus, flies F16 fighters. But let there be no misunderstanding. These young people are among the very best trained anesthesiologists in the country. We are very proud of them and we, the surgeons and the nursing staff, will sorely miss them when the first of July comes around.

Stanford Anesthesia News

A Biography of Richard Mazze
by Kevin Fish and Jeffrey Baden

Dr. Richard Mazze was born in New York City in 1934. He obtained his BA from Columbia University and his MD from the State University of New York, Downstate Medical Center in 1959. His internship was at Brooke Army Hospital in San Antonio, and he completed his residency in anesthesiology in 1963, at the Walter Reed Army Hospital in Washington D.C. After residency he continued in the US Army for five more years serving in Germany, Pennsylvania, and Washington, D.C.

In 1968, Dick left military service with the rank of Lt. Colonel, and moved to Stanford University School of Medicine as Assistant Professor of Anesthesia. He was a major force in the design and construction of the post-1989 earthquake, state-of-the-art, Palo Alto VA Medical Center. He was also responsible for many improvements in patient care including formation of a multidisciplinary ICU Service that still remains under the direction of a member of the Anesthesiology Service. He became Professor Emeritus in 1999, but as of 2006 is still teaching and practicing anesthesia part-time at the VAPAHCS.

Dick’s interest in research was evident early in his career. While in the Army he was one of the first to report succinylcholine-induced hyperkalemia in neurologically damaged casualties returning from Vietnam (Anesthesiology 31:540-7, 1969). However, his work in peri-operative renal function and anesthetic toxicity was the hallmark of his Stanford career. In 1971, with Jim Trudell and Michael Cousins, Dick published in Anesthesiology (35:247-52, 1971) what has become a landmark paper in anesthesiology, detailing the relationship between the volatile anesthetic, methoxyflurane, and its metabolism to inorganic fluoride, a potent nephrotoxin. (In fact, this paper will be featured in the October 2006 issue of Anesthesiology in the Classic Papers Revisited section.) For the remainder of his career, he studied the toxicity of volatile and gaseous anesthetic agents, publishing over...
A Biography of Richard Mazze
(continued)

130 articles in the scientific literature. One of the most important was a landmark registry study of reproductive outcome (no effect attributable to anesthesia) in 5,405 women having non-obstetrical operations during pregnancy (Amer J Obstet Gynecol 161:1178-85, 1989).

An additional administrative accomplishment was Dick’s tenacious pursuit of research space and faculty positions for the Anesthesiology Service at the VA, allowing many junior faculty members to launch their research and academic careers. Among others, these junior faculty included many now well-known individuals such as Jeffrey Baden, Michael Cousins, David Gaba, Mervyn Maze, Don Stanski and Steven Shafer, who went on to develop outstanding programs, many of which are still productive today. Dick also had a keen eye for clinical talent, luring Frank Sarnquist and Kevin Fish to the VA, where they ran the clinical service for many years.

While those are the facts about Dick Mazze’s academic life, they only tell a small part of the story about someone who has inspired many individuals during his career. On the local front, his talents as Chief elevated the Anesthesiology Service at the Palo Alto VA to its current position as one of the premier departments in the VA system. As Chief of Staff of the VAPAHCS, his vision and persistence led to drastic changes in many areas, including the introduction of outpatient surgery many years, before any other VA. He handled all challenges and conflicts with dedication and integrity until they were overcome or resolved. He thus was able to prepare the VAPAHCS for the 21st century and enhance its reputation as a leading Medical Center throughout the country. Within the Stanford Department of Anesthesia and the Stanford Medical School, his outstanding leadership qualities were apparent while he performed numerous academic roles. Nationally, his keen eye for clinical talent, luring Frank Sarnquist and Kevin Fish to the VA, where they ran the clinical service for many years.

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On the personal side, Dick has lived on the Stanford campus during his Stanford career. He is an ardent supporter of Stanford athletics and almost never misses a home football, baseball or men’s basketball game. He and his wife, Sheila Cohen, have a combined seventy years of service in the Stanford Department of Anesthesia.

Dick is one of the most highly respected figures of American anesthesia. Numerous accolades and awards have been showered upon him over his academic lifetime. His thirty-seven-year career in the Stanford Department of Anesthesia truly has been outstanding.

Editor’s note: Dr Mazze tells us, “I go cycling in the foothills most everyday. I have been fortunate enough to have had three sabbatical leaves in France. I’ve been blessed with good health and a most enjoyable job at Stanford. One of the best aspects has been … the privilege of working with many wonderful people.”

Stanford Anesthesia News

Obstetric Anesthesia Update
By Ed Riley

Labor and Delivery continues to be a busy service. We again had over five thousand deliveries and, following the national trend, our Cesarean delivery rate is now between 25% and 50%. With this wealth of clinical material, the rotation continues to provide a valuable learning experience for our residents, fellows, and medical students. Additionally, we now have three residents assigned to do obstetric anesthesia each month and two fellows who split their time between teaching, research, and clinical care.

We currently have five core faculty in the OB anesthesia group. Sheila Cohen, Steve Lipman, Brendan Carvalho, Jeremy Collins, and myself. With the varied interests of the members of the group, we have been able to consistently improve the service performance, teaching, and research endeavors.

Jeremy Collins has a special interest in emergency airway management. He has improved our preparedness for airway disasters in OB in several ways. He has organized and improved the equipment in our difficult airway cart. We now have a video fiberoptic scope and a video laryngoscope. The video component of these scopes helps the Attending teach and assist with intubations (not to mention the added comfort level an Attending feels by being able to watch what is happening). Most important, Jeremy teaches emergency airway management to the residents in a more sophisticated manner than we have ever been able to in the past.

Steve Lipman is continuing his work in simulator-based education. We now have residents getting certified for Neonatal Advanced Life Support via a simulation-based course. In addition, Steve is developing a simulation-based training session for multidisciplinary management of obstetric emergencies. The residents are participating in the development of these sessions.

Brendan Carvalho’s speaking career is blossoming, as he has been invited to speak at major obstetrical anesthesia meetings throughout the world. His next major speaking event will be the Summer Update on Obstetric Anaesthesia, a joint meeting organized by the Society for Obstetric Anaesthesia & Perinatology and Obstetric Anaesthetists’ Association, held at Trinity College, Dublin, Ireland in August, 2006. Brendan’s research career is also taking off. He was awarded an NIH grant that will assist his research on cytokines and their relationship to acute and chronic pain after Cesarean delivery. We are also excited that Brendan will be collaborating with David Clarke and Martin Angst, two basic pain researchers in our department.
This collaboration allows Brendan to bridge the gap between bench science and clinical medicine. This translational research is challenging, but it holds great promise for advancing clinical care in the future.

Alex Butwick completed his fellowship last summer and stayed on as a part-time faculty for a few months before heading back to England to further his training. This last spring he won the award for the best paper by a fellow at the annual meeting of the Society for Obstetric Anesthesia & Perinatology. He is going to be coming back to Stanford in late 2006 to join us on the faculty. We are looking forward to his return.

Sheila Cohen continues to be an integral part of our team and valuable mentor to all the members of the group. Her wealth of experience, contacts, and wisdom has helped each of us in our careers. She is a particular favorite amongst the residents - whenever I run into former residents, they always tell me that the lessons they learned from Sheila are ones they use in their practice every day.

As you can see, the division has grown and now offers a wider range of experiences, both educationally and research wise.

As a Board approved specialty, we have created a high-risk OB anesthesia clinic. The intent is for us to see any patient that is high-risk or complicated in any manner as far as anesthesia is concerned. This gives us time to come up with a sensible and workable plan before the patient arrives on Labor and Delivery ready for a Cesarean delivery or epidural for labor.

After these patients are assessed in the clinic, we have a multidisciplinary meeting with the OB department and discuss the patients. This helps us to understand our complicated patients better, and the meetings improve communication between the services with regard to the high-risk patients.

What is the high-risk OB clinic?

The high-risk OB anesthesia clinic is held over in the OB/GYN clinic building every Wednesday afternoon. It is run by one of our OB anesthesia fellows. Patients are referred to the clinic by their obstetricians. The intent is for us to see any patient that is high-risk or complicated in any manner as far as anesthesia is concerned. This gives us time to come up with a sensible and workable plan before the patient arrives on Labor and Delivery ready for a Cesarean delivery or epidural for labor.

After these patients are assessed in the clinic, we have a multidisciplinary meeting with the OB department and discuss the patients. This helps us to understand our complicated patients better, and the meetings improve communication between the services with regard to the high-risk patients.

What were the circumstances leading up to its establishment?

The high-risk OB anesthesia clinic was started in late 2004. It was the brainchild of one of our fellows, Dr. Leslie Andes. Without her inspiration and perseverance this clinic would not have been established. Leslie was frustrated with the ad hoc way that we were seeing high-risk patients. We encouraged the obstetricians to send the complicated patients to see us on the Labor and Delivery floor. This was great, and the obstetricians appreciated the service. However, the patients would show up somewhat randomly and would be seen by whoever was available.

Sometimes the fellow was working in the OR that day or busy with something else and the resident or Attending would see the high-risk patients. Other times we were too busy to see the patient, and she had to wait to be seen or was told to come back another time. Another problem was that information about the patient was not always communicated to the fellows very well. Since the fellows coordinated the care of the high-risk patients, this was a big problem. Communication was also poor between the services. Leslie felt that we could do a better job of coordinating the system, so that fewer patients fell through the cracks, and she was correct. The system is working very well now.

What are your role and responsibilities in the clinic?

My role is to make sure the fellows are able to staff the clinic, provide back-up consultation for the very difficult cases, and attend the high-risk multidisciplinary meetings.

Can you give an example of a success that was a direct result of now having the clinic?

It is hard to point to a specific high-risk patient and say that she would have slipped through the cracks or shown up in the middle of the night without a proper work up and plan for her anaesthetic care, but we definitely have fewer cases of that happening now. In addition, I think we have more thoughtful and thoroughly researched care plans now. I truly believe the clinic is helping us deliver better care. The only real challenge is that we lose some of our flexibility on Labor and Delivery, when we send the fellow over to the clinic. When that person is gone, it is more difficult to get the residents out for Wednesday conference or have some uninterrupted time for teaching.

What are the clinic's future goals?

The immediate goal is to get all of the private OBs to send their high-risk patients to the clinic. All the high-risk patients from the Stanford clinic are sent to the clinic, but I think we see only about 70% of the private patients. We just need to make the private obstetricians more aware of whom they should send to us and educate them on how this helps us take better care of the patients. Eventually, it might be nice to see all the pre-op Cesarean patients in clinic.

Stanford Anesthesia News

Obstetric Anesthesia Update

(continued)

Announcements

J. Kent Garman receives the California Society of Anesthesiology 2005 Distinguished Service Award

On an annual basis the Committee on the Distinguished Service Award reviews the nominees for the CSA’s highest award, only one of whom can be presented to the House of Delegates for consideration. The Bylaws specify that a recipient be an individual who has demonstrated outstanding and meritorious service to anesthesia and the CSA.
Since the inception of the Distinguished Service Award in 1974, there have been only 20 such individuals deemed worthy of this prestigious recognition. The CSA House of Delegates voted unanimously to present to Dr. J. Kent Garman, the 21st such honoree, the CSA’s Distinguished Service Award in recognition of his outstanding contributions to the California Society of Anesthesiology organization, to our specialty of anesthesiology, and to the myriad of other activities in which he has participated.

Al Hackel Receives The Robert M. Smith Lifetime Achievement Award

by Elliott Krane

Frequently we work so closely with a person that we fail to recognize the magnitude of his accomplishments. Today we honor Al Hackel, MD, who was awarded the Robert M. Smith award for lifetime achievement and contributions in pediatric anesthesia at the annual, combined winter meeting of the Society for Pediatric Anesthesia (SPA) and the Anesthesia Section of the American Academy of Pediatrics (AAP).

This prestigious award is given only when the AAP anesthesia section’s governing body deems an individual worthy of receiving it. Al is such a worthy individual. Not only has he played a vital role in developing the SPA and AAP, but he has catalyzed ACGME’s recognition of pediatric anesthesia fellowship training.

Moreover, Al has led the field in developing local, state, and national standards—in both fellowship training and in the perioperative care of children. That few of us realize Al’s contributions speaks to his humility. Al has worked tirelessly behind the scenes over decades to make anesthesia safer for children, not just at Stanford, but also nationally and internationally. Despite his retirement from active clinical duty, he continues to imagine and innovate, as he explores the role of simulation. Congratulations, Al.

Audrey Shafer Publishes Children’s Novel

Audrey Shafer has written The Mailbox, a children’s novel (ages 9 and up), due out Oct 10, 2006 from Delacorte at Random House.

Here’s the jacket copy:

Vernon Culligan has been dead to the town of Drayford, Virginia so long that when the crusty Vietnam veteran finally dies, only one person notices. Twelve-year-old Gabe grew up in the foster care system until a social worker located his uncle Vernon two years ago. When he comes home from school to discover that his uncle has died, he’s too stunned to react—so he does nothing. But the next day, returning from school, he discovers a strange note in his mailbox:

“I have a secret. Do not be afraid.”

And his uncle’s body is gone. Thus begins a unique exchange between Gabe and a secret correspondent. Flashbacks reveal how Gabe and Vernon’s relationship changed their lives, and how war affects soldiers, even decades later. Eventually, Vernon’s death will be discovered, and Gabe and the mystery note writer must learn to move forward. The Mailbox is a touching and beautiful story about connections—and about how two people in need can save each other.

Audrey Shafer was educated at the Philadelphia High School for Girls, Harvard, Stanford and the University of Pennsylvania. She is honored to work at the Veterans Affairs Palo Alto Health Care System as an associate professor of anesthesia, Stanford University School of Medicine. She and her two fantastic teenagers have two large dogs and a cobwebby mailbox. The Mailbox is her first novel.
An Interview with John Ahlering, Adjunct Clinical Faculty for Two Decades

by Cliff Schmiesing

After three, long, underpaid, overworked years as a Stanford anesthesia resident—not to mention the five previous years in medical school and internship (and sizeable accumulated debt)—it is understandable that so many graduating residents opted to leave Stanford to begin careers elsewhere in private practice and other academic institutions. However, time has a way of softening the harder edges of residency. The interest and desire to reunite with Stanford and to give something back is what motivates some anesthesiologists to return to Adjunct Clinical Faculty. At Stanford, Adjunct Clinical Faculty are appointed by chairs in clinical departments for the purpose of participation on a voluntary, part-time basis, usually in the role of teacher. John Ahlering, an Adjunct Clinical Faculty for over fifteen years, recalls his two-year residency in Anesthesia as one of the best times of his life. His involvement with Stanford is long and colorful.

John wanted to make his own way when he entered Stanford as an undergraduate in 1969. Of note, John’s father became an anesthesiologist in the early 1960s at the age of fifty and with seven children at home! John paid his way through college, working full-time evenings as a stocking clerk in a Menlo Park grocery store. Although these were tough times financially, tuition at Stanford amounted to only one quarter of his salary. Today, it’s hard to imagine paying for room and board alone on what a clerk makes. Also, the campus was a different place then. American involvement in Vietnam, the student movement, and protests were tangible forces on campus.

Oddly enough, medicine—anesthesia in particular—was at the bottom of his initial career list. While an undergraduate, he worked in Ellis Cohen’s lab with Drs Kendig and Trudell, analyzing metabolites of halothane in human livers from deceased donors during the early years of Shumway’s heart-transplantation program.

After graduation from college, he attended UCSD’s Medical School. John returned to Stanford as an anesthesia resident (1978-80). He recalls these two years fondly, becoming part of the “Stanford family” in a way he had not as an undergraduate. To be sure, residents worked hard then as the program was very compressed. Even then the Attending would disappear for prolonged stretches during cases. There was no preop clinic, so nearly all patients were admitted the night before, even for cataract surgery, and residents were expected to see them on the wards after completing their cases. Leaving the hospital before eight or nine PM was unusual. Cardiac surgery and cardiac anesthesia were still developing. John recalls spending many nights in the hospital caring for his postop heart patients. This allowed him to develop experience and skills that served him well after residency. In addition to all these responsibilities, he served as the chief resident during his second year. However, residency was not all hard work—he had season football tickets.

At the time, the real estate boom was just beginning in Silicon Valley. The Ahlerings purchased their first home in Midtown Palo Alto for ninety thousand dollars, and then watched it more than double in value in just two years. At that rate, he made more money sleeping at night in his own home than in the hospital call room.

Many of our present senior faculty members were junior at that time, and faculty and residents frequently socialized together. John recalls poker nights played with residents and faculty, including Kent Garman, and happy hours in local watering holes with Stanley Samuels and Jay Brodsky—a tradition that continues. John named his first child after Kent Garman.

John shared some interesting General OR history with me. Charles Whitcher had an early electronic anesthesia-recording device by which he could reconstruct the events of a case, including a detailed analysis of resident errors in anesthetic administration. Then as now, Kevin Fish knew the anesthesia machine backwards and forwards. John recalls being grilled on every last patient detail while on ICU rounds with Tom Feeley.

Interplast was in its early years and fostered especially collegial relations between plastic surgeons and the anesthesia department. The newer portion of the hospital that contains the Main OR was added at this time, and John offered an explanation for the puzzling Ambulatory Surgery Center ramp. This was the first health care project for the architectural firm that designed the hospital addition in the early 1980s, and they did not take into account the more exacting seismic requirements for hospital construction. As a result, the design for the floors was too thin. This error was not corrected until too late and evening out the old and new hospitals required “fudging” with ramps on the second floor. This also led to the shortest elevator ride in the world—barely half a floor.

After completing his anesthesia training, John moved back to San Diego where he joined a large private practice group, focusing on cardiac anesthesia for the next twenty-five years. Raising five children, more inpatient preops, and more nights in the cardiac ICU watching over sick postop heart patients made returning to Stanford to serve as an Adjunct Clinical Faculty impossible. However, in 1990 John left his group to practice independently, which gave him more control over his time. He was able to return to Stanford for two weeks each year, as well as play a bigger role in the lives of his children and take on responsibilities outside the hospital in his community, where he currently serves on several boards including support for the San Diego Zoo.

On the face of it, being an Adjunct Clinical Faculty is not a lucrative undertaking; it’s more like a charitable donation without the tax break, when one considers lost income. John admits this is a consideration but has gained real benefits over the years. He gets a “free” continuing education working with the residents. “They take for granted things you didn’t even know.” The opportunity to work with senior residents whom he worked with during their first year is enjoyable as well, especially to observe development of their skills over time. While he rents a bicycle and cycles to the hospital and around campus. John shares his opinions freely with the residents and tries to present a picture of what private practice is like compared with an academic one, which includes a healthy dose of reality as seen from his perspective (e.g., being stuck in tough cases going well beyond twelve hours without a bathroom break, let alone being relieved to go home, or feeling obliged to purchase Christmas gifts for over 40 of his surgical colleagues as a gesture of good will and good business).
An Interview with John Ahlering
(continued)

But being an Adjunct Clinical Faculty does have some fringe benefits. The department provides lodging and a small meal stipend. John Ahlering is truly part of the Stanford family. He has served as past president of the Anesthesia Alumni Association. He even helped rebuild the VA Palo Alto Hospital, indirectly. His brother-in-law, who remains the Secretary for Veterans Affairs, wrote the multimillion-dollar check to Dick Mazze who was then Chief of Staff at the VA to rebuild the hospital following the devastating destruction caused by the Loma Prieta earthquake in 1989.

John has also devoted a significant amount of time and effort to overseas anesthesia, particularly in India. John’s idea of a great vacation involves the practice of anesthesia in some location away from his home in San Diego.

Speaking with Dr. Ahlering, I realized how hard he has worked in all his many endeavors and the effort he devotes to maintaining his relationship with our department. The Stanford Anesthesia Department really is a big, but not so very big, extended, interconnected family. It is perhaps too easy to let time, geography, career, and family obligations increase our sense of separation from the Stanford Anesthesia community. The opportunity to work with great people has always been an important reason that I work here at Stanford. John is one such individual. On behalf of the Department of Anesthesia, I would like to thank Dr. Ahlering for his generosity, enthusiasm, and commitment, past and present, to Stanford and the Anesthesia program.

Western Anesthesia Residents Conference 2006
by John Brock-Utne

The 44th Western Anesthesia Residents Conference (WARC) was held at the Cliff, Snowbird, Utah from May 5th-7th of 2006. It was hosted by the Department of Anesthesiology at the University of Utah under the leadership of Michael K Cahalan, Professor and Chairman. The format this year was different and I think much better. The conference started on Saturday morning with all residents required to present their work/case reports in the form of a poster presentation. There were 109 presentations divided into three Poster Sessions on Saturday from 8 am to noon. After that there was no organized activity. During the poster session, each presenter was asked by a group of judges to give a five minute presentation of his or her abstract. Those associated with the 12 top-scored abstracts were invited to present their work on Sunday morning as an oral Power Point presentation. The top three residents were awarded prizes, and the remaining 9 received diplomas.

Many of you who attended WARC while at Stanford will remember that a large proportion of the residents got to give oral presentations that were scheduled anytime from early morning to 5 pm on Saturday and early morning to noon on Sunday. There were also poster sessions on both days. This meant that WARC was a very busy and intense weekend for all. However it was not always like that.

Dr. Cahalan reminded us that the first WARC he attended at Breckenridge, Colorado in 1979 was like the one he arranged now at Snowbird. After the morning presentations, some of us went skiing. It was fantastic with blue skies and a lot of snow. There was a lot of snow, since Snowbird is at 8000 feet and the cable car took us to 11500 feet. I met and skied with Jeff from Florida. I thought I was reasonably safe skiing with someone from Florida. Boy was I wrong! This guy was a terrific skier.
At this year’s WARC the department was very well-represented (see picture, from left to right JBU, Damian Horstman, Jim Wong, Einar Ottestad and Jung Hung). Ron Pearl and Larry Saidman also attended, but they were unavailable for the picture. Damian and Jung presented a case report each, while Einar and Jim presented research. We also had the charming company of one of our Chief Residents, Jennifer Marcus, who attended the Chiefs’ Dinner Meeting on Friday evening.

Of the 4 residents who participated, 3 got prizes. Einar and Jim were included in the 12 finalists. Jim came 3rd for his work entitled “The Beta2 Adrenergic Receptor PDZ binding motif: Assessment of its role in cardiac protection.” This was done in association with among others Brant Walton and Drew Patterson. Jim’s paper was also chosen as one of the eight best California Resident research papers. He was invited to the annual California Society of Anesthesiologist meeting and got again 3rd place. A wonderful achievement.

Einar’s presentation, done with Geoff Lighthall, was titled: “A scoring system to evaluate the management of septic shock. Is it useful?”

Damian got first prize for his case report entitled: “TEE monitoring of intracardiac thromboses following FEIBA in a cardiac surgery patient.” The other authors on his case report were: Chris Thu (another chief resident), Christina Mora Mangano and Pieter van der Starre.

Saturday night was the usual gala dinner, with a guest speaker Jennifer Jordan, an award-winning author, filmmaker and screenwriter, with years of experience as a journalist. She entertained us with extracts from her book: Savage Summit: The true story of the first five women who climbed K2. It was very interesting.

After that a 5-man band struck up with music like the U-2 and the Beatles. Much to our amusement, 4 of the 5 band members were Anesthesia residents from the department at Utah. The fifth was one band member's father on the saxophone. He was wonderful. The Stanford group occupied the dance floor to the very end. We all had a lovely party. Just ask them.

In May of 2007 the WARC will be in Sacramento. When will Stanford host the WARC? Well it is not before 2020.

This 44th WARC was the best format I have seen in my 18 years of involvement with WARC.

Stanford Anesthesia News

A Biography of Stanley Ian Samuels
by Jay B. Brodsky

Stanley Ian Samuels was born on January 15, 1939 in Belfast, Northern Ireland, the only child of Basil and Stella Samuels. His mother died when Stanley was only 3 years old, so his father moved him to Dublin, Ireland to live with his childless aunt and uncle, while his father continued working in Belfast. Basil would take the train from Dublin to Belfast every weekend to be with Stanley.

Sadly, his father died just 4 years later, and Stanley's only childhood memories are of life in Dublin.

His early education was exclusively in Dublin, where he received a B.A. degree from Trinity College in 1960, and his medical M.B. degree in 1962. It was during that period that he met another medical student at Trinity College, John Brock-Utne, the first of several meetings in Ireland and England with people who would eventually find their way across to our Stanford faculty.

Stanley originally planned on a general medical practice, so he immersed himself in learning internal medicine, pediatrics, and obstetrics. He was senior house officer in emergency medicine (Meath Hospital, Dublin in 1962), senior house office in general medicine (Meath Hospital, Dublin in 1963), and intern in obstetrics (Maternity Hospital, Hull, Yorkshire, England in 1964-1965).

He became a Diplomate in Obstetrics from the Royal College of Obstetricians and Gynaecologists in London, England in 1964.

In 1966 he was awarded an M.A. degree from Trinity College in Dublin. Although to an American reader this may sound impressive, Stanley informs me that this degree is basically bought (“proceeded” in English terminology) by the recipient, after paying for a good dinner and drinks.

Between January 1965 and June 1968 Stanley was a general medical practitioner in Dublin, with an appointment as Clinical Assistant in paediatrics at the local hospital.

In 1966, his friend, a dentist named David Harris, asked Stanley why he didn’t do anaesthetics—and after all he said, it was “easy and profitable.” Those two points appealed to Stanley. However, realizing that he knew next to nothing about anaesthetizing anyone, Stanley prudently sought and received special training at a local Dublin hospital.

Apparantly you didn’t have to match for a residency in Dublin in 1966.

Stanley enjoyed anaesthetics, so he continued as a resident in anaesthesia at Addenbrooks Hospital, Cambridge, England from July 1968 to July 1969. It was then that he met his future wife, Lesley Sayles, who was completing her orthodontics residency in Cambridge.

Stanley was involved in the first liver transplant in England—a fact that he withheld from Harry Lemmens, when Harry was organizing the anesthesia coverage for the Stanford Liver Transplant program.
A Biography of Stanley Ian Samuels
(continued)

This being England, he continued to transfer from one training position to another. He was resident in anaesthesia at Queen Charlotte’s Maternity and Chelsea Hospital for Women, London (1969-1970), St. Thomas’ Hospital, London (1970), and Magill Department, Westminster Medical School, London (1970-1971). At Westminster he shared call with two fellow anaesthesia residents, Sheila Cohen and Jeffrey Baden. Another coincidence—Lesley’s roommate, in London, was Sheila Cohen. He remembers a bearded, hippie-appearing visiting professor lecturing at Westminster—that visitor was, in fact, the then hippie-anesthesiologist and future colleague Richard Mazze.

Between breaks in his anesthesia training, he would spend time moonlighting as a ship’s doctor on cruise liners. The tuxedoed young Doctor Samuels would entertain passengers at his own Doctor’s Table for dinner. During the interview preparing for this article, he refused to go into further detail about the life of a single, eligible doctor on a cruise ship at his own Doctor’s Table for dinner.

Stanley earned a Fellowship (A.B.A. equivalent) from the Faculty of Anaesthetists, Royal College of Surgeons, Dublin, Ireland in 1971, and continued on as Chief Resident in Anaesthesia, Middlesex Hospital, London from December 1971 to February 1973.

Anyone who knows Stanley has heard his many anecdotes. My favorite is the episode with Lady Jane Vane Tempest-Stewart, the then fiancée and later wife of the Aga Khan, multimillionaire and spiritual leader of the world’s Ismaili sect of Muslims. She required minor surgery one evening, and Stanley was the junior resident on-call for anesthesia. Lady Jane was meeting the Aga Khan later that evening in Geneva, so surgery could not be delayed. Stanley’s Attending, the famous H.C. Churchill-Davidson had dinner plans that apparently were more important than Lady Jane’s operation, so he left Stanley on his own. Stanley remembers the surgeon (and part of the story is the aristocratic, condescending surgeon’s accent) describing the patient as having “a little bit of a chest infection…” but it should be nothing to a man of your experience, Samuels,” Lady Jane survived.

In March of 1973 Stanley was hired by the chair of the Stanford Department of Anesthesia at the time, Phil Larson, to come to Stanford as a Physician Specialist in the Anesthesia Department. The appointment was to be for one-year. Lesley, having completed her training, joined him, and they were married in 1973.

As is often the case in our department, his one-year appointment changed into a 30-year career at Stanford—Assistant Professor (1974-1980), then Associate Professor of Clinical Anesthesia (1980-1989), and finally Professor of Anesthesia (Clinical) (1989) until his retirement in 2004.

Although Stanley published many clinical papers and book chapters, his clinical skills and popularity in the operating room are what he is best remembered for. When he and I were the only two “schedulers”, he was always the “good cop” to my “bad cop.” Every once in a while, but not very often, we would change roles and really confuse the anesthesia residents, surgeons and nurses.

With the aid of his secretary, some-times co-author, but always “sister” Aud Pullens, Stanley founded and served as chairman of the Association for International Development in Anesthesia, an organization well remembered for the annual party it hosted at American Society of Anesthesia annual meetings. Stanley also served as a member of the American Committee of Representation and delegate to the World Federation of Societies of Anaesthesiologists, and as chair of the Overseas Teaching Program in Anesthesia. He was also President of the Arthur E. Guedel Memorial Anesthesia Society.

The unlikely combination of Richard Jaffe and Stanley Samuels conceived, edited and continue to edit the Anesthesiologist’s Manual of Surgical Procedures, an extremely popular book, soon to be in its fourth edition.

Stanley was an early, and frequent, volunteer with Interplast, Inc., the organization established by Don Laub to provide reconstructive surgery and anesthesia for children in developing countries. Up until recently, he continued to travel the world using his teaching and clinical skills to help children in need. Many of our residents have had the good fortune to accompany Stanley on these trips where they’ve learned to perform anesthesia under primitive conditions.

If a child with complex problems required surgery, Interplast would bring that patient to Palo Alto. Because funds were scarce, procedures were performed in the local surgeon’s office. Stanley and I were involved in what was perhaps the first pediatric out-patient, toe-to-finger free-transfer, in Don Laub’s office on Welch Road in the early 1980s. (In those days anyone was allowed to do pediatric anesthesia). Stanley served on the Interplast’s Anesthesia Committee until his retirement.

He retired from anesthesia practice in 2004. Luckily, Lesley Samuels continues to have a thriving orthodontics practice in Palo Alto. They are blessed with three wonderful children, Ben (born 1976), Josh (1979) and Emma (1982). Emma is a second-grade teacher at her alma mater, Keys School in Palo Alto. Josh is earning his PhD in archaeology at Stanford University, and Ben (with talents obviously inherited from his father) has used his expensive degree from Brown University to become a performing actor/musician/clown in London.

Stanford Anesthesia News

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In retirement, Stanley has gone back to general medical practice, volunteering his time at the Samaritan Clinics in Redwood City, working with Norman Rosenstock, retired anesthesiologist Lynn Rosenstock’s husband. After studying Spanish for over 20 years, he can now understand “buenos días”, “adios,” and “dolor”. He enjoys keeping active on the Internet and through e-mail with the JIGGERS or the Jewish-Irish Interest Group. He also enjoys attending Stanford football games (if “enjoys” is the right word for Stanford football) with Jeff Baden, Dick Maze, and with Mervyn Maze before he left for England.

Unfortunately, Stanley was injured in a serious motor-vehicle accident in March 2006. After a long convalescence, one that continues, I am happy to say that Stanley is now on his way to full recovery; he attended the party for our graduating residents earlier this month. Throughout this entire ordeal, Stanley has remained the Stanley we all remember, never once loosing his sense of humor….unfortunately, for weeks after the accident it really did hurt when he laughed.

What Stanley Samuels did for us was to be that special, unique and wonderful person whom those who worked with him will always remember with love and fondness.

A Biography of Stanley Ian Samuels (continued)
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